VIRGINIA DENTAL Journal

VOLUME 93, NUMBER 4 • OCTOBER, NOVEMBER & DECEMBER 2016

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DR. VINCE DOUGHERTY

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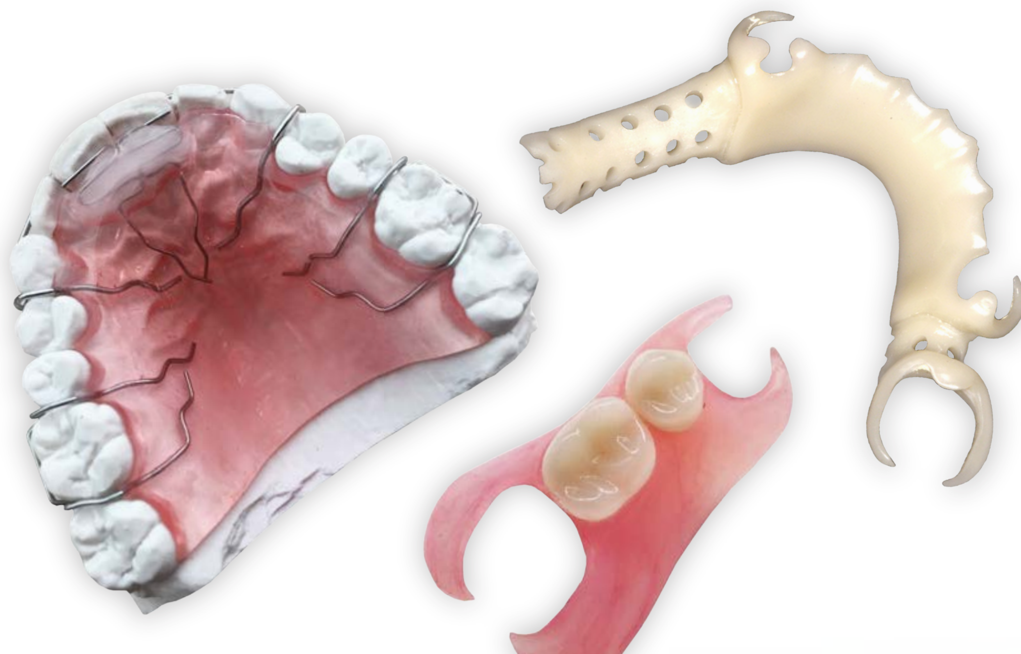

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40 UNDER 40

A feature of the Virginia Dental Journal, "40 under 40" will introduce you to VDA members under forty years old in forty words or less.

DR. CLAIRE DICKEY FARR

I am a third generation "Dickey" dentist in Roanoke where I joined my father's group practice Drs. Lynch, Dickey and Singleton, Inc as an associate dentist. I also work part-time for Smile Virginia providing dental care to children in their schools.

Virginia Dental ASSOCIATION

AADEJ American Association of Dental Editors & Journalists

VIRGINIA DENTAL JOURNAL

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PRESIDENT'S MESSAGE

Dr. Vince Dougherty

I would like to extend a sincere thanks to Dr. Rick Taliaferro for all he has done this past year. It's been an incredible year legislatively under Rick's leadership. He has done an amazing job with the Membership Committee and getting the Ambassador program ready for the big roll out. Having the Facebook VDA member-only group available for the flow of information serves as a closed conduit for our members to gain valuable information and perspective on all aspects of dentistry. Here, we can discuss best practices, dental office management, professional challenges, upcoming events, advocacy issues, continuing education and anything else under the VDA umbrella. I urge all members and especially the younger members to take advantage of this huge benefit.

I have heard repeatedly that The Virginia Meeting is too costly for younger members and makes it difficult for them to be delegates. In addition, many members have expressed their difficulty in taking multiple days off of work. I will immediately initiate a task force to study how we can decrease this meeting by one day. I am hopeful The Virginia Meeting in 2018 will run Friday thru Sunday, thus keeping costs down for all members as well as days out of the office. I see no reason why we can't conduct business on a more expeditious schedule.

My main goal this year will be to make sure all VDA member dentists understand the value of membership and take advantage of everything membership has to offer. I would also like to look for ways to increase the value of membership. I know all of you feel the value of membership and I want to share that value with others.

For me, the value of membership may be different than yours. I personally love the camaraderie of what I feel are the utmost professionals. This is harder to find in a small office. I have served on other boards, but can tell you in dentistry, the level of professionalism is higher than anywhere I've seen. Everyone has a chance to be heard and there is balance on all solutions. I feel we are always moving in the right direction and the answer is always to do the right thing for our patients and our profession.

For many, the value is the incredible advocacy machine we have. Under Rick's leadership we were on the successful side of each legislative item this year. There is no guarantee of this in the future. If you have not seen the *Wall Street Journal* article from several weeks back titled "You don't need to be a dentist to fill a cavity" I urge you to look at this. The *Wall Street Journal* is the most widely circulated newspaper in the country. The article is very pro mid-level provider. There will be more and more pressure for mid-level providers in more states. For this reason, I am for the Ohio Plan. It never hurts to have another feather in our cap when they come knocking on our door and they will. I am also excited to know that all licensed dentists in Virginia will help with the underserved population. This plan will also potentially help redistribute dentists from areas that have too many dentists into areas of need.

It is harder to practice dentistry now more than anytime I can remember. There are more government regulations and pressures from insurance companies. How many times have you heard "This is not a covered service?" The answer is more and more these days. There is pressure from insurance companies to reduce fees. Insurance companies are now trying to diagnose our patients. This is our real red line. There is pressure of overhead, supplies, payroll all going up and fees going down. There is also increased pressure from student debt.

The answer to these problems is to stick together and come up with strategic solutions. Our membership numbers are growing slowly, but we have been losing market share due to the increasing number of dentists. We need to increase our market share to protect the future of dentistry and the future of our patient. I'm asking for your help. The VDA is asking for your help. Most importantly, you should be asking for your own help for your future and the future of fellow dentists.

I have taken the liberty of asking the VDA staff to customize a list of fellow member dentists in your zip code. I ask that when you see them at dental functions, at church, or in your local community, you thank them for caring about the future of dentistry. Thank them for being wise enough to know the ADA disability and life insurance plans are some of the best available. Thank them for contributing to Advocacy through ADPAC. Thank them for wanting to live up to the ADA Code of Ethics. Thank them for wanting to be a part of the tripartite's top notch Continuing Education courses.

You might be surprised to see some dentists you work with closely who are not on the list. You might wonder "why aren't they members?" You might think to yourself "don't they see the value?" "Don't they know that if they have student debt they can get a great rate on refinancing through the ADA?" "Don't they know the ADA is going to bat for them regarding insurance issues?" "Don't they want to be a part of our strong growing family of dentists?"

Please ask them to be a part of organized dentistry! Don't ask because you want to reduce your VDA dues. Don't ask because I'm asking you. Ask because you want to share the value the VDA has to offer. Dr. Al Rizkalla asked me to be a member one day, and here I am. I want to share and grow the value… for our future.

CORRECTION

Correction Virginia Dental Journal Vol 93 #3 July-September 2016: In Dr. Taliaferro's President's Message concerning the addition of another citizen member to the Virginia Board of Dentistry, Dr. Taliaferro stated that 'the bill was carried over to 2017.' The sentence should have stated 'that the bill was passed, but without the language referring to adding a citizen member to the Board of Dentistry.' We regret any misunderstandings on this subject.

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AN INTERVIEW WITH DR. VINCE DOUGHERTY

WHY DOES DR. VINCE DOUGHERTY WANT TO BE VDA PRESIDENT?

I want to be VDA President because we're facing many more challenges than I have seen in my career. I want to show the members who don't know the value of the VDA and also find more ways to create value. I want to create a strong, growing family of dentists that work for the profession and help each other. Camaraderie is a huge benefit and I want people to share in that. There are lots of well-respected leaders – I will work with them and all members to move the association in a mutually agreed upon, direction as time goes on. It is more important now than ever to be at the table guiding all the upcoming forces facing dentistry.

TELL US WHY THIS IS A GREAT TIME TO BE A DENTIST IN VIRGINIA.

For me one of the big reasons is change. I was in practice with my dad and very little changed while he was in the practice. Now we have digital x-rays and impressions, better materials…we're able to do a superior job for our patients. There's a need for us to help our patients. There will be many more positive changes, and technological advances and there will always be a need for good dentists.

WHAT ADVICE DO YOU HAVE FOR DENTISTS WHO WANT TO BE IN LEADERSHIP ROLES?

I think anybody in a leadership role gains more than they give. They gain great assets and knowledge. I love that we work together – we may not agree but we usually come to the right conclusion. Perseverance is a real big thing for me – if there's something you believe in, you have to persevere to get the job done. Consensus is always important. Our role as leaders is to listen to everyone's thoughts. We're here to serve the members. We are a membership driven organization. It's a great thing we have so many available leadership roles and leaders. It helps you in your own practice as well as helping the membership. I always urge younger members to be involved. Their future relies on leadership moving things in the right direction.

TELL OUR READERS HOW THE "AMBASSADOR" PROGRAM WORKS.

For members who have a passion for growing our "family" of members, the Ambassador Program gives them the tools to inform (others) of the value we have to offer. Ambassadors know how to talk to each different group of members. It targets non-renewals, those moving in, and longer term non-members. The program is backed by persona research at the ADA level. We have Ambassadors from all components go out and grow our membership. It's essential for each Component to be active and take ownership of the program. I want to thank (Dr.) Rick Taliaferro for his leadership, for getting this off the ground, and Dr. Elizabeth Reynolds as chair of the Council on Membership for her efforts to get this going.

HOW DO YOU SEE DENTISTRY CHANGING IN THE NEXT 10 YEARS?

I think there'll be a lot of forces moving dentistry in certain directions. Small group practices will be much more prevalent. There will be some integrated models of medical and dental practices. Because of those changes, the things the VDA has to offer will be more important. I wish I could say student debt will go down, but I don't know that is going to happen. It is important that everyone is involved in these changes that help the profession and the patient. Practice models may change – DA2s are not being used, but CDHCs may help guide patients to dentists.

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Not long ago, a young lady headed for her freshman year in college arrived for a recall visit. I asked if she'd chosen a major, knowing that most freshmen haven't thought that far ahead. Without hesitation she replied "Human Nutrition, Foods, and Exercise". Taken aback by her prompt reply, the only comment I could make was that the Obesity Epidemic would make her job opportunities limitless. She agreed.

According to the Centers for Disease Control, one in six children and one in three adults is obese.[1] The CDC also points out that obesity is a risk factor for heart disease, stroke, diabetes, and some forms of cancer. A myriad of cultural, economic, and technological forces underlie the epidemic. Even a layperson knows Americans eat too much, exercise too little, and spend too much time in front of televisions and computer monitors. Obesity impacts not only the practice of medicine, but our dental practices as well.

But how might this malady affect the practice of dentistry? After all, doesn't improved dental health, with declining tooth loss among adults of all ages, and decreasing edentulism, allow patients to consume a healthier diet? It would be logical to assume that obesity would be associated with increased dental caries, but the results of scientific studies are mixed. Some found a positive correlation between childhood obesity and dental caries[2], and others found no relationship.[3] In adults, the results were likewise mixed: some studies found no association between obesity and decay[4], and others concluded overweight individuals had higher rates of dental caries.[5]

The relationship between obesity and periodontal disease may be even more complex. Dursun et. al. found that obesity in young women was significantly correlated with periodontal disease.[6] Song et. al. found that insulin resistance, not obesity, was the determinant for predicting severe periodontitis.[7] And Wilkins et. al. reported that obesity led to periodontal disease, but was contingent on the presence of interleukin-1 genetic variations.[8]

So, is obesity linked to dental disease (caries and periodontitis)? Perhaps. We can be certain that increased Body Mass Index (BMI) does lead to heart disease, degenerative joint disease, diabetes, and obstructive sleep apnea (OSA). Let's consider joint replacements, or arthroplasty. As obesity becomes more common, total joint replacements are often indicated.[9] Some orthopedic surgeons continue to demand antibiotic prophylaxis prior to dental treatment, despite the release of new guidelines in 2015, and dentists must prescribe and confirm patients' compliance before each procedure. Failure to comply may lead to broken appointments, rescheduling, and additional documentation for dental offices.

The relationship between diabetes and periodontal disease is well-documented. Likewise is the relationship between diabetes and obesity. Gallup reports that of the five states with the most reported diabetes, four of the five also have the highest rate of obesity.[10] From periodontal disease to poor wound healing to xerostomia, diabetes complicates many aspects of dental treatment and makes treatment outcomes less certain.

Although it took many years of longitudinal studies to confirm, the American Heart Association now says obesity, as measured by BMI, "independently predicts coronary atherosclerosis".[11] Dental offices must be well-versed in drugs used to treat heart disease and their side effects, such as antihypertensives (xerostomia), calcium channel blockers (gingival overgrowth), and anticoagulants and platelet inhibitors (increased bleeding times and interpretation of INR data). Elevated blood pressure, which is much more common in obese patients, has precluded many dental treatments at the time of appointment.

Many dental offices now provide treatment for Obstructive Sleep Apnea (OSA) with removable appliances, upon the diagnosis and recommendation of a physician. Obesity is a "major risk factor for the development and progression of OSA".[12] Sleep apnea has been linked to hypertension, congestive heart failure, atrial fibrillation, diabetes, and pulmonary hypertension, all of which complicate dental treatment and require additional precaution and preparation on the part of the doctor and staff.

Therefore, whether or not obesity causes dental disease, defined as caries and periodontitis, it makes the provision of dental care more difficult. I haven't mentioned some of the engineering and ergonomic aspects of modern dentistry affected by obesity, such as chair position, airway maintenance, and four-handed dentistry. I find (empirically) that administering an inferior alveolar nerve block is more difficult in obese patients: anatomic landmarks are more difficult to locate. The epidemic shows no sign of abating. "It is easier to change a man's religion than to change his diet", said anthropologist Margaret Mead. Dental offices of the future may need to be designed (and re-designed) to accommodate an increased number of patients with a BMI greater than 30.0 kg/m².

It would seem commonsense to provide nutritional counseling to dental patients, given that there are so many opportunities apart from medical appointments. (Alas, we need not anticipate insurance reimbursement for time spent.) Prospective dental students may consider pursuing undergraduate studies in nutrition, foods, and exercise. If our recall patient seeks a career in dentistry, she'll be well-prepared.

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1 http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html
2 Zaror SC, Sapunar ZJ, Munoz NS, Gonzalez CD. Association between overweight and early childhood caries. Rev Chil Pediatr 2014; 85(4): 455-61
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9 http://health.usnews.com/health-news/patient-advice/articles/2015/04/15/knee-replacements-obesity-and-weight-loss
10 http://www.gallup.com/poll/122405/Obesity-Diabetes-Across-States-Clear-Relationship.aspx
11 http://circ.ahajournals.org/content/96/9/3248
12 Romero-Corral A, Caples SM, Lopez-Jimenez F, Somers VK. Interaction between obesity and obstructive sleep apnea. Chest. 2010: 137(3):711-719

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Following an extensive market review and analysis by the VDSC Board of Directors, VDA Services is pleased to announce ACG as our newest endorsed vendor. Based in Midlothian, Virginia, ACG has a long history of providing wealth management services including retirement plan design and administration services, tax aware investment management and financial consulting for dentists and their practices.

The VDSC had been considering an endorsement of a wealth management firm for some time. These services are essential for dentists and having a trusted vendor that has been vetted by peers can take some of the apprehension out of choosing a firm to assist with challenging financial situations. Taxes destroy a large portion of wealth for high income professionals. ACG's goal is to help member dentists decrease taxes through various advanced financial strategies. At the core, tailored retirement plan design and administration allows dentists to defer thousands of dollars in taxes. Additionally, ACG provides financial planning, tax aware investment management and wealth management to provide direction to the financial lives of dentists.

J. Saunders Wiggins, CFPÒ, AIFÒ President at ACG commented: "Dentists face financial challenges from the get-go. A later career start, potentially high student debt, additional practice debt to start or acquire an ownership interest in a practice and high taxes along the way create immediate and on-going hurdles to financial independence. We understand this and help dentists develop an impactful plan to address their financial concerns and goals. We help them create a vision of their financial future. We help them put their money to work, and worry less about finances, no matter what stage of their financial life cycle they are in."

As part of this endorsement relationship, ACG is offering exclusive benefits to members of the Virginia Dental Association. To learn more about these valuable benefits, contact Sandy at 800-231-6409 or jswiggins@acgworldwide.com. ACG is located at 1640 Huguenot Road, Midlothian, Virginia 23113 and on the web at www.acgworldwide.com/vda.

VDA Services is a service mark of the Virginia Dental Association. VDA Services is a program brought to you by the Virginia Dental Services Corporation, a for-profit subsidiary of the Virginia Dental Association.

LETTER TO THE EDITOR

THE MALADY OF PRESENTEEISM

Dr. Henry Botuck

Presenteeism is not a disease in and of itself, but, nevertheless, it could cause you, your staff, or your patients to become ill. Presenteeism, in a nutshell, is going to work while still infected with a contagious disease. According to the CDC, 68% of workers go to work too soon after contracting a contagious illness and, thereby, potentially spread it around the office and to patients.

With the annual flu season upon us, we are likely to see presenteeism at its zenith. Add to that the norovirus ("stomach flu") and you, or some of your staff, could become the vector for illness that runs through your entire office. (pun intended)

Unfortunately, alcohol rubs are not very effective in disinfecting hands harboring the norovirus. Thoroughly washing with soap and water is much better. CDC recommends that "stomach flu" sufferers should not come to work for 48 hours after symptoms have gone, and flu sufferers should not come to the office until their temperature is normal for 24 hours without the use of medications.

And now we are faced with "presenteeism". Why? Well some workers say that they cannot afford to stay away from their jobs (no paid sick leave). In this area 85-90% of dental offices have some sick leave/vacation policy. The other 10-15% needs to join the 21st century.

Others feel that their absence will put an undue burden on their colleagues. (loyalty). Doctors and staff who come to work while "sick" with communicable diseases are not heroes!

They should be considered impaired. They are a real risk to immuno-compromised patients, cancer patients, and transplant patients. They are more prone to making judgmental errors, have decreased productivity, and serve as vectors for disease transmission.

Good intentions can have bad consequences. If you have a communicable disease, don't think you can just take a pill to reduce discomfort or fever and go to work.
STAY HOME!

LETTER TO THE EDITOR

BEWARE: HEMANGIOMAS IN ORAL SOFT TISSUE

Dr. Marvin E. Pizer*

How can a completely benign tumor take a life? I saw it happen! In my senior year of my oral surgery residency, I lived in a private home in the suburbs of Pittsburgh. I knew the next-door neighbors, a middle-aged couple. About 10:00 p.m. one evening, I heard a loud call for my help from the female member of the household next door. The husband was pouring blood from his mouth and the profuse bleeding was impossible for me to control. The lesion was raised on the buccal mucosa, and pale red in color. I tried to compress the lesion with pressure intra- and extra-orally with gauze and tea to no avail. An ambulance was called, the patient was sent to the nearest emergency room, and there almost all the bleeding was controlled. I knew nothing about his medical history, but he died the third hospital day. From the history I was exposed to by the family, he died from a coronary embolism, and this was attributed to the hemangioma on his buccal mucosa. Apparently his family physician and dentist never gave this lesion any concern!

Hemangiomas are benign tumors formed by the proliferation of blood vessels. There are two histologic classifications of hemangiomas:

1. Capillary hemangioma – composed of capillary-like blood vessels with no surrounding capsule
2. Cavernous hemangioma – composed of large vascular channel and lined with flat endothelium

There are two clinical classifications of hemangiomas:

1. Infantile hemangioma – these appear after birth and there is usually rapid growth for 6 to 9 months, and then slowly they get smaller and lighter in color. At age of 12 there is no visible mass, only a yellowish mucosa or telangectasia

2. Congenital hemangioma – this tumor is seen at birth. Their course is unpredictable – some will rapidly regress and others persist in adult patients. They range in color from shades of red or blue. They may be flat or raised, even pulsatile. (1)

It is helpful to try and make a clinical diagnosis because the two clinical hemangiomas have different behavior patterns. I have found this extremely difficult. Most adult patients do not recall whether the hemangioma was present at birth or appeared after birth. Children with their parents are more likely to know. The parents with infants and children of all ages seem to know the most for a clinical diagnosis.
Here are some factors to consider in treatment based on diagnosis:

1. Medical history
2. Age of patient
3. Noted lesion at birth or after birth?
4. Is lesion getting larger, smaller, or the same?
5. Does tumor impinge on vital structure or making a problem for swallowing?
6. Any history of hemorrhage from tumor?
7. Color of tumor – will it blanch under pressure?
8. Is it pulsatile?
9. Any vascular lesions in other parts of the body?
10. Size and location

The treatment is essentially the same for almost each clinical (2) hemangioma.

1. f the tumor is getting smaller and fading – close observation
2. Should this tumor, less than 2 cm in circumference but in a place where oral function could injure the hemangioma, I excise with electrocautery or scalpel with an incision 6mm from the tumor and then blunt dissect until approaching blood vessels entering the hemangioma. I use hemostats and tie the vessels and then remove the hemangioma. Next I undermine the surrounding mucosa so that a primary closure is accomplished.
3. When the tumor is more than 3 cm but not impinging on a vital structure, I usually use a sclerosing solution around the periphery of the tumor and then into the mass and observe for one month. If the mass becomes firm and fading in color, I proceed to excise the lesion. In some patients I try again with sclerosing solution and do the surgery when I feel the vessels are fibrosed. The sclerosing solution I used was sodium morrhuate.
4. When the hemangioma is invading vital structures or preventing physiologic functions such as swallowing, I then get an MRI to determine the actual size and its relation to other structures. When viewing the results of the MRI, it is convenient to question the radiologist about the radiation modalities that might sclerose the vessels and reduce the size of this hemangioma. I will not use radiation on infants, and children even if they are teen-aged. For some patients I prefer intra-lesional sclerosing solution or intra-lesional steroids. Do not rush into surgery. I wait at least one month and then decide whether to repeat additional steroids or many of the other sclerosing solutions. When I feel comfortable performing surgery, I almost always utilize the hospital for obvious reasons. The patient may need blood, the operating room usually has the equipment necessary to control bleeding, such as the scalpel-like instruments that seal capillary and small vessels as excision proceeds. It is sometimes necessary to obtain a hematology consult – it is the hospital where the patient can receive immediate care.

Reference:
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***Formerly:**
1) Clinical Professor of Oral and Maxillofacial Surgery, Virginia Commonwealth University, Richmond
2) Emeritus Staff, Alexandra Hospital, Alexandria, Va.

Patient I; Slides #1 and #2
Infantile hemangioma – age 5 - no evidence of regression
Buccal mucosa – surgery
Diagnosis: Cavernous Hemangioma

Patient II; Slides #3 and #4
Congenital hemangioma x 2 – age 9 months – bleeding on palpation
Lateral border of tongue – eating problems – surgery
Diagnosis: Capillary Hemangioma

Patient III; Slides #5 and #6
Congenital Hemangiomas – age 27 – no involution
Buccal mucosa – Radiation 300 rads; surgery 5 months post radiation
Diagnosis: Cavernous Hemangioma

Patient IV; Slide #7
Congenital Hemangioma – age 20 – no involution
Lower lip – no change in many years – sclerosing solution intra-lesional – surgery
Diagnosis: Capillary Hemangioma

Patient V; Slide #8
Infantile Hemangioma – age 28 – no involution after age 12
Lower lip x 2 – many years duration with no changes – surgery
Diagnosis: Capillary Hemangiomas

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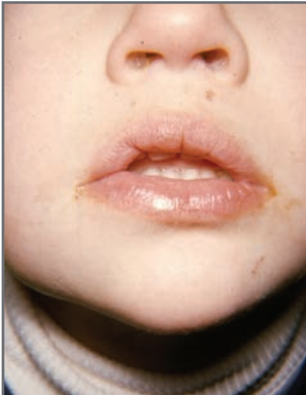
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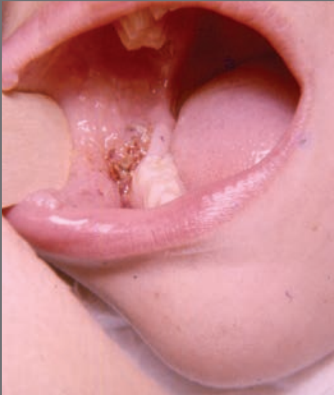
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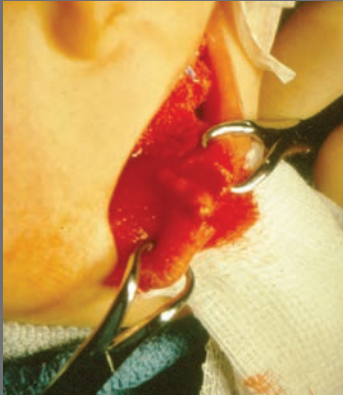
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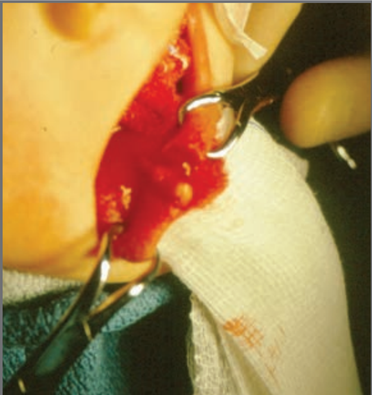
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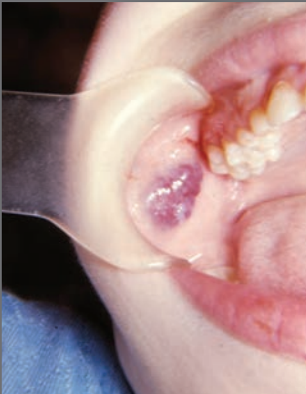
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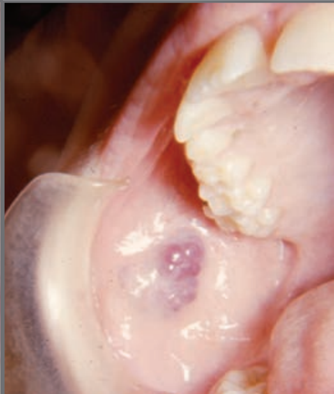
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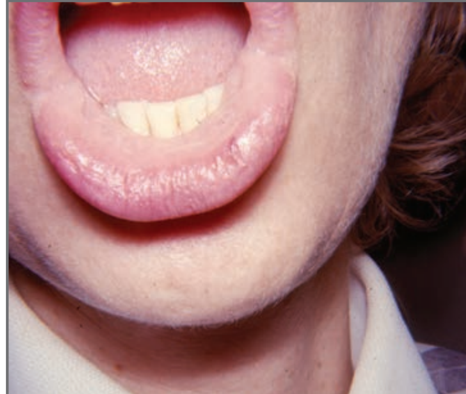
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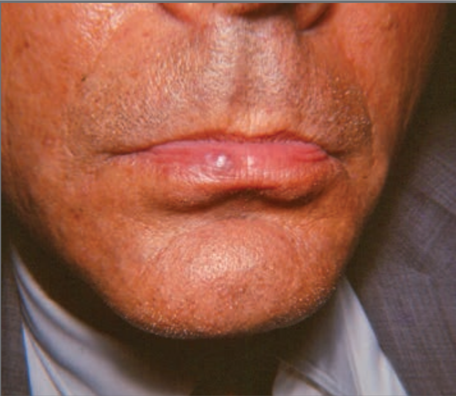
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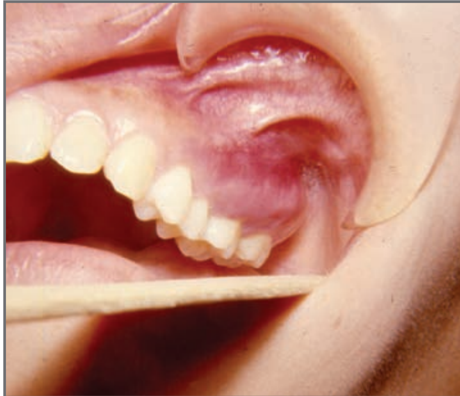
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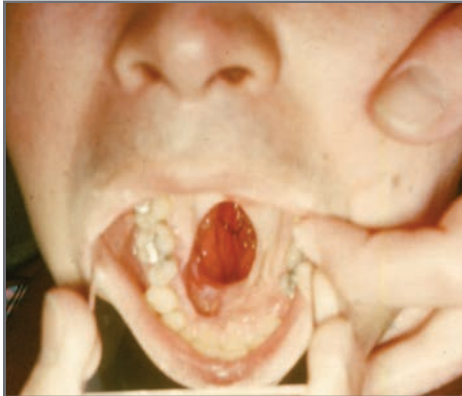
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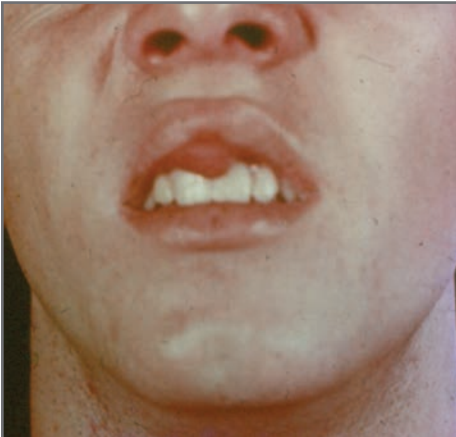
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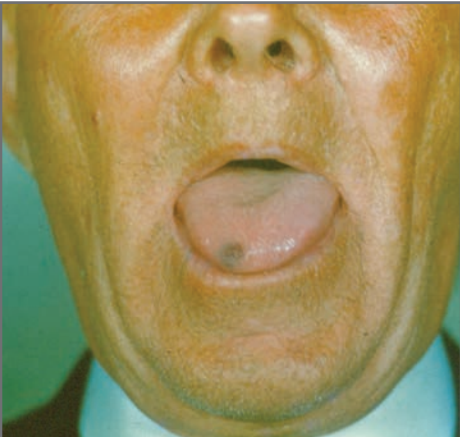
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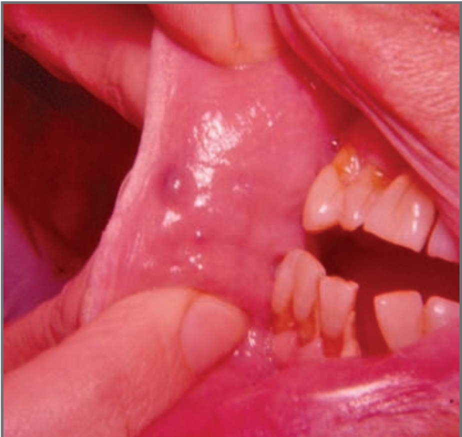
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CURRENT PREFERENCES IN ACCELERATED ORTHODONTIC TOOTH MOVEMNT TECHNIQUES IN ORTHODONTICS

S Ujaoney, B Shroff, C Carrico, S J Lindauer; Department of Orthodontics, Virginia Commonwealth University School of Dentistry, Richmond

ABSTRACT

Objectives: To assess the current trends in preferences and utilization of accelerated orthodontic tooth movement (AOTM) techniques in Orthodontic Practices in the United States.

Methods: Electronic surveys were sent to 1120 members of the American Association of Orthodontists to evaluate their individual preferences for, utilization of, and willingness for future use of AOTM techniques in their practices.

Results: The survey's response rate was 7.5%. Of these, 35% currently use AOTM technique(s). Fifty-five percent of the current users are beginners while 10% are advanced users. The three most preferred AOTM techniques currently used by the respondents include intraoral tooth vibrations (53%), micro-osteoperforation (33%), and corticotomy (10%). The 65% of respondents who do not currently use AOTM technique(s) cited lack of demand (71%), lack of scientific evidence (53%), and lack of training (36%) as the most common reasons for the not using the technique(s). A higher proportion of non-users versus users believe that there is no scientific evidence to support the use of intraoral tooth vibrators, pulse electromagnetic field, low intensity laser radiation, and micro-osteoperforations. Also, 69% of current non-users suggested that they do not anticipate incorporating AOTM technique(s) in their office in next 2 years. The other 31% suggested that they are likely to incorporate intraoral tooth vibrators (65%), micro-osteoperforations (59%) and corticotomy (24%) in their practices in the near future.

Conclusions: Among survey respondents, the current number of users of AOTM technique(s) is less than that of the non-users. The majority of users of AOTM technique(s) are beginners with most preferring intraoral tooth vibrators, micro-osteoperforations and corticotomy to reduce treatment time. Most non-users cited lack of demand among patients for the lack of use of these techniques in their practices. Current non-users are likely to use intraoral tooth vibrators, micro-osteoperforations and corticotomy in the future.

INTRODUCTION

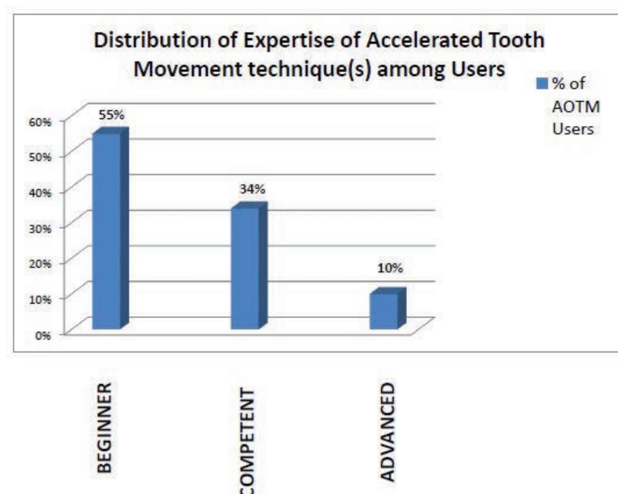
The average orthodontic treatment duration with conventional fixed orthodontic appliance is 2-3 years[1], and any reduction in this treatment duration positively influences the level of treatment acceptance amongst general populations[2]. This reduction in treatment times by various accelerated orthodontic tooth movement procedures are desirable to both the providers and the patients as these procedures decrease the likelihood of caries3, white spot lesions[4, 5, 6], and external root resorption [7, 8] associated with long orthodontic treatment times.

As patients frequently request shorter treatment times[9], accelerated tooth movement aided by intraoral tooth vibrators[10], pulsed electromagnetic fields[11], low intensity laser therapy[12], corticotomy[13, 14], periodontal ligament distraction[15] and dento-alveolar distraction16 has been popularized in orthodontic practices in recent times[17].

Several research papers have discussed various aspects of accelerated orthodontic tooth movement technique(s) individually. For example, a systematic review by Hoogeveen[18] et al evaluates the safety and effectiveness of corticotomy and dental distraction as methods to shorten the orthodontic treatment time in adolescent and adult patients. The evidence based on low-to-moderate quality studies evaluated in this paper suggests that surgically facilitated orthodontics seems to be safe for the oral tissues and is characterized by a temporary phase of accelerated tooth movement. Thus concluding that corticotomy and dental distraction methods effectively shortening the duration of orthodontic treatment. Similarly, a systematic review and meta-analysis study by Gkantidis[19] et al evaluated the effectiveness of accelerated orthodontic tooth movement through surgical (corticotomy, inter-septal bone reduction) and non-surgical approaches (Low-intensity laser, photo-biomodulation, pulsed electromagnetic fields) in orthodontic patients. The study found some evidence for the effectiveness of low laser therapy and corticotomy techniques whereas the evidence for inter-septal bone reduction was found to be weak. Photo-biomodulation and pulsed electromagnetic fields showed very weak evidence of effectiveness. Although, these studies bring light to effectiveness of individual surgical or non-surgical AOTM technique(s), there is limited evidence on the desirability, utility and current and future preferences about the accelerated orthodontic tooth movement techniques amongst the orthodontists in their practices.

A study by Uribe[10] et al evaluated patients', parents', and orthodontists' perspectives on orthodontic treatment duration, their willingness to use AOTM techniques and appliances and the costs the individual group is willing to pay for them. They found that the orthodontists and patients alike are interested in the accelerated tooth movement techniques. They also suggested that less-invasive techniques had greater acceptability among the study population. However, there is no information in the literature investigating the current utilization, level of expertise, orthodontist's rationale for using versus not using an AOTM technique(s) and the future possibilities of incorporation of these technique(s) in their practices. The purpose of this study

Figure 1: Distribution of Expertise for those who currently utilize Accelerated Tooth Movement technique(s) :



was to investigate the current utilization, current and future preferences, reasons for utilization or non-utilization and willingness to use AOTM technique(s) among orthodontists practicing in United States.

METHODS

This study was conducted using a survey and was approved by the Institutional Review Board at Virginia Commonwealth University. The web-based survey was made available to 1120 orthodontists in United States with assistance from the American Association of Orthodontists and VCU Orthodontic Alumni Foundation. The electronic survey was randomly emailed to orthodontists in April 2015 and again to non-respondents in May 2015. The members were requested basic demographic information. In addition, it explored the preferences, amount of utilization and future preferences of AOTM technique(s) among users and possible reasons for non-use among orthodontists that do not currently use AOTM technique(s). Descriptive statistics were used to summarize the data using the frequency (n) and percentages. Chi-squared tests were used to determine associations between responses to various questions wherever applicable. A significance level of 0.05 was used for all statistical tests and all analysis was performed in SAS Enterprise Guide v.6.1.

RESULTS

A total of 85 orthodontists completed the electronic survey (7.5%). Out of which 35% currently use accelerated orthodontic tooth movement (AOTM) technique(s). No statistically significant association was found between age, gender, and practice characteristics of an orthodontist, percentage of patient request for shorter treatment times and the utilization of AOTM technique(s). Fifty-five percent of the current users were beginners while 10% were advanced users. The three most preferred AOTM techniques currently used by orthodontists were intraoral tooth vibrations (53%), micro-osteoperforation (33%) and corticotomy (10%). Sixty-five percent of respondents reported that they do not currently use AOTM technique(s) and the most common reasons for the not using the technique(s) were lack of demand (71%), lack of scientific evidence (53%), and lack of training (36%). Specifically, statistically significant difference in number of users versus non-users believe that there is no scientific evidence to support the use of intraoral tooth vibrators, pulse electro-magnetic field, low intensity laser radiation, and micro-osteoperforations. Also, 69% of current non-users suggested that they do not anticipate incorporating AOTM technique(s) in their office in next two years. Meanwhile, 31% current non-users of AOTM technique(s) suggested that they are more likely to incorporate intraoral tooth vibrators (65%), micro-osteoperforations (59%) and corticotomy (24%) in their practices in near future. A statistically significant difference in the perceived risk for complications for pulse electromagnetic field and dento-alveolar distraction was found between users and non-users of AOTM technique(s).

Figure 2: Most Preferred Accelerated Tooth Movement technique(s) by Users:

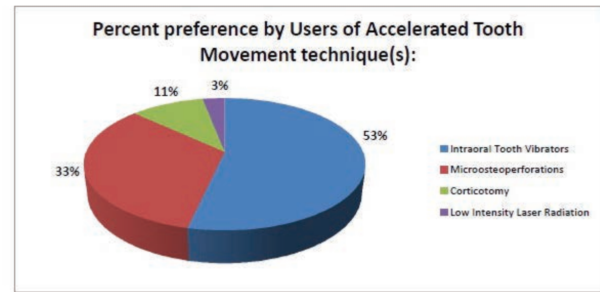
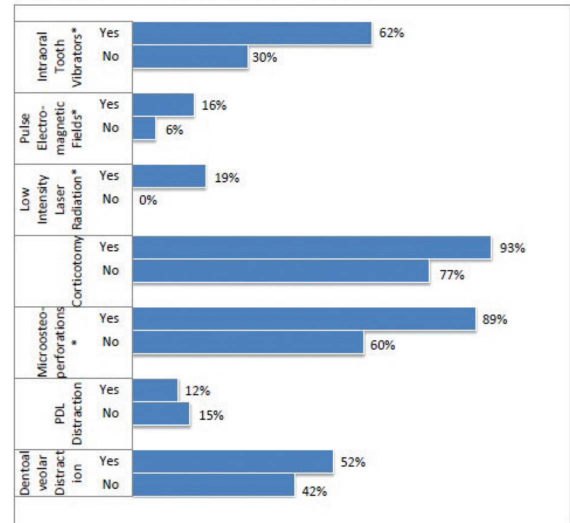


Figure 3: Which methods are supported by scientific evidence?



DISCUSSION

The purpose of this study was to investigate the current utilization, preferences, reasons and willingness to use AOTM technique(s) among orthodontists. Even though the response rate to this electronic questionnaire was 7.5%, the demographics of the orthodontists who responded to the survey were representative of the membership of American Association of Orthodontists. As the utilization of accelerated orthodontic tooth movement technique is relatively recent and unexplored by many, it may have contributed to this low response rate. Another reason could be could be its method of dispersal to the recipients - electronic versus paper. Electronically sent surveys have a higher chance of getting lost in spams or overlooked over other concurrent emails. Many research studies have shown that paper-based mail surveys continue to receive better response rates compared to the electronic surveys[20-23].

In our study, orthodontists suggested that less than 20% of their patients desire reduction in orthodontic treatment time, which is in contrast to the study by Uribe et al[10] who indicated that 74.90% patients would consider alternative treatment modalities to reduce the orthodontic treatment time. Our study has shown that the use of AOTM techniques is not widespread among orthodontists in the US. The common reasons cited by orthodontists for this non-utilization include lack of demand among patients, lack of scientific evidence, and lack of training. Other possible reasons may include lack of infrastructure for these techniques and lack of the advanced skills required for using some of these methods. This highlights the great potential for increasing the awareness among patients about these techniques. Also, more scientific studies that would test the efficacy of these techniques and hands-on training of orthodontists in these methods will help with their increasing the popularity of these procedures. The majority of users were beginners at using AOTM techniques, who have used the methods for a few months and have successfully completed at least 2 cases. We found an interesting pattern for the most commonly used AOTM technique: intraoral tooth vibrations (non-invasive) followed by micro-osteoperforation and corticotomy (invasive techniques). Orthodontists that most prefer intraoral tooth vibrators are less likely to use corticotomy (a more invasive technique) as an alternative method for accelerated tooth movements. On the other hand, orthodontists that most prefer corticotomy only use micro-osteoperforation technique as an alternative method for accelerated tooth movements over other commonly used AOTM techniques. Our study also found that about 31% of current non-users of AOTM techniques anticipate using the current most preferred techniques (intraoral tooth vibrators, micro-osteoperforation and corticotomy technique) in the next 2 years. This points to a lack of scientific evidence-based studies on the other techniques. Further research on these techniques might help with greater utilization of those methods that are proven to be as good as or better than currently preferred methods. In our study, a significant difference in the perceived risk for complications for pulse electromagnetic field and dento-alveolar distraction was found between users and non-users of AOTM technique(s) which further supports the need for relevant scientific evidence. Our study has some limitations. First, the response rate to the survey was low and therefore there was not enough sample size to do sub-group analyses such as between advanced and beginner users of AOTM techniques. Second, it is possible that some of the respondents might be using techniques that were not

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listed in the survey, for example combination of AOTM techniques (intraoral tooth vibration and micro-osteoperforations) as mentioned in the study by Uribe et al. It would be interesting to see whether preferences for particular AOTM methods change as the orthodontists gain more experience and expertise over time, future studies conducted to evaluate this may be helpful.

CONCLUSIONS

- Thirty-five percent of the responders currently use AOTM technique(s) in comparison to 65% of non-users.
- Fifty-five percent of the users of the AOTM technique(s) are beginners who have completed at least two orthodontic cases using AOTM technique(s)
- Current users of AOTM technique(s) prefer using Intraoral tooth vibrators, Micro-osteoperforations and Corticotomy
- Majority non-users of AOTM technique(s) stated the three most common reasons for non-use of AOTM technique(s) are lack of demand among patients, lack of scientific evidence to support the use of AOTM technique(s) and lack of training.
- Future use of the intraoral tooth vibrators, micro-osteoperforations and corticotomy may be considered among current non-users.

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TABLES AND FIGURES

Table 1: Demographics of the survey respondents:

Demographics	Percentage
Age	
25-35 years	15%
36-45	26%
46-55	32%
56-65	25%
66-75	2%
Gender	
Male	78%
Female	22%
Which best describes your practice?	
Solo Private Practice	72%
Group Orthodontics Practice	15%
Group Multidisciplinary Practice	9%
University based Practice	2%
Hospital based Practice	1%
How long have you been in Orthodontic practice?	
0-5 years	13%
6-10 years	7%
11-15 years	21%
16-20 years	16%
21-25 years	16%
26-30 years	15%
>30 years	11%

Table 2: Reasons for not using Accelerated Tooth Movement technique(s):

Reason for not using AOTM technique (s)?	Frequency
1. There isn't enough demand among my patients	71%
2. Lack of Scientific Evidence	53%
3. Lack of Training	36%
4. My Practice Isn't Set-up for AOTM	11%
5. Other	16%
6. I am Not Aware of These Techniques	7%

Table 3: Methods considering for future implementation

Which of the following Accelerated Tooth Movement technique(s) would you implement in your clinical practice?	Percent
1.Intraoral Tooth Vibrators	65%
2.Micro-osteoperforations	59%
3.Corticotomy	24%
4.Pulse Electromagnetic Fields	6%
5.Low Intensity Laser Radiation	6%
6.Dentoalveolar Distraction	6%
7.PDL Distraction	0%

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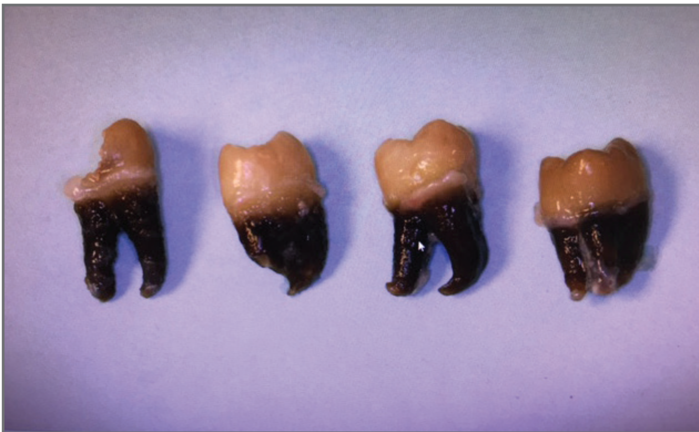
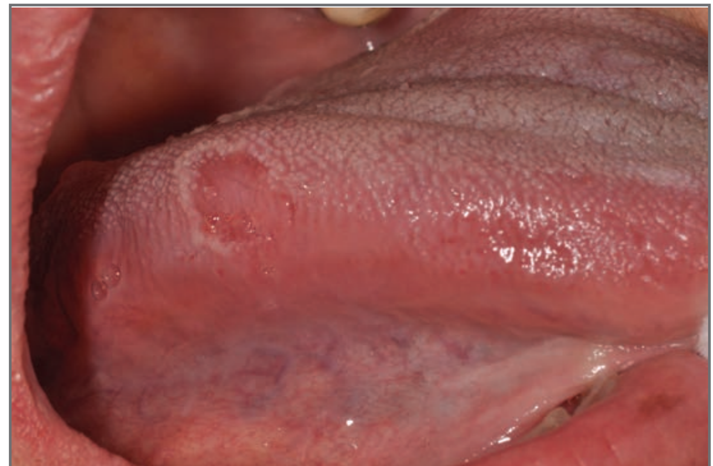
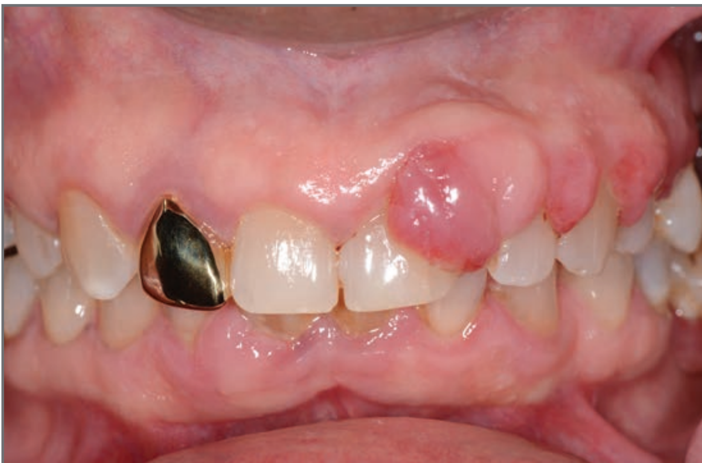


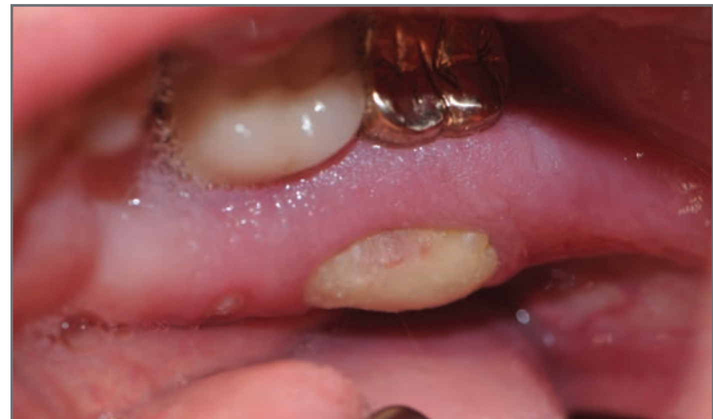
Case 1: Four extracted teeth submitted by Dr. Anna Moore



Case 2: Incidental finding on head and neck examination

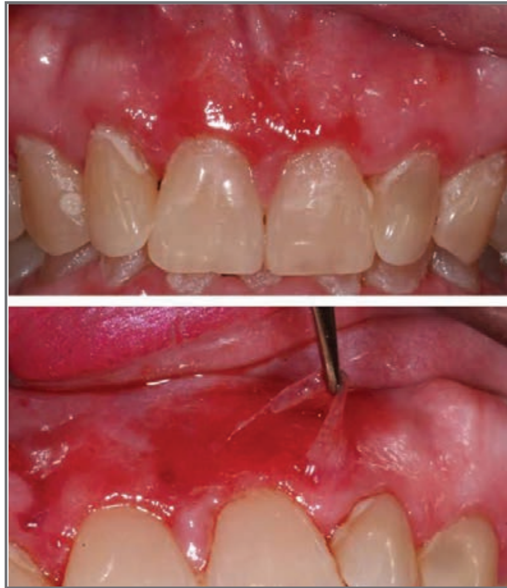


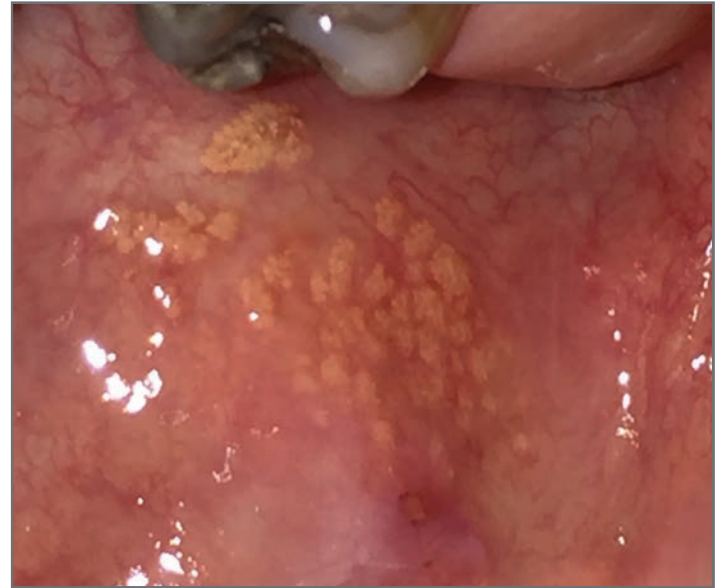
Case 3: Incidental finding on head and neck examination submitted by Dr. Stoianovici.



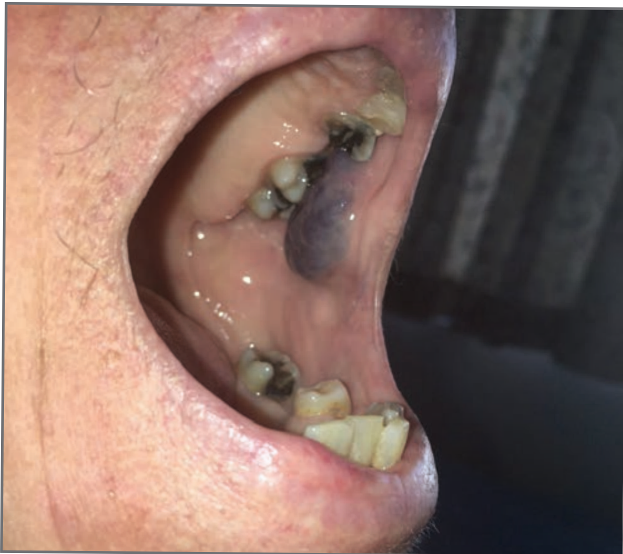
Case 4: Painful lesion of left mylohyoid ridge.

Case 5: Case submitted by Dr. Doug Mann that showed positive Nikolsky sign.

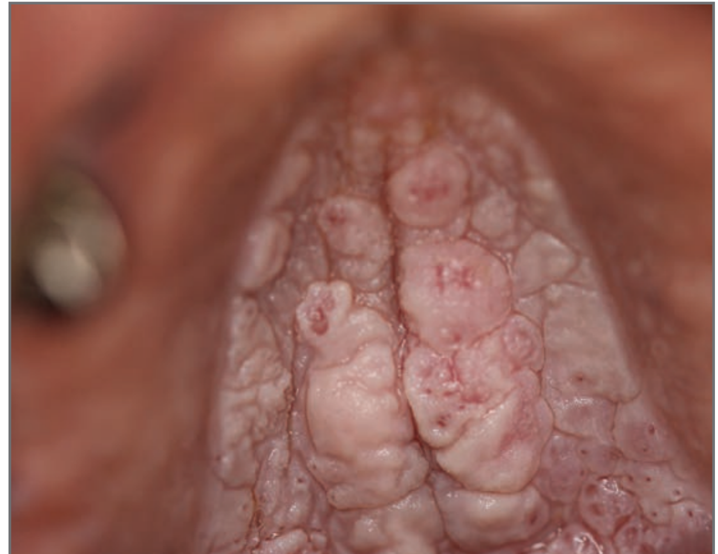




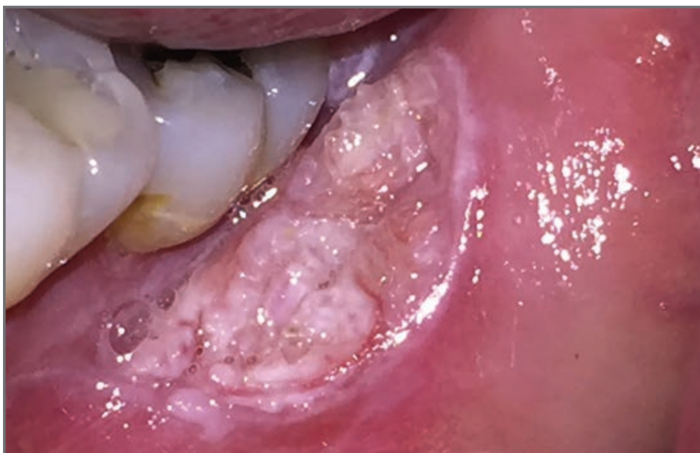
Case 6: Incidental finding.



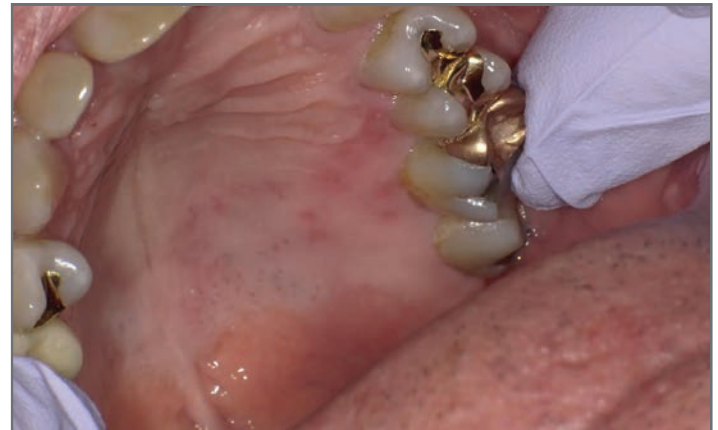
Case 7: Blue lesion present many years and has not changed in size.



Case 8: Patient smokes a pipe.



Case 9: Found at initial appointment.



Case 10: Painful area of the palate of four-day duration that has occurred previously.

CONTINUED ON PAGE 19

MANAGEMENT OF A LIP PIERCING STUD EMBEDDED IN THE LIP

Daniel M. Laskin DDS, MS; Professor and Chairman Emeritus, Department of Oral and Maxillofacial Surgery, Virginia Commonwealth University

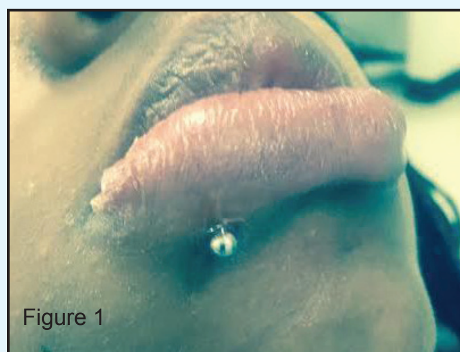


Figure 1

Figure 2

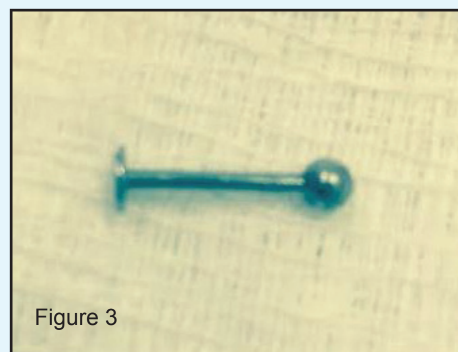


Figure 3

ABSTRACT

Background: Although minor infections following lip piercing are not unusual, most are generally treated successfully with antibiotics. Case Description: This report describes the management of a case in which delayed treatment resulted in the oral aspect of a stud becoming embedded in the lip and requiring surgical removal.

Practical Implications: This report emphasizes the role of the dentist in advising patients with lip piercing about the potential for causing chipping of the incisors and gingival recession and the need for periodic examination.

Although body piercing has been a cultural practice dating back to the antiquities (1), it has recently gained new popularity in Western society (2). Of particular interest to the oral and maxillofacial surgeon is piercing of the lip and tongue, which can be associated with various oral and dental complications, including early and late infections (3, 4). The following report describes the management of an unusual situation in which a patient developed an infection involving a lower lip piercing that resulted in the backing of the stud becoming embedded in the lip and preventing the patient from removing it.

CASE REPORT

The patient, a 19-year-old female, presented to the Emergency Department of the Virginia Commonwealth University Health System Hospital with a complaint of lower lip swelling and drainage at the lip piercing site for approximately 2 weeks. She reported that the piercing had been done about 2 months ago and she had not had any problems until about 2 weeks ago when she developed swelling around the stud and a small amount of drainage. The swelling had resulted in the intraoral backing becoming embedded in the lip, preventing removal of the stud. She went back to the studio where the piercing had been done and they also were not able to remove it.

The patient's history was negative for alcohol, tobacco or recreational drug use. Her temperature was 37.3° C. The lip was swollen and tender, with a small amount of yellow drainage at the outer piercing site, and the backing of the stud was not visible on the inner surface of the lip. The patient was prescribed clindamycin, 600 mg q8hrs for the infection and ibuprofen for pain. Because her Emergency Department visit was on a Saturday, she was referred to the Department of Oral and Maxillofacial Surgery for further treatment on Monday.

On presentation to the Oral and Maxillofacial Surgery Clinic the patient was afebrile, but there was still swelling of the lip and the backing was still not visible. (Figure 1, 2). A radiograph of the lip was taken to see what type of backing was present. This revealed that it was a not a barbell (a bar with two balls), but rather there was a ball-shaped stud on the skin surface and a flat, disc-shaped, screw-on backing on the mucosal surface. Pressure on the extraoral stud did not result in the backing appearing on the inner surface of the lip. The patient was informed that it would require surgical removal under local anesthesia and informed consent was obtained.

After obtaining anesthesia of the right side of the lip with a mental nerve block using 2% lidocaine HCL containing 1:100,000 epinephrine in order to avoid further distention of the tissues, a 5 mm incision was made through the mucosa and underlying muscle overlying the backing, which was exposed by gentle dissection. The backing was then unscrewed and the stud was removed (Figure 3, 4). The wound was thoroughly irrigated with sterile saline and then closed with two 000 catgut sutures. The patient was instructed on proper wound care and continued on clindamycin for 5 days. When seen a week later, the swelling had subsided and the area was healing normally.

DISCUSSION

The complications following lip piercing can be classified as early or late. Complete healing of a lip piercing can take from one to three months (5). Early complications include mild pain, swelling, and mild infection (4). Late complications include recurrent infection, gingival recession and chipping of the teeth (6). Since the infection in this patient occurred two months after the lip piercing, it can be considered an early complication.

Generally, when an infection develops, the patient can remove the lip stud and the infection either resolves spontaneously, or the patient can be treated with antibiotics. In this case, the patient failed to remove the stud in the early stages of the infection and subsequent swelling resulted in the backing becoming embedded in the lip, making removal impossible without surgical access.

Dentists who see patients with lip piercings should be sure that they are aware of the need for proper oral hygiene and keeping the stud clean to avoid infection. They also need to inform such patients about the possibility of damage to the incisor teeth and gingival recession in the area of the piercing, since they probably have not been told about such complications by the piercer, and counseled about permanent removal. Those who con-

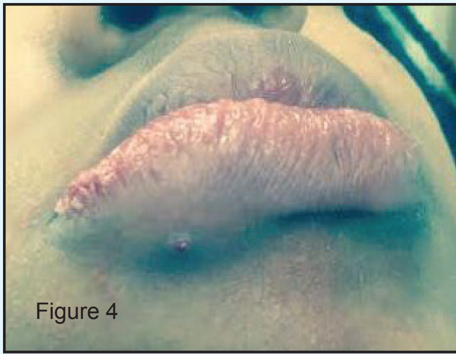


Figure 4

tinue to wear the stud should be encouraged to have routine periodic reevaluation for signs of dental complications.

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LEGENDS

Figure 1. Extraoral view of the lip stud.

Figure 2. Intraoral view of the site where the backing is embedded.

Figure 3. The lip stud following removal.

Figure 4. Extraoral view of the lip following removal of the stud.

WHAT IS YOUR DIAGNOSIS?

ANSWERS REVEALED

CONTINUED FROM PAGE 17

PATHOLOGY PUZZLER

Dr. John Svirsky

1. The patient had been on Minocin. This was the appearance of the extracted teeth.
2. Geographic tongue
3. Pyogenic granuloma
4. Exposed bone on the mylohyoid ridge. Typically it will sequestrate. This area takes a long time to heal.
5. Benign mucous membrane pemphigoid.
6. Sebaceous gland lobules/Fordyce granules
7. Hemangioma
8. Nicotine stomatitis
9. Verrucous carcinoma
10. Intraoral herpes

40 UNDER 40

DR. DUSTIN REYNOLDS

Physicist, Fireman, Endodontist. With a degree in Physics from Hampden-Sydney, Dr. Reynolds served the community as a firefighter/EMT until completing his dental training at West Virginia University. He practices Endodontics in Lynchburg and is adjunct faculty at VCU.

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ORAL SURGERY ABSTRACT:

FERNANDES KS, GLICK M, DE SOUZA MS, KOKRON CM, GALLOTTINI M. ASSOCIATION BETWEEN IMMUNOLOGIC PARAMETERS, GLYCEMIC CONTROL, AND POSTEXTRACTION COMPLICATIONS IN PATIENTS WITH TYPE 2 DIABETES. JADA. 2015; 146(8):592-599

It has been reported that patients with diabetes are at increased risk for infection following surgical procedures due to immunocompromise. However, there is little evidence relating postoperative infections after dental extractions. This study was designed to correlate postoperative dental infections with extractions in the diabetic population versus a healthy adult. Inclusion criteria included those who were older than 18 years old, and required extraction of an erupted tooth due to dental decay. Exclusion criteria included those with greater than 4mm periodontal pockets, use of antibiotics, chemotherapy or radiation, hormone therapy, bisphosphonate use, smoking, drug or alcohol use, and current infections. Fifty-three (53) patients with diabetes and 29 patients without diabetes were followed for 60 days after dental extraction to evaluate healing. Prior to extraction, a CBC, HbA1c, non-fasting blood glucose, and neutrophil function test, among others were obtained on the participants. The patients were examined at 3,7,21 and 60 days after surgery and wound healing was evaluated. Complete epithelialization was determined to be when the surgical site had epithelized over the entire alveolus. Delayed wound epithelialization was defined as an extraction site that had not completely epithelized at postoperative day 21. Complications that were evaluated included edema, erythema, trismus, cellulitis, and unpleasant taste. On post-operative day 3, edema, erythema, and pain were not considered to be complications, as these were deemed to be normal during that time. Healing was evaluated between the diabetic and non-diabetic groups using these criteria. Healing patterns were also correlated with the previously mentioned blood tests. One (1.9%) of the 53 diabetic patients reported unpleasant taste. Seven (24%) of the non-diabetic patients reported complications including unpleasant taste, malaise, and trismus. In the diabetic group, 17% were found to have delayed epithelialization at postoperative day 21, whereas no patients in the non-diabetic experienced delayed healing. All patients in both groups showed complete healing without signs of infection at post-operative day 60. There was no statistically significant difference between complete wound healing times and neutrophil dysfunction or increases in HbA1c. In conclusion, the diabetic group was more likely to have delayed epithelialization at day 21. However, it was complete at post-operative day 60 and this delay was not associated with pain, infection, or any other post-operative complication. These results imply that antibiotic prophylaxis in diabetic patients may not be necessary after dental extractions as they were not at an increased risk for infections or other post-operative complications in this study.

JASON WOOD, DMD;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center.

ORAL SURGERY ABSTRACT:

DEZSI BB, KORITSANSZKY L, BRAUNITZER G, HANGASI D, DEZSI C. PRASUGREL VERSUS CLOPIDOGREL: A COMPARATIVE EXAMINATION OF LOCAL BLEEDING AFTER DENTAL EXTRACTION IN PATIENTS RECEIVING DUAL ANTIPLATELET THERAPY. J ORAL MAXILLOFACIAL SURG. 2015; 73(10): 1894-1899

This study evaluated the effects of various parameters on local hemostasis after odontectomies in patients receiving different combinations of dual antiplatelet(DAP) therapy due to coronary heart disease (CAD). Patients with CAD, one of the most common causes of death worldwide, are often in need of extractions. Due to the nature of the medications they take, oral and maxillofacial surgeons and other dental professionals need to know the effects these medications have on bleeding. This study looked at a total of 129 patients who underwent extractions. All patients had previous percutaneous coronary intervention and were on DAP therapy, which consisted of aspirin and clopidogrel (Plavix) or aspirin and prasugrel (Effient). The bleeding time end point was complete cessation of oozing from the extraction site. The study also looked at various other factors, including local anesthetic with or without epinephrine, and post-extraction placement of sutures versus gauze pressure alone. The results of the study showed that prasugrel had a statistically significantly longer bleeding time compared to clopidogrel. The study also showed placing sutures helped in obtaining hemostasis, and that epinephrine in the anesthetic had no meaningful effect on bleeding time. The study concludes that although bleeding may be prolonged with patients taking DAP therapy, especially prasugrel, minor surgeries including dental odontectomies may still be performed safely.

TREVOR B. HOLLEMAN, DDS;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

BELL CL, DIEHL D, BELL MM, BELL RE. THE IMMEDIATE PLACEMENT OF DENTAL IMPLANTS INTO EXTRACTION SITES WITH PERIAPICAL LESIONS: A RETROSPECTIVE CHART REVIEW. J ORAL MAXILLOFAC SURG. 2011; 69(6):1623-1627

Immediate implant placement into freshly extracted sockets may be a viable treatment option in some scenarios. The authors of this study wanted to go a step further and determine if immediate implant placement into extraction sites with a history of chronic periapical lesions will also show similar results.

The authors conducted a retrospective chart review of 922 immediately-placed implants in a total of 655 patients. Of the 922 implants, 285 were immediately placed into an extraction socket that had a history of chronic periapical infection. The remaining 637 immediately-placed implants in sockets with no history of periapical pathology served as a control group.

All implants included in the chart review were placed by a single provider, using a similar surgical method. This included a preoperative Peridex oral rinse and 600 mg of IV clindamycin. Teeth were extracted with care to preserve surrounding bone and sockets were subsequently debrided with a curette and irrigated. Osteotomies were performed using surgical stents and Straumann tissue or bone level implants were placed into the prepared osteotomies. Residual sockets were grafted with platelet-rich plasma (PRP) and a bone filter was used to capture any residual bone throughout the surgery, which was used for subsequent grafting. A xenograft was used if additional grafting material was necessary. If a residual socket greater than 1mm remained after suturing, Collatape soaked in PRP and was placed over the bone graft to promote soft tissue healing. Lastly, implants were loaded after a 3-month healing period. Patient had a mean follow-up time was 19.75 months (Range= 3-93 months).

In the group which had implants immediately placed into extraction sockets, 7 of the 285 implants failed for a success rate of 97.5%. In the control group, 8 of the 637 implants failed yielding a success rate of 98.7%. The authors also attempted to correlate other factors which may affect success rates such as age, gender, smoking, diabetes, bisphosphonate use, radiolucency of adjacent teeth and implant stability at time of placement. Out of these variables, the only one which showed any statistically significant difference in implant stability was the presence of periapical pathology in retained teeth adjacent to the implant being placed.

Overall, the results of this chart review show no statistical difference in the implant success rate between the experimental and control groups. The authors suggest that immediate placement of implants into sockets affected by chronic periapical pathology should be a safe and viable treatment option. What the authors fail to describe in the study is the specific criteria of measuring implant success. This crucial piece of information will help readers compare results with various other studies on this topic.

BALRAJ S. KANG, DDS;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

FEBBO A, CHENG A, STEIN B, GOSS A, SAMBROOK P. POSTOPERATIVE BLEEDING FOLLOWING DENTAL EXTRACTIONS IN PATIENTS ANTICOAGULATED WITH WARFARIN. J ORAL MAXILLOFAC SURG. 2016; 74(8): 1518-1523

Many patients are on anticoagulant therapies for various reasons ranging from history of myocardial infarction to deep vein thrombosis. This study assessed the risk of bleeding among patients needing dental extractions and currently undergoing warfarin therapy. This was a retrospective case control study comparing 439 patients totaling 1,022 extractions and 439 control patients totaling 1,049 extractions. In this study patients with an INR <2.2 were treated in the same manner as the control population. Patients with an INR between 2.2-4.0 received suturing of oxidized cellulose into the socket and tranexamic acid mouthwash. Patients with an INR greater than 4.0 were referred back to the prescribing physician to ensure that their INR was in therapeutic range. Patients with an INR >4 had increased risk for bleeding with no therapeutic benefit. None of the control cases required postoperative bleeding control. None of the patients with an INR <2.2 required postoperative bleeding control. Nine of the patients with an INR ranging from 2.2-4.0 required postoperative bleeding control, one of which required admission into a hospital for transfusions.

In accordance with previous studies, halting warfarin treatment for INR values between 2.0 and 3.5 is unnecessary for dental extractions and can be potentially dangerous for patients. Patients with an INR less than 2.2 had similar bleeding risks as the control patients who were not on warfarin treatment. General dentists can use this study to help guide their decision making. For patients with an INR from 2 to 3 there is a 1 in 100, to 1 in 25 chance risk of bleeding. For patients with an INR greater than 3 there is a significantly increased risk for bleeding at approximately 1 in 11.

DAN TRAN, DDS;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

ESPOSITO M, GRUSOVIN MG, COULTHARD P, WORTHINGTON HV.DIFFERENT LOADING STRATEGIES OF DENTAL IMPLANTS: A COCHRANE SYSTEMATIC REVIEW OF RANDOMIZED CONTROLLED CLINICAL TRIALS. EUR J ORAL IMPLANTOL. 2008;1(4):259-76

An electronic search was conducted across multiple databases including TRIP database for medical guidelines, Cochrane systematic reviews, PubMed clinical queries including randomized controlled trials, and Google Scholar regarding the topic of loading time and success of dental implants. The highest Level IA evidence that resulted in evidence with a reportable outcome was a Cochrane systematic review with inclusion criteria of all randomized controlled trials and no language restrictions. Of the 30 randomized control trials that were identified, 22 trials totaling 976 patients were included. The systematic review defined immediate loading as within one week, early loading as between one week and two months and conventional loading as greater than two months. Twelve (12) trials compared immediate versus conventional loading, 3 trials compared early versus conventional loading, 6 trials compared immediate versus conventional loading. Success was measured by prosthesis and implant failure as well as marginal changes in bone level. Statistically significant difference was observed on a per implant basis but not on a per patient basis. The systematic review suggests that immediately loaded implants fail more often than conventionally loaded implants. In addition, it was found that immediate loaded implants had a lower failure rate than the early loaded implant group. This indicates that the traditional thought of delayed loading resulting in a higher overall success rate remains true; but, in addition, demonstrates that restoration and loading of an implant between one week and two months results in higher failure than immediate loaded implants. Although variable torque was used for immediate loaded implants it was reported that a higher torque value was necessary for their success when compared to delayed implants. Although this was Level I A evidence from a Cochrane Systematic review including randomized control trials, it should be noted that follow up time of implant success was no greater than one year. It should also be known that more recent systematic reviews are available on this topic, but no others have demonstrated a significant result.

DANIEL HAWKINS, DMD;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

KANG F, HUANG C, SAH MK, JIANG B. EFFECT OF ERUPTION STATUS OF THE MANDIBULAR THIRD MOLAR ON DISTAL CARIES IN THE ADJACENT SECOND MOLAR. J ORAL MAXILLOFAC SURG. 2016; 74(4):684-692

The purpose of this retrospective cross-sectional study was to determine the correlation between eruption status of mandibular third molars (MTM) and distal caries in mandibular second molars (MSM) in order to suggest guidelines for prophylactic removal of third molars. Compared to previous studies that used conventional imaging, such as periapical and panoramic radiographs, this study used cone-beam computed tomography (CBCT) as a more accurate method to detect caries. A total of 500 CBCTs were obtained from 469 patients undergoing extraction of third molars at the Affiliated Stomatology Hospital of Tongji University in Shanghai, China. Patients ranged in age from 16 to 59 years. Two oral and maxillofacial imaging experts evaluated the presence of distal caries in MSMs. Eruption status of MTMs was quantified by determining MTM impaction depth, MTM angulation, distance between cemento-enamel junctions of MTMs and MSMs, presence of pericoronitis, patient age, and patient gender. Data were analyzed using the chi-squared test and regression analysis.

The prevalence of distal caries in MSMs was found in 52% of CBCTs obtained. The presence of distal caries in MSMs was over 3 times more likely with adjacent MTMs that had inclinations of 43° to 73°, and over 2 times more likely in patients 27 to 59 years of age than those 16 to 27 years of age. Statistically significant associations were also present in MTMs that were above or level with the occlusal plane of the MSMs, and MSM-to-MTM distances of 6 to 15 mm. The presence of distal caries in MSMs was not found to be associated with patient gender.

In the dental community, there are currently many arguments for and against the prophylactic removal of third molars. This study suggests that MTMs should be prophylactically removed when angulation is between 43° and 73°. Angulation is a more reliable predictor of MSM distal caries than MSM-to-MTM CEJ distance. Finally, patients 27 years of age and older with asymptomatic third molars should be more vigilant of their impact on neighboring dentition.

AZIN SAYAH, DDS;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

FIGUEIREDO R, CAMPS-FONT O, VALMASEDA-CASTELLON E, GAY-ESCODA C. RISK FACTORS FOR POSTOPERATIVE INFECTIONS AFTER DENTAL IMPLANT PLACEMENT: A CASE CONTROL STUDY. J ORAL MAXILLOFAC SURG. 2015; 73(12): 2312-8

Since the initial presentation of osseointegration by Dr. Branemark in the 1960s, the use of endosseous dental implants has significantly increased and become what some argue as the standard of care for restoring the edentulous patient. And as with any increased frequency in procedure and/or application of new materials, comes an associated increase in number of failures and complications. Though current failure rates have greatly improved with the continued evolving technology (commonly cited failure incidence of 1-2%), implant placement is still not a completely benign procedure and without risk. Surgical trauma, occlusal forces, infection, medical comorbidities, and bone quality all have been previously mentioned as prognostic predictors and factors affecting implant success/survival. This study looked to determine any possible risk factors for post-operative infections, and to assess/explain their effect on early implant failure.

The study was a retrospective case-and-control study completed at the Master Degree Program in Oral Surgery and Implantology of the University of Barcelona, and included an evaluation of 474 patients (1,625 implants) treated February 2009 through October 2012. The implants were all placed by a third year resident, with placement protocol per manufacturer recommendation. All patients were given post-operative antibiotics (amoxicillin for one week). The infected group was defined as any patient with purulent drainage and/or fistula, pain/tenderness, local swelling, or fever at the surgical site. The control group was created by evaluating the 3 surgical patients immediately following an 'infected' patient. The patients' age, gender, American Society of Anesthesiologists classification, smoking habit, periodontal disease implant manufacturer, location in mouth, number of implants, primary stability, submerged versus non-submerged, and post operative follow up were all recorded and used in analysis of the results. Bivariate and multivariate analysis of the data were performed.

The infection group was comprised of 22 patients, and control group of 66 patients (out of total of 474 evaluated). The mean age was 56.8 years (infection group) and 51 years (control group). The median time from implant placement to noted infection was 28 days. Notable findings showed males and submerged (buried) implants were associated with post-operative infection. Post-operative infection during the osseointegration period caused an increased risk of early implant failure (odds ratio of 78.0).

Though previous research has shown smoking to be a probable risk factor for implant failure, no correlation was noted in this study. The only notable significant finding the authors present is of the correlation between buried mandibular implants and an increase in post-operative infection (leading to a near 80-fold increase in risk for implant failure). The authors hypothesize that this is due to an uncovered implant providing a more aerobic environment (less infection prone). The authors discuss the other variables analyzed (age, comorbidities, implant stability, etc), however no other significant findings were found in the data. This is possibly due to a smaller sample size. Additional studies would aid in more clearly defining peri-operative risk factors, and aid in future implant treatment planning for our constantly evolving patient population.

DR. CHARLES BOXX;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

40 UNDER 40

DR. KATY BRANDT

Dr. Brandt is a recent graduate of the University of Iowa, studying general dentistry and dental public health. She moved to Charlottesville this past summer to work in private practice. She is one of three doctors in her practice.

ORAL SURGERY ABSTRACT:

DEEB GR, SOUNG GY, BEST AM, LASKIN DM. ANTIBIOTIC PRESCRIBING HABITS OF ORAL AND MAXILLOFACIAL SURGEONS IN CONJUNCTION WITH ROUTINE DENTAL IMPLANT PLACEMENT. J ORAL MAXILLOFAC SURG. 2015; 73(10): 1926-1931

Various prophylactic antibiotic regimens have been proposed to minimize the incidence of infections and failure after implant placement. However, no standardized regimen currently exists. Consequently, the perioperative use of prophylactic antibiotics in dental implant placement continues to be widespread and variable. Given the lack of consensus in the published data, the purpose of this survey was to determine the current pre- and postoperative antibiotic prescribing habits of oral and maxillofacial surgeons in conjunction with routine dental implant placement to determine whether any consensus has been reached among this group of practitioners.

Electronic surveys were sent to all members of the American College of Oral and Maxillofacial Surgeons (ACOMS). The questions asked were related to: 1) whether antibiotics were routinely prescribed either pre- or postoperatively during routine dental implant placement, and, 2) if so, what antibiotics, dosage, frequency, and duration were used. The survey participants were also asked to specify whether they were in solo private practice, group private practice, academia, military, or "other."

A total of 217 responses were received, with the following results:

- Overall, 112 of 217 (51.6%) prescribed antibiotics preoperatively; 152 of 213 (71.4%) prescribed antibiotics postoperatively during routine dental implant placement.
- 72 (34%) indicated that they prescribed antibiotics both pre- and postoperatively.
- The most common preoperative regimen used was amoxicillin 2 g given 1 hour before the procedure (32%, n = 36).
- The most common postoperative regimen used was amoxicillin 500 mg 3 times daily for 5 days (53%, n = 81).
- No significant differences were found between those who prescribed antibiotics preoperatively according to practice type.
- In contrast, a statistically significant difference between the percentage of those who prescribe postoperatively – those in academia prescribed significantly less often than did those in private practice.

To date, the use of prophylactic antibiotics to prevent postoperative infection after dental implant insertion has been suggested, with mixed results reported in published studies. Some investigators have reported greater implant survival rates with the use of preoperative antibiotics, while others have found no difference in the incidence of postoperative infection and survival rates of implants with the use of pre- and/or post-treatment antibiotics. A Cochrane systematic review by Esposito et. al. in 2010 of 4 random controlled trials (RCTs) comparing various prophylactic antibiotic regimens versus placebo reported a statistically significant reduction in implant failure, with a risk ratio of 0.4, suggesting that the use of preoperative antibiotics can be beneficial. The most recent Cochrane systematic review (2010) evaluated a total of 6 RCTs that compared the administration of various prophylactic regimens versus no antibiotics with a minimum follow-up period of 3 months. They concluded that oral administration of 2 or 3 g of amoxicillin at 1 hour preoperatively significantly reduces the incidence of failure of dental implants. The review was unable to conclude whether adjunctive use of postoperative antibiotics is beneficial and which antibiotic is the most effective.

Although multiple RCTs have provided evidence that the use of preoperative antibiotics might reduce implant failure, only 51.6% of the 217 respondents to the survey indicated that they use antibiotics preoperatively before dental implant placement. Interestingly, despite the absence of any scientific evidence to support the use of antibiotics in the postoperative period after routine dental implant placement, most (71.4%) of the clinicians in the study indicated that they prescribe postoperative antibiotics. The results of this study confirmed that there appears to be no consensus among oral and maxillofacial surgeons regarding antibiotic use during routine dental implant placement. Furthermore, most of the antibiotic regimens being used are not in accordance with the recommendations current in the published data.

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40 UNDER 40

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ORAL SURGERY ABSTRACT:

BALTAYAN S, PI-ANFRUNS J, AGHALO T, MOY PK. THE PREDICTIVE VALUE OF RESONANCE FREQUENCY ANALYSIS MEASUREMENTS IN THE SURGICAL PLACEMENT AND LOADING OF ENDOSSEOUS IMPLANTS. J ORAL MAXILLOFAC SURG. 2016; 74(6):1145-1152

This was a retrospective study based on patient implant data to investigate the predictive value of resonance frequency analysis (RFA) in assessing implant survival. RFA is an emerging method for evaluating implant stability and this study aims to determine whether it can be used to reliability predict implant survival and aid with determining whether the implant has osseointegrated. RFA is a noninvasive method of subjecting the placed implant to a lateral bending test similar to how structural engineers evaluate building stability, which generates a quantifiable measurement called the implant stability quotient (ISQ). Higher resonance frequencies imply a stiffer bone-implant interface and increased stability. Previous studies cited in this article show that implants with ISQs of less than 60 have questionable stability and those greater than 70 can be considered very stable. Data was collected on 703 implants during placement and 1,154 implants before loading over a 5 year period. All implants were placed and ISQ measurements were obtained by a single experienced oral and maxillofacial surgeon in a private practice setting. The study used multiple implant systems including 3i, Straumann, Nobel, and Branemark. The ISQ measuring device (made by Ostell) was used during placement and before loading. The implant patients were grouped according to whether a 1-stage or 2-stage placement occurred along with whether an early or traditional loading protocol was used. The implants were all placed using a standard protocol using a handheld torque driver and percussion test for determining whether a 1 or 2 stage protocol would be used. A special transducer was then secured to the implant at a standard torque value of 10 N-cm and the ISQ values were obtained. This study found that all implant failures (n=17) occurred with an ISQ of less than 66 at time of placement and less than 67 regardless of the loading protocol. 2-stage implants had higher survival rates than 1-stage implants at an ISQ less than 60 suggesting that 1-stage placement is reasonable if the ISQ is greater than 60. The data reported also suggest that RFA is a more accurate test when it is performed sometime after placement, which is thought to be because the bone remodels after implant placement and the amount of remodeling can be difficult to predict at implant placement. Some limitations of this study include a single operator, low number of failures, and a two-year follow up period (though most implant failures happen within first year, a longer period may have provided more ISQ correlation with implant failures). Overall, this study showed increasing ISQ values correlated with increasing sensitivity in detecting implant failure. More studies are needed though to better understand the relationship between ISQ and long-term implant survival.

DR. BRYAN WHEELER;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

DE OLIVEIRA JCS, DE OLIVEIRA GAG, BASSI APF. COMPARATIVE ASSESSMENT OF THE EFFECT OF IBUPROFEN AND ETODOLAC ON EDEMA, TRISMUS, AND PAIN IN LOWER THIRD MOLAR SURGERY: A RANDOMIZED CLINICAL TRIAL. J ORAL MAXILLOFAC SURG. 2016; 74(8): 1524-1530

This was a double-blinded randomized paired crossover control trial comparing the effects of ibuprofen and etodolac for post-operative edema, pain and trismus. Twenty male and female patients ranging from sixteen to thirty five years of age, with similarly positioned third molars according to the Pell and Gregory (Class II B) and Winter (Mesioangular) classifications. Patients were randomly assigned to either receive 600mg of ibuprofen three times/day for three days or 300mg of etodolac three times a day for three days. Both groups were given 4mg of decadron administered one hour before surgery and were also administered 500mg of acetaminophen every six hours as needed.

A randomization program was used to select which impacted tooth would be removed first (#17 or #32) and which medication the patient would be given, either ibuprofen or etodolac. Then a minimum of twenty-one days was given for recovery and then the remaining impacted mandibular third molar was removed and the patient was given the opposite drug. The same surgeon removed all the teeth. The surgeon and patients were blinded to which medication was being administered at all times. The NSAIDs were started immediately post operatively.

Data was collected on day two and seven when the patients were seen for follow up and pain scale scores were completed and measurements of edema and trismus were done at these times. Data that was gathered was analyzed for normality of distribution using a Shapiro-Wilk Test. Kruskal-Wallis tests were used to analyze post-operative edema. Finally a two-way analysis of variance was used to analyze pain scale data.

The etodolac group had less edema and trismus from day two to day seven at which point there was no difference. Immediate post-operative pain was better controlled by etodolac for the first six hours and after that there was no difference reported, although the etodolac group required less need for additional rescue analgesics. In conclusion etodolac had less edema, trismus and pain after removal of impacted mandibular third molars.

VANCE PATRICK HALL, DMD;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

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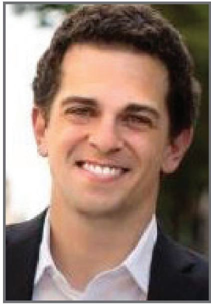

5 WAYS TO GROW YOUR PRACTICE'S FACEBOOK PAGE

Danny Rubin, Vice President, Rubin Communications Group

By now, many of you might have a Facebook page for your dental practice. That's a great first step in "being on social media" and engaging with your patients online.

Or perhaps you've had a page for some time but need fresh ideas to attract new followers and grow your audience.

As the public relations partner of the Virginia Dental Association, the Rubin Communications team has developed a list of five ways to make the most of your dental practice Facebook page.

1. Schedule content ahead of time
Facebook allows you to schedule posts in advance, and it's a stress-free way to offer new content in a consistent way. Here's an idea: at the start of each month, schedule several pieces of content over the next four weeks, particularly content you tend to include on a regular basis (ex: happy patient photos, announcements).

Once you schedule the posts, that's it. The job is done. Of course, there will always be spontaneous moments where you will want to post right then and there, but scheduling content will make you feel more in control.

To schedule a post, click the "carrot" icon to the right of the "Publish" button and then select "Schedule."

2. Tell memorable patient stories
Every patient has a story. Perhaps a child had a fear of the dentist's chair, overcame it and walked out of the office smiling. Or a person had not come to the dentist in many years and was relieved to get through with the visit. Relay the person's story on Facebook and include a happy photo (if it's a child you need parent's permission, of course).

People love to engage on Facebook with stories that make them feel good. Always be on the lookout for compelling patients who are willing to share their situation. The better the story, the more interaction on Facebook. And that means more "fans" and exposure for your practice.

3. Show off your team
Don't be afraid to post photos of your team working together and having a good time in the process. Your patients want to connect with you and feel comfortable visiting.

Build on the patient relationship (in between appointments) by reminding people what a special practice you have. This strategy is especially worthwhile for pediatric dentists – make the parents feel like coming to you is the best decision for their children!

4. Make people smarter
Be the expert on oral health care. That means sharing important advice so patients can properly care for their teeth.

Post interesting articles, create "memes" with quick one-sentence tips and allow your audience to feel informed and up to date.

And remember that the VDA posts "Tooth Tips" every Tuesday with oral health information that you can share on your practice's Facebook page.

"Advice" posts can often be scheduled ahead of time since they're not time sensitive.

5. Include "boosting" in your marketing budget
In this edition of the VDA Journal, our PR team included an insert with instructions on how to "boost" a Facebook post. In other words, how to sponsor the post with a small budget so it reaches a larger audience.

I recommend you set aside a monthly budget of $100-200 and "boost" posts you think people will like the most (see points #2-4 on this list) or the ones that gain traction organically.

While it doesn't make financial sense to "boost" everything you publish, 2-3 posts a month will go a long way to help you gain new "fans." For $200 a month, a Facebook page with 300 fans could reach a few thousand people – plus you can target the posts to men/women, a certain age range and city/cities where your audience lives. Facebook advertising is a cutting-edge way to advertise in the modern age.

Danny Rubin is vice president of Rubin Communications Group, the PR partner of the Virginia Dental Association. You can email Danny with any Facebook-related questions at danny@rubincommunications.com.

WHAT SHOULD DENTISTS POST ABOUT ON SOCIAL MEDIA?

30 GREAT SOCIAL MEDIA POST IDEAS FOR DENTISTS

Consistently posting on social media can be hard to do after a while. So, we thought we'd give you some inspiration! Here are 30 ideas on what to post about when you've had a hard day and are stumped on what to post about.

COMMUNITY AND VOLUNTEER EVENTS

1. Visit an elementary school to teach children about oral health and share this event with your followers.
2. Highlight volunteer work your practice is involved with.
3. Host a charity drive and promote it leading up to and on the day of the event (e.g. food, blood, toys, etc.)
4. Help promote events happening in your community like a pet adoption near you. People like to help spread the word!
5. Share information about scholarships you offer or are aware of, particularly for dental school students!

OFFICE CELEBRATIONS AND ANNOUNCEMENTS

6. Celebrate your staff with a happy birthday message. This will resonate with your loyal patients!
7. Congratulate your staff when they announce a pregnancy (given that they feel comfortable sharing this news).
8. Show your practice's personality and post photos of holiday parties, costume competitions or white elephant gift exchanges.
9. Have a new gadget in the office? Show it off!
10. Announce conferences that you are attending.
11. Share your experiences at CE events. People like to know that their dentist is keeping up with the times!
12. Introduce new-hires with a photo and quick bio.
13. Explain a new process that your practice has implemented to improve patient experiences, like confirming or rescheduling their appointments seamlessly online.
14. If you're in the news, it's OK to brag a little! Share local press about your practice.
15. Give your followers updates on holiday hours.

TESTIMONIAL CONTENT

16. Share your own positive, native reviews. Facebook allows patients to review you, so if someone has something nice to say "share" the post and thank them publicly.
17. Highlight before and after photos (with the patient's permission, of course).
18. Re-post any positive posts that patients post about and tag your practice in.

PROMOTIONS

19. Hold themed days such as Denture Days or Patient Appreciation Days. Having a blog post that explains the promotion helps too.
20. Offer a discount to new clients. Tip: Promotions are best shared near end of calendar year when people are thinking about their expiring benefits.
21. Create a Patient of the Month program and congratulate patients publicly.

EDUCATIONAL CONTENT

22. Create a list of common questions and answer one common question each week, such as "What to do in a dental emergency?"
23. Discuss your opinion of fashions trends that affect oral health such as piercings, jewelry in teeth, and other uncommon cosmetic procedures.

Entertaining or Humorous Content

24. Share celebrity dental news like Sharon Osbourne losing a dental implant on live television.
25. Entertain your patients with celebrity before and after smile comparisons.
26. Uncover myths about dentists debunked.
27. Highlight fun facts about dentistry. A quick google search can help come up with a few.
28. Make kids laugh with cartoons about dentists. Use your best judgment to determine if this is consistent with your practice's voice and personality.
29. Re-post relatable content such as these Buzzfeed articles about dentists. Use your best judgement to determine if this is consistent with your brand as well.
30. Repost old content that did well as a #TBT (throw-back Thursday) post.

For more information about social media management for dental practices, download our free guide to Running a Dental Practice in the Age of Social Media.

Article written by Fanny Barrientos, Marketing Specialist at ProSites. ProSites is endorsed by VDA Services for their website design and online marketing solutions including search engine optimization (SEO), social media, and pay-per-click advertising. VDA members receive 25% off the standard website set-up. For more information, or to start a free trial, call (888) 932-3644 or visit www.ProSites.com/VDA.

ETHICS: INTERNET SEARCHES

Dr. A Garrett Gouldin;
Member, Ethics and Judicial Affairs Committee

A recent complaint to our component Ethics Committee from a member dentist might best be addressed by the advisory opinion 5.F.6 in the ADA Principles of Ethics and Code of Professional Conduct. The complaint came from a specialist. The specialist was surprised to see multiple dentists without specialty credentials showing up in a Google search when she typed in ''specialist in (the town in which she practices)". Advisory opinion 5.F.6. states that "Dentists may use services to increase the visibility of their web sites when consumers perform searches for dentally-related content. This technique is generally known as 'search engine optimization' or 'SEO'. Dentists have an ethical obligation to ensure that their websites, like their other professional announcements, are truthful and do not present information in a manner that is false and misleading in a material respect."

Even if a web designer has assisted in writing the dental practice webpages, the owner must be involved and ultimately the owner is held responsible for the practice website and all of its content. Additionally, the owner dentist is also responsible for associating with a website company that utilizes sound, ethical SEO methods; from a legal standpoint, ignorance in such matters is not an adequate excuse. 5.F.6. concludes with "Also, any SEO techniques used in connection with a dentist's web site should comport with the ADA Principles of Ethics and Code of Professional Conduct."

As dentists, we are not expected to understand the algorithm used by Google for various searches. In the case above, the dentists that are improperly representing as specialists likely are not aware that they are showing up in this search. It is a difficult thing to self-police, no doubt. But as 5.H. points out, "Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct."

Every dentist that advertises has a responsibility to be truthful, and as always to put the patient's needs first. We would do well to communicate with one another as colleagues when we see a situation such as the one above. Another option is to make your component's Ethics Committee aware of the potentially unethical finding so that they might notify the colleague to allow corrective action.

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EDIC RISK MANAGEMENT | WITHIN YOUR CONTROL

Instructions and Explanations – Do Your Patients Understand Yours?

Debra Udey | EDIC Risk Manager
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A recent article in the *Wall Street Journal*[1] discussed the difficulties patients have retaining information given at a doctor's appointment or a hospital stay. In situations where news of a serious condition has been conveyed, this is certainly understandable. Trying to process such information can be stressful. Retaining everything that has been said may be nearly impossible. According to the article, some doctors are recording the information for patients so they can listen to it as many times as they need to understand it and it has helped their comprehension.

The good news is that dentists are not often the bearer of such bad tidings. Nonetheless, it is important that patients understand what you tell them about their conditions as well as the instructions you give them. Patients are your partners in care, and if they don't do their part, all your good work can be for naught.

It is not news that patients don't remember information their clinicians tell them. Though the statistics cited in the Wall Street Journal come from a study performed in 2003, there are no newer studies suggesting the numbers have improved. That study indicated that 40-80% of medical information provided by healthcare practitioners is forgotten immediately[2]. Even worse, the study showed that almost half of the information that was remembered was incorrect.

There are several ways that a patient's failure to remember what you tell him or her can be harmful. Some things can be fairly serious (such as not taking the necessary precautions to stop bleeding that may occur after a tooth extraction or failing to go to a Periodontist when referred), while others are less serious but still important (not flossing or brushing thoroughly).

Patient's failures to remember information can also "hurt" the office. Telephone calls asking for information that was discussed during the office visit can clog up the phone lines and prevent more important calls from being answered or placed in a timely manner.

What can be done to help patients remember what you tell them? Several things can work. First, think about your instruction sheets for various conditions and follow up for procedures. Do they give enough information? Do they explain why the instructions you are giving them are important, and what will happen if they don't follow them? If you make a referral to a patient to a Periodontist, have you explained why it is important to see the referral and what can happen if they don't? Perhaps if they had an information sheet they could read again on their own time, they might better understand the importance of following your instructions and do so.

It is also important that instruction sheets have enough explanation to make them useful. Think about what you are telling the patients. Do you explain why you are giving the instructions and why they are necessary? Since patients forget 40-80% of what you tell them, and half of what they remember is wrong, the more opportunities you give the patient to understand the information, the better the chances they will follow the instructions.

Second, look at the instruction sheets you give patients to assess whether they can understand them. The instructions should be in very plain language. Considering that the reading level of the average American adult is somewhere between the 5th and 8th grade level, your forms and information should contain language the average adult can read. There are many resources online that can assess the reading level needed to understand printed language (you can Google "reading level calculator" to find one). If the verbiage on your forms is too complicated, simplify it by using less complicated words and shorter sentences. You might even give the form to your 5th grader at home to read (or borrow your neighbor's) to see if he or she understands the information.

Third, for a period of time, track the questions asked by patients calling the office. If you find that some questions are asked more often, think about how you can improve your explanations at the time of the appointment, or whether an information sheet or instruction form would help. Be willing to alter your forms when necessary to assure the patient's best understanding.

You do your best to provide optimal care for your patients. Your patients need to do their part, and they can do that more effectively if they understand what they need to do and why it is necessary. To do this, they need to receive the right information and understand it. Giving them this information in a format they can understand will help. There are many situations where electronics enable easy communication. But sometimes, a piece of paper might be just the ticket. ■

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[1]What Patients Need to Recall After a Hospital Stay, Wall Street Journal, December 1, 2015. [2]Kessels, RPC, J R Soc Med. 2003 May; 96(5): 219–222

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THRIVING IN A COMPETITIVE ECONOMY

TIPS TO OVERCOME OBSTACLES

Dr. James R. Schroeder

Our profession is morphing before our very eyes yet we are often too busy to notice the change taking place just outside the front door. As often as we press the *refresh* button on our computer, we should clean and *refresh* the lens we look through to examine our practice. By doing this exercise of assessment on a regular basis, we protect ourselves from drifting into a practice of the past instead of one progressing into the future. Let's be honest, the complexity of establishing a practice or taking on an associate - who has extremely limited technical skills and experience, while carrying the burden of student debt in the $200,000 to $300,000 range - makes it challenging at best for everyone. Many young graduates who return and visit with me discuss the struggles they face with their debt and the limitations they confront - with dental skills and career choices. The corporate model has focused on young dentists and has become increasingly appealing to this population as they multiply across the country.

How do we respond to this rapidly changing world where the half-life of knowledge becomes shorter and shorter?

A few recent changes further illustrate our need to refresh our screen: iPhone 7, cars without drivers, scanning in place of dental impressions.

An approach I use with students and recent graduates is to continue learning and become a life-long learner and student! We often establish fixed behavior patterns as time moves on and we become more comfortable. Although the experience garnered through time is invaluable, an open mind with the desire to grow and achieve is a crucial part of progressing into the future.

Develop a fresh outlook

Think of yourself as a toddler who just started learning to walk. In the wide eyes of a child this fresh view of the world is perceived as the start of a new journey, a journey of endless possibilities as they embrace each opportunity to fully explore. With renewed vigor and the unsurpassed eagerness each new discovery holds, the toddler's quest is almost unstoppable.

With the passing of time, new experiences become less frequent, our perceptions shift and with that, possibilities that bring opportunity can be overlooked.

As you enter your new world, forget preconceived ideas about what 'should be' versus the reality you see in front of you. As our industry evolves and our patients along with it - we should be asking ourselves; do we need to make any adjustments or take a look at how external forces are affecting us internally? How do we view our patients, the practice and our overall growth? Is what you've been doing all along and what you are comfortable doing enough? Are we always searching for opportunities that achieve our goals and provide growth for staff as well as the practice?

The following suggestions may be uncomfortable for some, as different personality types handle each situation differently. Some may feel "things are good, we're doing fine, don't rock the boat, why change anything?" Renowned author Jim Collins states, "Good is the enemy of Great" and that "Greatness is not a function of circumstance. Greatness, it turns out, is largely a matter of conscious choice, and discipline. "

If we choose to stay comfortable and are not willing to risk something different or unusual, we end up settling for the ordinary or worse, mediocracy.

• Situations and people often may seem like annoyances but if developed, can become amazing opportunities that can help develop your practice.

• One of the most endearing opening statements a new patient can hear, "How may I help you?" (An attitude of serving each other and the patient - must permeate your office. Patients feel it as well as sense it.) This has to be the attitude of everyone and must come from the receptionist as soon as the patient walks through the door, the hygienist greeting the patient as she is seated in her chair, and the doctor as he works with patients and staff.

• By the end of the first appointment we should know our patients well enough to know what they value. With that knowledge, presenting a treatment plan in a language they understand and in terms of what they value most. It provides clarity for them and the ability to make a decision to move forward. Fifty percent of dentistry is related to the treatment of disease while the other fifty percent is related to treatment that is elective. (What's important to the patient and what outcome do they want?) The staff member and doctor should be able to answer that question after the first appointment.

• Two words that all ages value and understand are: **preserve and prevent** - "we would like to preserve your existing teeth and the oral health that provides structure for your smile, how you eat, and at the same time be free of pain" In addition, we want to "prevent any future problems that can cause other issues and create more expense" - preserve and prevent becomes your mantra. Get ownership from the patient"is that what you are interested in and what you would like to do?" preserve and prevent. Practice how you communicate a patient's needs. Everyone processes information differently. If you have not communicated in terms that a patient understands with consideration to what they value and what is important to them, the patient will not feel confident enough to move forward. People will spend their hard earned money and invest precious time - on what they value. Your goal as a leader is to develop and influence people to make healthy choices that will benefit the quality of their life. This will be a lifelong art and a skill that continues to develop. Without this level of understanding and how important communication is to the patient, a practice becomes extremely limited with little or no potential for growth.

• Some weekend and holiday emergency patients were some of my greatest raving fans. These visits can be better than a paid TV commercial or paper advertisement. Making yourself available (even when it may not be convenient for you) is a key factor in growing your practice. A good principle to remember that aligns with "how may I help you?" – it's not about you, it's about the patient.

• Many of the things I am discussing center on engaging the patient. If you do not engage the patient, they probably won't come back and if they do, they will not be part of your referral base. Engaging the

patient and staff members to be loyal to you and your practice starts with the heart. This is a very difficult concept for many physicians and dentists to comprehend. The heart is where trust begins. If you do not create an environment of trust for patients so they will trust in your practice, the road ahead will be difficult at best.

• Once engagement has been established and continues throughout the oral exam, a discussion about how you can help the patient achieve their goals, their desired needs and wants, is appropriate if a solid foundation of trust has been established. With that base of trust, you and the patient can be confident discussing treatment plans and what works best relative to their goals. Available options may need creative solutions and provide a comfort level for a patient to make the decision to move forward. This provides accountability for the services the patient will receive, and clearly illustrates its value in terms of the investment in their oral health.

• Talking about the cost of a procedure or money without connecting it to patient value and oral health is prohibited - at all times. The value one obtains through oral health and preserving their teeth should be reinforced throughout their visits. We often forget we are in competition for limited dollars as the market becomes more crowded, more competitive, and we don't have a Madison Avenue marketing budget to advertise what we do. Your team must be masters at communicating honest value in terms of patient needs. If your office staff is not excited or believe in what you do and how you do it, your patient care will have limited success.

• In today 's dental market the doctor cannot hide behind the face mask or work quietly behind the scenes. Extravert, introvert, whatever- vert, you must introduce yourself to the community. Not very many people are going to come to you and welcome the 'new guy' on the block. Identify twenty pharmacies, doc in the box, ERs, and child care centers in your area. Develop a letter of introduction about you and the staff and perhaps a professional courtesy with your business card. Conversations at child development centers should also take place: "Good morning, is the director available, my name is Dr. Joe." (The night before after you've looked at the website and read a little about the director, offer a compliment. "Hi Ms. Jones, I saw what a great facility you have here and wanted to let you know that I've just opened my practice about two miles from your center. I've also had training with dental accidents and dental emergencies. If you ever have a need, we certainly will do our best to see your children immediately whenever possible. I am also available for short education programs for children or parents. If your staff ever has any problems tell them to feel free to call me." Sometimes if you have complimented them on their beautiful facility they may offer a tour or you may say "May I have a few brochures in case I have patients in need of childcare?" If they offer a tour they often will introduce you to staff at which time you can give them your card. These kinds of conversations must be done with discernment and a genuinely warm, caring attitude. Not like a pushy used car salesman. The greatest thing you must understand about private practice/public setting; in your years of school you were evaluated on your skills, in the public you are evaluated on your leadership abilities and most importantly your relationship skills. I find these visits will not occur regularly if you do not have a deliberate plan that is marked on your calendar. (By the inch it's a cinch, by the yard it's hard.)

• Become a maniac at acknowledging people. Handwritten thank-you notes, follow-up phone calls, deaths, weddings, births all make an impact, are remembered, and imprinted in people's brains. This has to be genuine! If you don't give a rip about people, patients, or care about their needs they see right through it! And quite frankly if that's the case, you may want to rethink career options!

• Try to find something to express appreciation and gratitude to your patient ("and by the way if you have any friends that need a dentist, please give them my card. I also have had additional years of training and have experience handling emergencies and difficult or complex dental situations and availability after hours.")

• Appreciation is the fuel that energizes staff. When used properly it also allows you to address situations that did not work well or you don't want continued.

• Remind yourself that people came to you for your expertise in your field. Give them recommendations you think is in their best interest, and have a conversation about how you can make this happen for them.

YOUR enthusiasm for the patient, their care,and your profession will be the barometer for your staff. Whatever it takes, wherever you are and whenever you can; show an external excitement about each day, throughout the day. Start the day with enthusiasm and excitement as soon as you arrive at the office with a cheerful greeting, and as you leave in the evening a grateful departure and "Thank you" for their work, with genuine enthusiasm about tomorrow.

All of these things will contribute to a healthy atmosphere and a growing practice. Beyond these tips are many organizational details that must be in place, understood by all staff members, with everyone working as a cohesive team. But that's for another day. In the meantime:

"The future depends on what you do today ... " -Mahatma Gandhi

Editor's Note: Dr. James R. Schroeder practiced dentistry in Richmond and is the founder of Leadership by Design. If you have any questions or would like help implementing a change in your office, contact Dr. Jim Schroeder at 804-897-5900. jim@drjimschroeder.com

40 UNDER 40

DR. RANA GRAHAM-MONTAQUE

Dr. Rana Graham-Montaque of Pediatric Dental Specialists of Williamsburg gets crazy excited about providing quality care for children and patients with special needs! During her spare time, the VCU School of Dentistry graduate enjoys quality time with her husband Rick and their two children.

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IMPACT TECHNOLOGY

VIRGINIA DENTAL POLITICAL ACTION COMMITTEE (VADPAC) UPDATE

Laura Givens, VDA Director of Legislative & Public Policy

Component	% of 2016 Members Contributing to Date	2016 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	40%	$45,500	$33,990	$268	75%
2 (Peninsula)	50%	$27,500	$23,790	$270	87%
3 (Southside)	38%	$14,000	$10,375	$314	74%
4 (Richmond)	37%	$67,750	$67,705	$345	99%
5 (Piedmont)	42%	$30,000	$26,295	$280	88%
6 (Southwest VA)	63%	$25,250	$26,056	$334	103%
7 (Shenandoah Valley)	48%	$30,000	$31,135	$280	104%
8 (Northern VA)	33%	$135,000	$106,765	$296	79%
TOTAL	**44%**	**$375,000**	**$326,101**	**$298**	**87%**

Total Contributions: $326,101

Goal: $375,000

WE NEED YOUR CONTRIBUTIONS TO RAISE $48,899

VADPAC would like to recognize components 6 and 7 for surpassing their goals for the 2016 year. We are nearing the end of this year, which means that there are only a few weeks left to make contributions for 2016 – **Don't sit on the sidelines while your colleagues pick up the slack!**

The goal has not yet been reached and rest assured our foes in the legislative process keep close tabs on how we do each and every year which is why we cannot afford any backsliding! We are so appreciative to all who made voluntary contributions and we still have the potential to reach our goal. Have you made your contribution yet for 2016? If not, there is still time! Please call Laura Givens to make a contribution over the phone at 804-523-2185 or email her at givens@vadental.org to be sent a form. VADPAC has the potential to grow substantially in the coming years but we need to have the collective support from VDA members.

Dues will be mailed in the next month or so for 2017 and we urge members to submit contributions when sending in your 2017 VDA dues payments. Your contributions are imperative to securing the livelihood of the practice of dentistry. When you give to VADPAC, you are raising the voice of dentistry and sending a strong message to our enemies – *pick a fight with us and you are in for a real battle!*

Please contribute! Contact Laura Givens at givens@vadental.org or 804-523-2185 with questions.

VDA'S LEGISLATIVE DAY ON THE HILL:

MARK YOUR CALENDAR FOR JANUARY 20, 2017

Every year, dentists from around Virginia and VCU dental students gather in Richmond for the VDA's annual Day on the Hill.

This is one of the most important days of the year for the VDA because it gives members the opportunity to join together to inform policy makers about the profession.

Breakfast will be at the Omni in downtown Richmond at no cost to you and our Day on the Hill is over before lunch.

Mark your calendar now for January 20, 2017! We look forward to seeing you in Richmond.

Updated ACA mandate

MEDICARE OPT-IN OR ENROLL REQUIREMENT

Over the past two years, dentists and their staffs have been seeking guidance regarding the regulations that require them to either opt-out of or enroll with Medicare and Medicare Advantage. It has been a confusing process and sometimes difficult to find answers but the ADA and VDA have tried to be a helpful resource. The deadline for taking action (either opting out or enrolling) has been extended several times and, as it now stands, the current deadline is February 1, 2017. Below are some answers some of the frequently asked questions that the VDA has received from members. We hope that you find this information helpful.

FREQUENTLY ASKED QUESTIONS

Do I have to do something (opt out/enroll) or can I do nothing?

If you do nothing, the patients for whom you prescribe any type of Medicare Part D drug with not be able to use their drug benefit. All of those Medicare patients would be notified that you are not qualified to write them prescriptions. Also, if you have patients with Medicare Advantage plans, you would not be able to bill for any of those services.

What if I opted-out already and now I would like to change my status and enroll?

If you have already officially opted-out, your status cannot be changed for 2 years (unless you contact CMS within 90 days of opting out). For those dentists who opted out before June 16, 2015, you must submit a renewal affidavit to all Medicare Contractors within 30 days after the current opted out period. If you opted out after June 16, 2015, Medicare will automatically renew your status at the 2-year deadline.

How do I Opt-Out?

You must complete an opt-out affidavit form through Palmetto GBA*, which is the entity that administers Medicare in Virginia. You can find the affidavit form online at http://www.palmettogba.com/Palmetto/Providers.Nsf/files/Form_Medicare_Opt-Out_Affidavit.pdf/$File/Form_Medicare_Opt-Out_Affidavit.pdf

*Providers located in the city of Alexandria and the counties of Arlington and Fairfax are considered part of the Washington, DC Metro area and therefore need to enroll and opt-out with **Novitas**, a different Medicare Administrator. For information on Novitas opt out and enrollment information, visit http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?_adf.ctrl-state=ikeeyzc_43&contentId=00098112&_afrLoop=666087582756479#!

How can I find my status and/or opt-out expiration?

A list of Opt-out providers is accessible from Palmetto GBA online and can be found at http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-Part-B~8FFEHK8181

Some other questions have been addressed by Palmetto GBA and can be found on their website at http://www.palmettogba.com/Palmetto/Providers.Nsf/files/FAQs_Dentists.pdf/$File/FAQs_Dentists.pdf

For additional FAQs, the Center for Medicare and Medicaid Services (CMS) has information on their website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf

SECTION 1557: HOW DOES IT AFFECT YOUR PRACTICE AND YOUR PATIENTS?

Effective July 18, 2016, all dentists who accept Medicaid, Medicare A, C and D and Medicare Advantage payments are responsible for following provisions under Section 1557 of the Affordable Care Act. This law basically requires that patients who receive federal assistance cannot be denied health services or health coverage or discriminated against in other ways in health services or coverage because of their race, color, national origin, sex, age, or disability.

As of the effective date, you are required to do the following:

- Arrange for translator/interpreter services if requested by a patient and necessary. For Medicaid providers in Virginia, DentaQuest will reimburse for these services and they have a list of approved interpreter services on their website. It is recommended that you contact DentaQuest if you would like information on the services and the process for reimbursement. Some other plans may also pay for these services and, if the service is needed for a patient, the recommendation would be for you to contact the particular plan to inquire.
- Post a notice of nondiscrimination in your dental office and on your website. This is required by October 16, 2016.
- Post taglines in your dental office and on your website indicating that the language assistance services are available at no charge. These taglines must be made in the 15 most common languages spoken in the state and they must be printed on your most important publications and communications. The 15 non-English languages for Virginia are: Spanish, Korean, Vietnamese, Chinese, Arabic, Tagalog, Persian, Amharic, Urdu, French, Russian, Hindi, German, Bengali, and Kru/Ibo/Yoruba. This is also required by October 16, 2016.

The ADA requested that the Office for Civil Rights extend the implementation deadline to allow sufficient time for ADA members to meet the requirements but this request was denied. The ADA has also asked that the most burdensome regulations be limited to only those practices employing 25 or more staff.

More resources can be found on the ADA website at http://success.ada.org/en/practice/operations/section-1557/section-1557-the-basics-on-what-you-must-do

The Health and Human Services Website also includes some resources for providers regarding these regulations.

- FAQs on the final rule: http://www.hhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-faqs-508.pdf
- Review the Civil Rights for Providers of Health Care and Human Services: http://www.hhs.gov/civil-rights/for-providers/index.html

DENTISTRY VISITS THE 2016 RNC AND DNC CONVENTIONS

MY PERSPECTIVE

Dr. Bruce Hutchison; Chair, ADPAC; Chair, VADPAC

Having just returned from attending both the RNC and DNC 2016 Conventions held in Cleveland and Philadelphia respectively, I thought I would report on the experience. It was an honor and privilege representing ADPAC and the ADA at each event. These are only my personal observations, the similarities and the differences of each, the cities, the people and the experience. I will stay away from political commentary, who is right and who is wrong – that's for you to decide. The ADA and dentistry were well represented at both conventions. Attending the RNC, July 18 to 21 were: Dr. Carol Summerhays, ADA President, and her husband Soames, Dr. Ron Lemmo, ADA Treasurer, Dr. Mark Zust, ADA Trustee, and his wife Phyllis, Dr. Bruce Hutchison, ADPAC Chair, Dr. Rick Andolina, ADPAC Chair-elect, Dr. Britt McCarthy, ADPAC Board Member, Dr. Gordon Austin, Delegate from Georgia, Dr. David Narramore, Delegate from Kentucky, and Ms. Sarah Milligan, ADPAC Director. The DNC Convention, July 25-28 was attended by: Dr. Bruce Hutchison, ADPAC Chair, Dr. Rick Andolina, ADPAC Chair-elect, Dr. Bernie Dishler, ADPAC Board member, and his wife Lana, Ms. Sarah Milligan, ADPAC Director, Mr. Peter Aiello, ADPAC Grassroots Manager, Ms Natalie Ponzer, ADPAC Senior Project Assistant, Ms. Nancy Mo, dental student at Columbia University and ADPAC Summer Intern, and Ms. Elieza Tang, dental student at Midwestern University and ADPAC Summer Intern. We each attended one or more days of the conventions and got to experience American politics firsthand. It was an amazing experience.

Emotions ran high and at both conventions, there was lots of passion and excitement. Both were attended by people who knew what they wanted. Both started out with discontent and even anger, but in the end, both parties made their decisions and left the conventions with a relatively unified direction and voice. The feeling of pure patriotism and love of country was abundant in both instances. American exceptionalism was celebrated and both had a feeling of wanting to do everything possible to keep America strong and on track. There was no doubt that America is the best country on earth, period. And that we can do even better- that was the common thread. I did not experience anyone who did not absolutely love America. I stayed away from the few demonstrators.

ADPAC co-hosted an event at each convention along with the Physician Specialty PACs. These included the Family Physicians, Orthopaedic Surgeons, Emergency Physicians, Radiology, Surgeons, OB-GYNs, Osteopathic Physicians and Anesthesiologists. As a quick aside, ADPAC works closely with this group, collectively called MADPAC- Medical and Dental PACs- to combine forces to be even more effective. They help us, and we help them. It is truly a symbiotic relationship and we all benefit from working together. This cosponsored event allowed us to have a very visible presence, on a relatively small budget. We got a lot of bang for our buck so to speak. Both of these receptions were held early Wednesday evening so that attendees could mingle for a while before heading to the actual convention centers. They both had a "Speak Easy" theme with a password to get in, "DOCS." Each had a small jazz band playing in the background with "speak easy" themed drinks and hors d'oeuvres. Attendees mingled with several members of Congress and we got to mingle with the other medical PAC people, staff and volunteer leaders. Both receptions were a big hit.

L-R: Dr. Bruce Hutchison, Rep. Renee Ellmers (R-NC)

Cleveland, Ohio did a great job of hosting the Republican National Convention. The city itself seemed to be totally geared up for the convention. The Quicken Loans Center, or the "Q" as it is called, hosted the event. The Q is located downtown so the city was hopping. Many streets were blocked off to allow just pedestrian traffic, and a perimeter was established that only allowed credentialed individuals into the "convention zone." A two block area known as 4th Street, the new and upcoming "in" area of Cleveland, was busy all day and all night. There were multiple street vendors selling T-shirts, buttons and other memorabilia everywhere you went. A little bit of a circus flavor to it. The police presence was obvious. There were groups of police from all over the country, but it seemed that Texas communities had sent a lot of the "extra" police to Cleveland. They were on horses, on bicycles, and on foot. Every cop we spoke with was polite and helpful. We thanked them all each day because we felt very safe and not at all uneasy. They were calm, but present. They did a great job. We noticed essentially no unlawful disturbances, and heard that the few that happened were quickly put down. A few arrests were made, but not many. The city was fun, active, and vibrant, but peaceful. Everyone I spoke with thought that Cleveland did an outstanding job hosting the event. From a host city point of view, I think this was a big success.

Philadelphia, perhaps because it is a larger city and that the Wells Fargo Arena was in South Philly and not center city, had a different feel. The city itself didn't seem to notice the convention much. It seemed like every day life continued on as usual. The police presence in the downtown area was not significant, but they were noticeable at the arena. Philadelphia Police, along with TSA and Secret Service agents and police seemed to have everything under control. Again, we

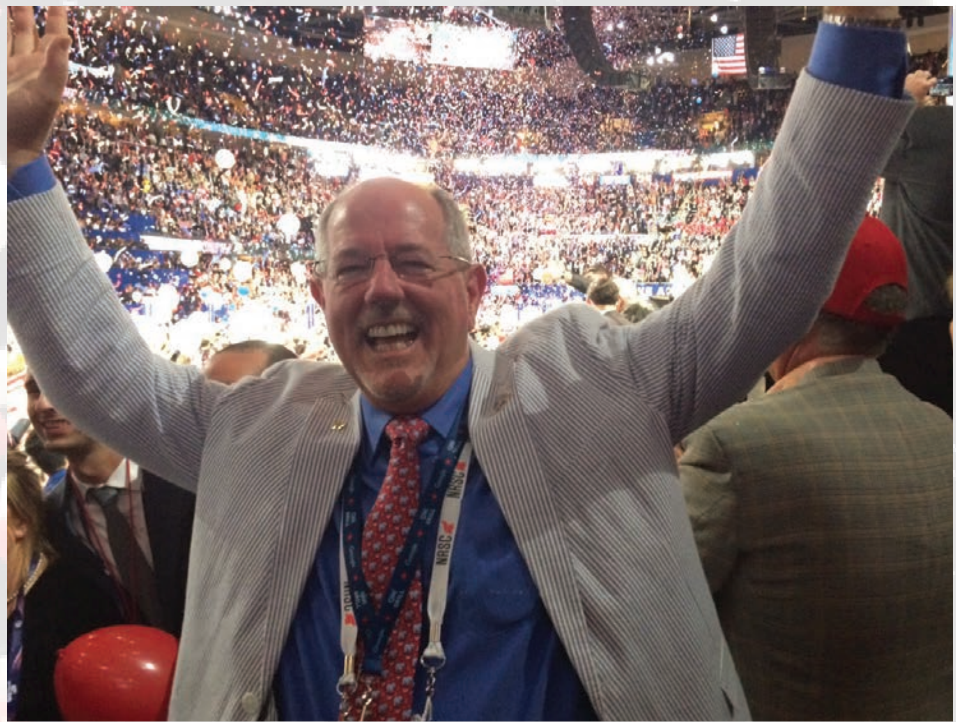
saw very few disturbances and heard very little about demonstrators. Security in Philly seemed a little more lax than in Cleveland, but again, we never felt unsafe. I was never able to find many vendors selling buttons, T-shirts and such, so I didn't really walk away with many souvenirs. That's too bad.

I attended the actual conventions Wednesday and Thursday nights both weeks. Both had beautiful stages built for effect- and built for TV: lots of lights, cameras and red, white, and blue. Both were patriotic, inspiring, and visually impressive. For the RNC, tickets were reserved for sections, then it was first come first seated in that section. We never had a problem getting a seat in our section. For the DNC, all seating was general admission, and they gave out way more tickets than there were seats. To get a decent seat you had to show up 3 or 4 hours early, and frankly, I just wouldn't do that. So our seats were pretty bad. The RNC had lots of TVs and a four-sided jumbotron so that everyone could see everything, The DNC had very few TVs available, no jumbotron, so with the seats we had, we saw almost nothing. The RNC made sure each of us had the opportunity to go "on the floor" with an escort at least once during our stay. I was also lucky enough to switch credentials with a delegate from Virginia who I knew and got onto the floor of the event. That was pretty cool - actually being on the floor and feeling the excitement and feeling like you were a part of it. The DNC did not offer that opportunity to us so we never actually got on the floor there. That's too bad – it too, would have been a great experience. As a guest and an attendee, I felt more welcomed at the RNC convention. They get my vote as the best host.

As far as content goes, the RNC seemed less organized, had fewer speakers, and lacked the quality and messaging of the DNC speakers. The DNC event was more organized, better choreographed, more on point with their messaging, and had an array of fantastic speakers. I felt the DNC tried too hard to be all inclusive- almost to a fault. It seemed a little artificial. The speakers at the DNC were better on the whole, and built their Convention to a crescendo. Both parties promised more than they can actually deliver, in my opinion at least. So for choreography and messaging, I give the nod to the DNC.

At each convention we were hosted to multiple breakfast and luncheon events. These included the New York Republican breakfast, lunch with Congressman Sam Graves from Missouri, lunch with the National Republican Senate Committee, breakfast with the Democratic Senate Campaign Committee and lunch with the Democratic National Convention Committee. Each of these events offered us the opportunity to meet and speak with Members of Congress. Each time I meet a Member, I am still impressed with the credibility our great profession carries with it. Members are thankful to what dentistry and the ADA have done for them, and for the public we serve. When we talk with them and say "We're from the ADA," they listen. They admire the way we keep them informed and how we care about our patients. I believe that all we do as far as advocacy for our profession is making a difference. They, the legislators, are noticing us. We have gotten their ear, and we have a good story to tell. We must keep pushing forward for our profession and our patients.

I am so thankful that I got to experience both conventions. It was an experience I will never forget. I actually walk away, less cynical than I was before. My observation is that both parties are doing what they can to keep America the shining jewel that it is. Yes- they have different approaches and different ideas, but that's the beauty of it. None of us have all the answers, but if we all take the time to listen, we take the time to debate the issues on their merit, we vote for the people we believe will do the best for America, we take the time to help educate our legislators, and we stay involved in the process- it can work. I love this profession and I love America. God Bless America.



MARTINSVILLE COMMUNITY DENTAL CLINIC CELEBRATES 10 YEAR ANNIVERSARY

Stephanie Vlahos, DDS; Associate Editor, Component 5

2016 marks the 10th anniversary that the Community Dental Clinic in Martinsville opened its doors to provide dental care to unemployed or uninsured children and adults. Founded by VDA members Dr. Mark Crabtree and Dr. Edward Snyder, the clinic has provided around 8 million dollars worth of care to more than 37 thousand dental patients.

Started after a major factory in Martinsville closed, the intent has always been to ensure that the healthcare needs of every person are met, no matter the economic conditions. For an average of $20 a visit, patients can receive needed dental treatment ranging from simple restorations to root canal therapy.

Dr. Mark Crabtree said “There was never any doubt about the need for the clinic. The doubt was whether the community could sustain the clinic. What has been accomplished here is a miracle.” The clinic is now a service that has become a model for others around the country.

Dental students from Virginia Commonwealth University School of Dentistry under the supervision of dentist Dr. James Hartigan provide quality dental care to patients. “This partnership is mutually beneficial. The students receive outstanding practical experience and learn the value of public health service, while our patients receive excellent care” Dr. Crabtree said. The clinic is considered one of the best extramural sites for VCU dental students in the commonwealth.

Nationwide, dental visits are increasing exponentially at hospital emergency rooms. One study has reported the number increased from just 1 million in 2000 to more than 2 million in 2010. However, often patients in emergency rooms still don’t receive needed treatment for financial reasons. Memorial Hospital of Martinsville-Henry County has seen a 34 percent decrease in dental visits since 2007, which is attributed to the clinic.

Just last year, the clinic saw a 15 percent increase in services provided. “The clinic represents the best of Martinsville-Henry County. This is a partnership that works and will continue to work as long as we have the support of the community” Dr. Crabtree said.

VDA MEMBERS TALK DENTAL HYGIENE ONCE MORE WITH SUMMER CAMPERS

Danny Rubin

On Friday, August 12, our members took on a fun assignment once again. They talked with campers in Northern Virginia about the importance of proper oral health!

Many thanks to Drs. Emily DaSilva and Carol Wooddell for spending time with the children. The two spoke to the campers at South Run RECenter in Springfield.

The camp, organized by Fairfax Parks & Recreation, is the largest summer camp in Northern Virginia. Children came into the room in several groups over a two-hour period to learn about the importance of brushing, flossing and taking care of their teeth.

This summer has been a busy one for the VDA dentists in Northern Virginia. In June, VDA dentist Dr. Sanford Montalto, and his wife, Rebecca, a hygienist, volunteered to educate seniors on their oral health. The event took place at the South County Senior Center in Alexandria. The senior center is part of the Fairfax County Parks & Recreation system.

And in July, Drs. Raymund V. Favis and Niloofar Mofakhami met with campers at Providence Rec Center in Falls Church for a discussion on how to be “mouth healthy.” Thank you to our friends at Fairfax Parks & Recreation for being such willing partners all summer long. Special thanks to Barbara Nugent, park services division director, for her help to coordinate the three volunteer events.

2016 MOM IN WISE COUNTY HELPS MORE THAN 1,200 SOUTHWEST VIRGINIA RESIDENTS

Danny Rubin

Once again, our members made a tremendous impact at the MOM (Mission of Mercy) Project in Wise County.

We provided free care for 1,232 people at the annual dental clinic, which took place July 22-24. We estimate the total value of donated care at $1,313,789. During the 2 ½ day event, our volunteers performed exams, fillings, extractions, cleanings and root canals as well as furnishing more than fifty patients with complete dentures.

This year marks the 17th consecutive we have volunteered at the Wise County Fairgrounds on behalf of the Virginia Dental Association Foundation (VDAF). To date, we have helped over 21,000 people in Southwest Virginia and donated more than $17.8 million in care.

“By returning to Wise year after year, the members of the VDA show how much they value the oral health of all Virginians,” said Tara Quinn, executive director of the VDAF. “We are grateful we can provide treatment to these grateful men, women and children and hope to do so for many years to come.”

One VDA dentist, Dr. Randy Lazear, and his wife, Vickie, have attended nearly every “MOM” in Wise since 2000. While in Wise, the couple camps out at the fairgrounds. Their dental assistant came along this time and brought her own tent too.

The trio arrived not by car but…by plane! That’s right. Dr. Lazear is a licensed pilot and flies everyone in his “four-seater,” as he calls it. It’s a three-hour flight from their home in Springfield and then a short drive in a rented car from the small local airport to the fairgrounds.

Why does Dr. Lazear come back year after year?

“Volunteering at MOM is a satisfying feeling,” he said. “The patients are so thankful for the help, and it makes us all feel good.”

Thank you to Dr. Lazear and ALL of the volunteers for another successful year in Wise. The next MOM is October 1-2, 2016 in Grundy.

Wise MOM is also made possible by partnerships with the Virginia Dental Association, VCU School of Dentistry and Dental Hygiene, The Health Wagon, Remote Area Medical, Virginia Health Care Foundation, the Lions Club and a host of other sponsors.
Here’s a breakdown of the treatment provided:

Total Patients: 1,232
Total Value of Donated Care: $1,313,789
Exams: 1,232
Fillings: 1,401
Extractions: 3,368
Cleanings: 140
Gross debridements: 24
Fluoride txt: 164
X-rays: 1,168
Root canals: 94
Complete dentures: 102
Partial dentures: 42
Denture adjustments: 19
Denture relines: 20

Many Thanks to Our Sponsors

2015-16 Silver, Gold, and Platinum Sponsors and Supporters

The generosity of our Silver, Gold, and Platinum Sponsors and Supporters helps ensure not only that we continue to serve those in need this year, but make a resounding impact on the oral health of thousands of Virginia by making the VDAF a stronger and more sustainable organization in the long term. We **TRULY APPRECIATE** the companies, foundations, and individuals who fully embrace our mission to provide access to dental care for underserved Virginians.

Virginia Dental ASSOCIATION

SENTARA®

Buchanan County Youth, Inc.

SPECIAL SMILES 2016 MOM PROJECT HELD AT UNIVERSITY OF RICHMOND

Barbara Rollins; Director of Logistics, Missions of Mercy

On June 11 the Special Olympics MOM project was hosted by the University of Richmond. Through partnerships with the VCU School of Dentistry and Dental Hygiene, University of Pittsburgh, School of Dental Medicine, Special Smiles of Virginia, Healthy Athletes Program, Virginia Dental Association and VDA Foundation 136 Special Olympics athletes received dental care valued at $32,667.

Dental treatment provided included:
Total patients: 136
Total value of donated care: $32,667

A special thanks to Dr. Matthew Cooke, lead dentist and site coordinator, for his continued leadership with Special Olympics MOM. If you have not had the opportunity to attend this project, we encourage your participation – we think you will find it to be a wonderful use of your time and talents.

Save the Date: Special Olympics MOM 2017 to be held on Saturday, June 10th. We invite volunteers to visit the VDA Foundation website and register at www.vdaf.org.

CENTURY MARK:

ROBBIE SCHUREMAN PARTICIPATES IN HIS 100TH MOM PROJECT

Richard F. Roadcap, DDS; Editor

For the last 19 years, Robbie Schureman has been the face of dental supplier Henry Schein, Inc. for many dental offices in Virginia. And for the last 17 years, he's attended Missions of Mercy Projects in Virginia and in other states. In July 2016 he volunteered for his 100th MOM Project, at the Wise County fairgrounds. He says he's grateful for the support of his employer, a company "who not only allows, but supports and encourages me to take part" in these outreach projects that provide access to care for those who cannot afford dental treatment.
Robbie is quick to give credit to others: his wife Karen; children Hannah and Joey; VDA volunteer dentists and their staffs; VDA Foundation members; and VCU School of Dentistry faculty and students. Without their teamwork and dedication, he says "none of this would have been possible". He treasures the friendships and associations forged at MOM projects in Virginia and elsewhere, and looks forward to each project, "but Wise is special". "For many of us, this is more like a family reunion than just a weekend of volunteer dentistry", He pointed out that not only doctors, but entire office teams turn out to help out patients in need.
MOM has provided $41 million in care for 61,000 patients in Virginia alone. In July, 1,232 patients were treated in three days at the Wise County fairgrounds, and patients traveled from several states, receiving all forms of treatment from oral hygiene and prevention, to oral surgery and complete dentures. Thirty-two states now hold Missions of Mercy projects, and depend on the dedication and perseverance of volunteers like Robbie Schureman to make dental care outreach not only a hope, but a reality for many communities.

DONATED DENTAL SERVICES AT WORK

Dear Donated Dental Services,

For many years, I struggled with the fact that I had a terrible smile. I wouldn't laugh, or smile in pictures, I had a hard time eating the foods I loved, and I had grown terribly depressed; while isolating myself in my room. I didn't have the money to go to the dentist and I didn't know what I was going to do. I was so ashamed. I kept getting sicker and sicker. Several times I ended up in the hospital with abscesses; and on a few occasions I was kept for many days. In fact, I was heading in that direction again and had this program and Dr. Krone's office not acted when they did, I would have most likely been in the hospital this past Christmas.

Thankfully, as I set here writing this letter, things have drastically changed in my life. Thanks to the DDS Program and Dr. Krone's office, I don't have to be afraid to smile anymore. In fact, I can't stop smiling now. I think it's safe to say that this program has saved my life. I have more energy, I have stopped hiding from friends and family, and I can honestly say that I feel good about myself. I don't have to fear judgment or ridicule and that is the most amazing feeling! I am now able to eat healthier and my digestion has improved due to the fact that I can now chew my food properly.

The first of this year, I thought about the resolutions I wanted to make. I realized for the first time in several years, I didn't have fear and worry about my teeth or my smile. I can think about reuniting with old friends and making new ones as well. My family has seen the change in me and say how I'm like my old self. I am happy. I feel joy and that is the most precious gift anyone can give another person.

Dr. Krone's office has been amazing! They've never made me feel like anything other than a paying customer. I never wait or had to be fitted in. They genuinely care about me and want to see me happy. They did everything possible to minimize my pain and asked for my input on my smile. The DDS program made sure I was assigned a dentist close to me and approved my dental work quickly. Everyone has been excited about my new smile and I just can't believe how smooth the whole process has been.

As I previously explained, I am in college now to get my degree in Psychology. I want to become a Substance Abuse Counselor when I graduate and I was afraid I wouldn't be able to talk to people, much less help them. Now, I can talk to other people without the fear that they will laugh at me, but more than that, I now feel like I can be professional looking and not discriminated against. In life, first impressions are very important and if you can't look the part, it is hard to play the part.

I just want you to know that if I can ever repay you, I will definitely do so (this is also true for Dr. Krone). I promise to help others in any way I can and I dedicate my life to saving people from drug addiction, as well as keeping families together through healing therapy. All in all, I promise that if I can't pay it back, I will definitely pay it forward. You all have changed my life by giving me my life back and for that I will be forever grateful!

Warm regards,
Lisa D.

VDA BOARD OF DIRECTORS

ACTIONS IN BRIEF - JUNE 17, 2016

1. Approved : The following Bylaw Amendment:

ARTICLE VII, Section 6.2
2. Dental Benefits Programs Committee
a. Membership: This Committee shall consist of one representative from each component society and four members-at-large representing four different dental specialties. A non-member may be appointed to serve on the committee in an advisory capacity for insurance issues.
Background: It is often a dental office staff person who handles insurance within dental offices, therefore; the committee members felt that it would be beneficial to include an office staff person who handles insurance in dental offices (a non-dentist) on this committee. Dr. Bigelow made a motion that was seconded and the committee voted unanimously to make the below suggestion to the VDA Board of Directors.

2. Approved: A resolution that the VDA will offer the option of an installment plan for the payment of dues, special assessments and any additional voluntary payments. This benefit is offered to all active and active life members. The plan is for a period of up to 12 months to begin in January. A member joining after January will have the dues divided by the months remaining with the last payment in December. The method of payment will be debit or credit card, or other payment method recommended by the VDA staff. All memberships will automatically renew, unless the member opts out.

These programs will be administered by the VDA staff with oversight by the Secretary/Treasurer and the Board of Directors.
Update to -2012 (VDA Policy)

3. Defeated: A resolution that each component, in times of hardship, may request reimbursement for expenses associated with one CE meeting per year. The reimbursement, if approved, is not to exceed $4,000.00. In order to qualify for consideration, the component must satisfy two criteria:
1.) They must show a current year-end deficit.
2.) They must exhibit a reserve fund balance of less than 50% of current year-end operating expenses.
This CE expense reimbursement request option will sunset on December 31, 2019.

4. Approved: A resolution to rescind #6 under “Administrative” in VDA Policy effective December 31, 2016.
~~6. The VDA Statewide CE Program will reimburse each VDA component up to $4000 for one approved CE program per year. This reimbursement will cover meeting expenses including but not limited to room cost, AV equipment, travel, speaker honorarium, meal costs, postage and printing, with suitable documentation.~~
-2002

5. Approved: A resolution that on a one-time basis, a licensed dentist applying for membership in the fourth quarter of the year, who has never been a member of the ADA and is not otherwise eligible as a new graduate, shall pay reduced dues at the rate of 0% of active member dues for the remainder of the year, when they pay 100% dues for the upcoming year. (VDA Policy)

6. Approved: A resolution to approve the 2017 Budget as presented.

7. Approved: A resolution to approve the endorsement of Hunter-Michael Investment Advisors, Inc. as the VDA asset management group.

8. Approved: A Memorandum of Understanding with the Virginia Dental Association Foundation

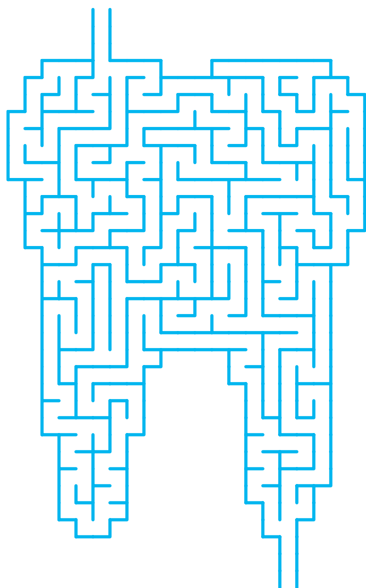
40 UNDER 40

DR. DIPA PATEL

Dr Patel is currently in solo practice in Arlington, Virginia. She maintains hospital staff appointments at Virginia Hospital Center and works with the oral surgery residency program at Washington Hospital Center.

She truly believes being an oral surgeon is the best job there is! When not working, she enjoys running, skiing, and sailing.

A HEALTHY DENTAL
CAREER BEGINS



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TRUSTEE'S REPORT

Dr. Julian H. "Hal" Fair, III; ADA Trustee, 16th District

This will be my last Trustee Article that I will share with you. It is hard to believe that I am finishing my term as your 16th District Trustee and how fast the last four years have gone. It has truly been an honor and a privilege serving you. I can't put into adequate words the appreciation I feel for the support you have given me throughout this incredible opportunity. It has, without a doubt, been the highlight of my career in service to our profession.

My last year as your Trustee, like all the years, has been busy and interesting. I continue to be most impressed with the dedication and thoughtfulness of the entire Board of Trustees, along with the incredible talent and skill of our ADA staff. I can say the same about our 16th District Delegation. Our district is represented well at 211 East Chicago Avenue.

My goal during this time has been to keep the membership informed through these articles. And during these four years there have been many issues that have been discussed. During my four years on the Board we have introduced the Action for Dental Health, the initiative for the Power of Three; Apitfy will be in 48 states by the end of the year, and during the time that I was the liaison to the Council on Membership we introduced the membership growth plan. Our advocacy efforts at the state and national level are stronger than ever and "thank you" to Dr. Bruce Hutchison for his leadership efforts this year as the Chair of ADPAC; continuing to make it one of the largest and most respected Healthcare PACs in the country.

At the beginning of this year we made some changes to our strategic plan: The 2017 budget focuses on these three strategies identified by the Board as priorities:

1) "Focus the message" to connect with individual members and potential members;
2) Design unique member outreach programs for targeting dental students and new dentists and "Fill the pipeline" for full-dues paying members; and
3) "Simplify", Standardize, and Rationalize how each level of the ADA operates and interacts with members actively in the best interest of the member rather than the organization.

The board believes that the process changes made this year put more emphasis on the importance of outcomes related to the advancement of the strategic plan rather than the financial budgeting process itself. I believe that you will see this new approach to our Strategic Plan and our Budget process pay dividends during our discussions at the ADA House of Delegates in October.

Finally, I want to take this opportunity to thank all of the 16th District volunteers from Virginia who have served and are presently serving on councils and committees on the national level. Thank you also to all of our delegates and alternate delegates who give of their time to serve organized dentistry in an effort to better this profession for all of us and those who will follow in our footsteps. Everyone always comes prepared and ready to participate in a positive way. I can say unequivocally that nationally the16th District is well respected - a testament to all of our present leaders and those who came before you.

Thank you again for this wonderful journey that you have allowed me to share with you.

WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership and Meeting Coordinator

TIDEWATER DENTAL ASSOCIATION

Francisco Aviles – Norfolk – University de San Carlos de Guatemala 2004

David Klucznik – Virginia Beach – East Carolina University School of Dental Medicine 2016

Jillian Rose – Norfolk – Nova Southeastern University 2016

Randi Wingate – Franktown – Virginia Commonwealth University 2016

PENINSULA DENTAL ASSOCIATION

Ayla Elsayed-Ali – Virginia Beach – Virginia Commonwealth University 2016

Oluwakare Opaneye – Hampton – Nigeria-University of Lagos 2006

SOUTHSIDE DENTAL SOCIETY

Ihab Abboud – North Chesterfield – Virginia Commonwealth University 2016

Ahmed Afify – North Chesterfield – Tufts University 2013

Roxanna Anvari-Tehrani – Colonial Heights – Virginia Commonwealth University 2016

Daniel Tiesworth – Midlothian – Virginia Commonwealth University 2015

RICHMOND DENTAL SOCIETY

Scott Bottoms – Richmond – Virginia Commonwealth University 2016

Minh Bui – Henrico – Virginia Commonwealth University 2016

David Durham – Midlothian – Virginia Commonwealth University 2010

Seana Hedayatnia – Richmond – Harvard School of Dental Medicine 2016

Christopher Kondorossy – Richmond – Virginia Commonwealth University 2016

Amit Mongia – Richmond – University of California San Francisco 2016

Brant Stanovick – Mechanicsville – Virginia Commonwealth University 2016

Graham Wilson – Henrico – University of North Carolina Chapel Hill 2012

PIEDMONT DENTAL SOCIETY

Swati Mittal – Roanoke – Virginia Commonwealth University 2016

Michael Morris – Roanoke – Virginia Commonwealth University 1991

Michael Muztafago – Roanoke – Virginia Commonwealth University 2016

Wesley Anne O'Brien – Salem – Virginia Commonwealth University 2016

Bradley Oliver – Roanoke – University of Maryland 2016

Deidre Smith – Roanoke – Virginia Commonwealth University 2016

Jaime Woodall – Collinsville – Virginia Commonwealth University 2016

SOUTHWEST VA DENTAL SOCIETY

Robert Ashby – Abingdon – Ohio State University 2016

Nicholas Bottorff – Blacksburg – Virginia Commonwealth University 2016

SHENANDOAH VALLEY DENTAL ASSOCIATION

Gauray Agarwal – Winchester – Virginia Commonwealth University 2005

Jamie Clark – Lexington – Virginia Commonwealth University 2013

David Curtin – Harrisonburg – Temple University 2012

Amber DeWeerd – Winchester – University of Iowa 2012

Sarah Janowski – Harrisonburg – Temple University 2013

Holly Legg – Charlottesville – Virginia Commonwealth University 2016

Niels Oestervemb, III – Winchester – University of Iowa Hospital Clinic 2011

Aaron Quitmeyer – Harrisonburg – University of Minnesota 2006

Philip Ruffner – Luray – Virginia Commonwealth University 2015

Zohra Saleh – Charlottesville – Virginia Commonwealth University 2015

Dierdre Terlep – Maidens – Virginia Commonwealth University 2016

Alexandra Wood – Charlottesville – Virginia Commonwealth University 2015

NORTHERN VA DENTAL SOCIETY

Pooya Aflatooni – Stone Ridge – Virginia Commonwealth University 2015

Sumra Ahmad – Fredericksburg – Virginia Commonwealth University 2016

Chelsea Balderson – Falls Church – Virginia Commonwealth University 2013

Kenjula Brown – Herndon – Ohio State University 2016

Joel Butterworth – Fredericksburg – Howard University 2015

Phu-Quy Cai – Manassas – Virginia Commonwealth University 2016

Assefa Demewoz – Lorton – Howard University 2011

Patrick Friend – Gainesville – University of Southern California 2010

Jenny Ha – Fairfax – University of Michigan 2008

Michael Han – Ashburn – Virginia Commonwealth University 2002

Anh Huynh – Burke – Virginia Commonwealth University 2015

Arpi Patel Khare – Alexandria – Univeristy of Maryland 2013

Sumeen Maur – Arlington – Medical University of South Carolina 2016

Brian Nalls – Fairfax – University of Pittsburgh School of Dental Medicine 2013

Mohamad Nassif – Fredericksburg – University of Colorado 2015

Simrat Sehmi – Fredericksburg – Virginia Commonwealth University 2016

Hasnain Shinwari – Dumfries – Pakistan 2004/Boston University School of Dentistry 2015

Sladjana Skrba – Chesapeake – Bosnia & Herzegovinia/University of Sarajevao 1985

Garima Talwar – Paeonian Springs – Loma Linda University School of Dentistry 2002

Keri Tran – Alexandria – Baylor College of Dentistry 2006

IN MEMORIAM: DR. EMANUEL MICHAELS

Dr. Mark A. Crabtree

We lost Dr. Manny Michaels only a few weeks ago, but his legacy of leadership through service to our profession lives on. Manny had a great talent for identifying young leaders and encouraging them to "give back, get involved and do the right thing". The VDA will miss his kind, quiet encouragement of our future leaders. Through the years, he imprinted many within our profession and beyond with the values of integrity and a willingness to serve our fellow man.

Manny recognized and promoted excellence in leadership with an emphasis on service. When I became Mayor of Martinsville, I promptly received a very nice note of congratulations and at its very end he challenged me not to forget dentistry. While I didn't think much of it at the time, as opportunities for service arose later, I remembered that I should always give back to the profession that has offered me so many opportunities. Many of our Association's leaders have been impacted by his thoughtful advice and caring words of encouragement. His presence helped shape a generation of VDA leaders.

Integrity, leadership and service are the core values of the International College of Dentists. Manny served with great distinction as President of the USA Section of the ICD. This was just one of many positions of leadership through which he embodied the principle of giving back as we are called and able. His example to us is that we should each be active in service not only to our profession but also to our family and community. Serving on the Board of Visitors of Longwood University with Ada, his wife of 43 years and the love of his life, I was blessed to learn from Manny's example of supporting her in her work as a public servant. With diverse interests and an inherent desire to help in any way he could, he further increased his positive impact in our state by rendering service to his community in many settings including his Congregation Beth El and numerous other Boards and Committees.

Manny Michaels made a true and measurable impact on our world. He was a positive influencer who enriched our lives and made dentistry a venerable profession. While we will miss him, he lives on in the service of those he encouraged to "give back, get involved, and do the right thing".

Editor's Note: Dr. Crabtree is a VDA Past-President

IN MEMORY OF:

NAME	CITY	DATE OF DEATH	AGE
Dr. William S. Cabell	Norfolk	September 1, 2015	82
Dr. Francis W. Sheild	Hampton	August 31, 2016	81
Dr. Emanuel Michaels	Virginia Beach	August 7, 2016	86
Dr. Ernest N. Duvall	Norfolk	July 9, 2016	91
Dr. Brodie M. Williams	Norfolk	April 30, 2016	93
Dr. John T. Kelly	Bristol	April 3, 2016	91
Dr. William B. Russell	Petersburg	September 15, 2016	96

JOBS – DENTIST

5293 – Associate Dentist Needed King George, VA
Busy family oriented dental office in need of a hard working, compassionate and ethical associate dentist. Mon-Thurs, no weekends. Accept only Cash and limited commercial insurance, no Medicaid. Dentist should be comfortable working with kids, teenagers, adults and elderly. You will be working along 1-Hyg, experienced DA, front desk and an amazing Office manager. Commission base start at 35% and up, depend on experience, efficiency and performances. Please send CV/Resume, qualifying candidates will be contacted for interview.
Mona; 657-777-3074; Monasiregar99@gmail.com

5296 – Associate Dentist – Hampton Virginia
Part-Time General Dentist - Hampton Virginia Great Opportunity - Our 30-year old well-established office with growing patient base is seeking an experienced General Dentist for 2 days per week. Prefer candidate with excellent communication skills and 3+ years clinical experience, but may consider a more recent graduate. Must be gentle, caring, reliable, and concerned with providing the utmost in quality patient care. Must possess Virginia license, DEA Number, current malpractice insurance and not have any pending malpractice claims or criminal record. Our highly-trained staff ensure efficient clinical production with no practice-management headaches. Competitive earning potential; earn up to $1000- per day or more. Day(s) negotiable. Potential to become a Full-Time position and future Buy-in is possible for the right person. Respond with resume.
Dr. Hutchings; 757-927-0672; mlhutch13@gmail.com

5313 – General Dentist
TIDEWATER VIRGINIA GENERAL DENTIST. Quality, progressive multi-office practice in Chesapeake, Norfolk, Suffolk, and Virginia Beach seeking dentists who are looking for a permanent position with ownership opportunities. This person must have the philosophy that the patient's care and best interest comes first. We are looking for DDS/DMD professionals who will deliver high quality, comprehensive dental care with genuine concern for the patient. Benefits for talented and motivated individuals include competitive salary, continuing education, medical/disability/liability insurance, 401K, profit sharing, deferred compensation and most importantly lots of team support from our dentists, hygienists, schedulers and other office staff. If interested in our practice, please contact: LWSS, Attn: Robin Greene, 1230 Progressive Drive, Suite 103, Chesapeake, VA 23320, (757) 410-2658 fax, robin@drslwss.com, (757) 962-6769 direct dial.

5337 – Associate Dentist King George, VA
We are seeking a self-motivated, experienced Dentist to provide high-quality lifetime patient care in a fast-paced and well-established family oriented dental office. As an associate Dentist, you will perform general clinical dentistry procedures such as exams, direct and indirect restorative work, tooth extractions and any other dental procedures. You will also perform crown and bridge procedures and provide fixed and removable prosthodontics care. The ideal candidate will have experience in private practice and feel comfortable diagnosing and presenting comprehensive treatment plans. We will be willing to mentor newer doctors too! The practice is open Mon-Thurs. Visa sponsorship available.
Mona; 657-777-3074; Monasiregar99@gmail.com

5347 – Associate Dentist – Lynchburg, VA
Well established state-of-the-art Dental Practice in Lynchburg, VA is seeking a full time associate general dentist. In practice for over 50 years, Riley Dental Associates provides comprehensive and cosmetic care to adults and children and offers a competitive compensation package accompanied by a highly trained staff. Cyndi Riley; 434-385-7707; cyndi@rileydentalassociates.com

5349 – General Dentist
Cardinal Park Family Dental Care, located in Northern Virginia, is looking for a new dentist to join the team. With our building expansion and continual increase in new patients, we are searching for a dentist that encompasses leadership, good communication skills, strong work ethic, a positive attitude and respect for all team members. At Cardinal Park, we continue to challenge ourselves to learn and use new dental advancements and technologies. In our office we are able to provide patients with endodontic, periodontics, oral surgery, implant dentistry, CEREC and Cone Beam imaging. Please forward your resume to ashton@leesburgfamilydental.com if interested. Thank you for your consideration.

5351 – Dentist Shenandoah Valley
Dental Health Associates We are looking for talented dentists to join our team full time or part time. We are a dentist owned multi office group practice in need of a seasoned dentist or a recent GPR/AEGD graduate. We offer comprehensive modern dentistry for the entire family. The candidate must have integrity and possess good interpersonal skills. You'll work with state-of-the-art technology and have valuable opportunities for continued education, training and mentorship. We are in the beautiful Shenandoah Valley of VA. www.MyDentalHealthAssociates.com Send cover letter and CV to: drlagrua@MyDHA.net

5353 – Associate Dentist
The Smile Design Centre has an immediate opening for a part-time (working into full-time) General Dentist. We boast an expansive 4500+ sq/ft, state-of-the-art, modern, digital facility to serve a growing population in Hagerstown and the surrounding areas. Current collection numbers are in excess of $1,100,000 providing the potential for a yearly salary of $220,000 for a full time associate with incredible growth potential. Benefits include health insurance and C.E. allowance. We have a large existing patient base seeking high quality PPO insurance providers. Our new patient growth is incredible, with an average of 50 new patients per month! We are willing to sponsor an H1-B visa for the perfect candidate. Our office and team has been known to be the cutting edge, trusted and passionate dental office in town. All phases of dentistry are practiced here and operations, business systems and marketing are well established. Applicant must have high-energy, a positive attitude, excellent communication skills and a great work ethic. Applicant must be goal oriented and focused on growth of self and practice. At least 1 year of private practice experience (preferred), knowledge of all phases of dentistry and a strong passion for Continuing Education are required. Must be fervent about learning, and willing to adapt in a constantly changing environment. We can't wait to hear from you!
Billie Lombardi; 301-739-5551; billiel@smiledesigncentre.com

5362 – Associate Dentist
Sapon & Swisher Dental PLLC is looking to hire an Associate Dentist. We have office locations in Waynesboro and Charlottesville Va. Our offices are modern and completely digital. We offer great benefits and compensation. We are looking for someone that is highly motivated and a great team player. If you are interested please send your CV or call to be contacted.
Brad Swisher; 434-566-9868; brad@swisherdentistry.com

JOBS - DENTIST

5365 – Dentist Opening
Our office has an immediate opening for a competent and compassionate Associate Dentist that can render quality care to adults and children. Prefer a provider who is detailed-oriented, has good communication skills and leadership potential. This is a great opportunity for professional growth and mentorship by a senior dentist. Our office located at Dahlgren King George, Mon-Wed, no weekends. Base salary $600/day + bonus 35% of collections. Please forward your resume to the email address listed below. candidates will be contacted for interview. Visa sponsorship available.
Lisa; 657-777-3074; kinggeorgedentist@gmail.com

5369 – General Dentist
Premier dental practice in Gainesville, VA is looking for a full-time associate to join our team. The practice has been a part of the wonderful Prince William County community for over 20 years. We are a skilled, fun and friendly team of general dentists, one oral surgeon and a periodontist who work well together to provide excellent care to our patients. Support staff goes above and beyond to support the doctors and deliver an unsurpassed dental experience for our patients when they visit our state-of-the-art office (digital sensors, icat, digital panorex, intraoral cameras, private consult, well-equipped operatories). Looking for someone who will interact kindly and compassionately with our patients and perform dentistry with the utmost integrity.
Faline Davenport; 703-754-7151; falinedavenport@me.com

JOBS – DENTAL STAFF

5298 – Dental – Billing/Insurance Coordinator
General Dentistry Billing/Insurance Coordinator Position. Position Requirements/Responsibilities: - Willingness to work every day with a kind, happy, fun attitude - Respectful, assertive, productive leader in our practice - Team player- low drama, happiness, no negativity - Effective and professional written and oral communication skills - Must have problem solving abilities and be able to handle multiple deadlines - Ability to read and manual dexterity for data entry - Post checks - File insurance claims - Handle all billing questions for patients - Check mail - Daily report/deposit - Verify and follow through on insurance claims - Front Desk Duties (answer phones, scheduling, etc.) - Collections/AR (meetings with doctors) - Extensive knowledge of dental insurance and billing - Knowledge in dental procedures and insurance verification - Excellent communication skills - Minimum 5 year experience with billing and insurance If you meet the requirements stated above, please submit your resume by responding via email to this ad. Principals only. Recruiters, please don't contact this job poster. do NOT contact us with unsolicited services or offers
RVAdentist@gmail.com

5358 – Dental Assistant
We are looking for an experienced and energetic dental assistant with a positive attitude to join our team in Fredericksburg, VA! X-ray certified experienced dental assistant who can adapt to a busy day while still maintaining attention to detail. Providing patients with oral hygiene instructions (reviewing gingivitis and periodontal disease process.) Providing prophylactic and fluoride treatments. Charting perio and treatments in the patient record. Taking and developing diagnostic dental x-rays on children and adults. Assisting with all dental procedures including crowns, root canals, extractions, and PSSCs. Four-handed dentistry is a bonus. Taking impressions for nightguards. Working with nitrous oxide. Assisting with chart audits and scheduling. Organizing and maintaining office inventory. Keeping office clean via OSHA standards. We use Open Dental Software and Lighthouse and are EHR certified. A desire to learn and improve on technique.
Nicole; 703-662-1432; drida@outlook.com

5368 – Front Desk Team Member Midlothian
We are looking for a friendly, knowledgeable, and compassionate team member to help us deliver high quality dental care with comfort and clarity in a light-hearted atmosphere. Our new team member will have experience working in a dental office, Dentrix and dental insurance knowledge a plus. Monday, Tuesday, Wednesday, and 1/2 day Thursday. Able to leap tall buildings in a single bound and flexibility to come early and stay late wonderful. Melanie 804-897-2900 drrandazzo@jrdentistry.com

PRACTICE TRANSITIONS

5294 – Practice for Sale in King George County Virignia
Collection in 2015: $446K and operates at 45% overhead. A well-run, long-established, family-oriented practice is looking for a compassionate and ethical doctor to continue the practice. Current doctor has to relocate immediately to another state due to family reasons. Mon to Thurs, 8hrs schedule. 30+ years of goodwill, a great referral base, averaging 20 new pts/mo by excellent internal marketing. Lots of potential to grow. Located conveniently on 301, close to Dahlgren Naval Base and Maryland bridge. 50 miles from DC and 60 miles from Richmond. 2 fully equipped operators and 1 Hygiene rm, Digital (Shick) X-rays in each room. A big Reception room, Private Office, Sterilization, Lab and 2 Restrooms, is located in a well-established, easily accessible, Professional building complex with ample parking. Highly competent staff that have worked well together. Contact: Mike | 804-426-4522 | mikerivera101@yahoo.com

5312 - I WANT TO BUY YOUR PRACTICE
Considering retirement? Maybe just looking for more time for vacation. You've earned it, you can sell you practice directly to me! I am a General Dentist in Northern Virginia looking for an ownership opportunity. Experienced in both the clinical and business aspects and interested in small or big practices. All terms negotiable. All inquires confidential. Avoid the high commission fees and email me at: Buymypracticenow@yahoo.com

PRACTICE TRANSITIONS

5316 – NRV/SW VA Dental Practice For Sale
Solo general dentistry practice in beautiful Pearisburg (Giles County), Virginia, for sale, just 30 minutes west of Blacksburg/Virginia Tech. This busy practice is in an underserved part of the state and serves Giles, Montgomery counties and S.E. West Virginia. Patients are mostly insurance (through employers Celanese, Volvo, Virginia Tech) and self-pay. Experienced office manager and assistant have been working in this practice for 20+ years. 1 full-time hygienist, 1 part-time hygienist. 4 operatories (2 hygiene, 2 operative). Office space is leased. Yearly gross income $500K+. Please call or email for further information.
Alistair Kok, DDS; 540-921-7040; alkokdds@gmail.com

5317 – Family Dental Practice (West End Henrico)
Solo General Dentist approaching retirement seeks Merger Sale {Patient records & goodwill) with established office or possible sale as a satellite or start up opportunity for experienced graduate or clinician Brabbit427@yahoo.com

5322 - General Practice #VA-1289: Lancaster County.
3 Operatories. Average collections $557,458. Average net profit $290,162 (52%)! Very profitable. Well-established practice. Southside of VA, 2 hrs from DC. Contact Amanda Christy, NPT (National Practice Transitions) 704-395-9286 x230, a.christy@NPTdental.com or register for FREE on our website (http://www.NPTdental.com) as a member for immediate updates.

5324 - General Practice #VA-1275: Gloucester County.
6 Operatories. Average collections $670,540. Average net profit $257,794. Great location; room for growth. Modern, large office. Family business. For details contact Amanda Christy, NPT (National Practice Transitions) 877-365-6786 x230, a.christy@NPTdental.com or register for FREE on our website (http://www.NPTdental.com) as a member for immediate updates.

5330 – Seaside Cash Cow
This practice personifies growth, with average collection increases of over 30% per year, this 3 year old practice which generated $374,000 in 2015 is trending up at the same rate in 2016. Situated in a remote coastal Virginia town, with virtually zero competition. Buyer will ease into success with ideal practice systems already in place. Perfect for the solo practitioner whom wants the easy lifestyle or a multi-practice buyer looking to expand operations. Please go to www.commonwealthtransitions.com and register for FREE as a buyer to receive detailed practice information.
Commonwealth Transitions; 434-262-2095; info@commonwealthtransitions.com

5331 – Greater Richmond on Main Turnpike
Opportunity galore with this established 4 treatment room practice collecting over $450k annually. Located within plain sight of one of the main roads in Greater Richmond, this buyer has an excellent opportunity to grow this great practice. Please go to www.commonwealthtransitions.com and register for FREE as a buyer to receive more detailed information.
William Schulz; 434-262-2095; info@commonwealthtransitions.com

5332 - Associate Placement Services
Commonwealth Transitions has added a division for associate placement. We specialize in screening Owners Requirements vs Associates Desires to produce a win-win associateship that saves both parties time and money. Please go to www.commonwealthtransitions.com and register as an associate to receive more detailed information on practice opportunities.
William Schulz; 434-262-2095; info@commonwealthtransitions.com

5333 – Dental Practice For Sale in Norfolk, VA
3 operatory practice collecting an average of $500k annually. Currently open 3.5 days per week. Seller is flexible with his transition plans. Space is also for sale. Please contact us at 678-482-7305 or info@southeasttransitions.com for details. Listing ID VA-1030.

5363 – Carpe Diem! In DC
Carpe Diem! Opportunities like this do not come around very often! All Fee For Service, 2-3 Treatment rooms with modern core Dental Equipment. This General Dental Practice located in one of the most affluent neighborhoods in all of the District of Columbia averages collections upwards of 450k with over 50% net to buyer. Truly a unique opportunity to purchase an established and successful practice which can be grown and expanded upon. Seller is willing to stay on and transition the practice to the right candidate. To apply for this premium opportunity, please go to www.commonwealthtransitions.com and register as a buyer for free.
Commonwealth Transitions, LLC 434-262-2095, info@commonwealthtransitions.com

5371 – Newport News Practice for Sale!
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Jim Schroeder; 804-897-5900; info@drjimschroeder.com

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VDA CLASSIFIEDS

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5335 - Commercial Offices, plus Function Dental Office
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Jim Fry; 703-625-3332; jimfry11@aol.com

PRODUCTS AND SERVICES

5370 – CEREC

Cerec computer, blue cam, and milling chamber for sale asking $25,000 obo for the combined set of two machines. Milling unit cerec 3 model #5898437 serial # 11890 year bought 12-17-2014 asking $8,000 cerec am blue cam and computer model#6212166 serial # 06798 4.2 Version software updated to blue cam in 2010 got a lot of use between 2004-2010 but that doctor left the practice. All annual maintenance has been performed by Patterson Dental, Chesapeake, VA. The last time we used the machine it was functioning just fine. Patterson has fired it up a couple of times per year and it works well. We are not computer specialists so we will not guarantee condition of the machines. They are offered “as is”. We will offer a 15 day return policy with full refund if the machines are returned in the same good condition that they were sold.

Lisa; 757-464-3514; lisa@baxterhogandds.com

40 UNDER 40

DR. TAREK ELBADAWY

After graduating dental school in Egypt; I completed my post graduate residency at the University of Maryland. Now, I'm fortunate to serve the community of Suffolk in my first brand new state of the art practice

TO ASSOCIATE OR NOT TO ASSOCIATE? THAT IS THE QUESTION

David Voth, Associate Editor; VCU School of Dentistry, Class of 2018

Do you know what you will do when you graduate from dental school? There are so many options to consider from starting your own practice to joining a mega-conglomerate dental business. Within each option there are new decisions to be made, with each choice opening a door to more choices and sometimes it feels as if we are lost in a maze of legal, financial, and dental language that would take another four years of training to fully understand. Alas, we must push forward and trust either ourselves or a qualified consultant to help decipher all the contractual language so we can finally sign our first real employment agreement. It is very exciting and very daunting.

Many routes are available to explore after we graduate. We can go into a residency program, solo practice or a large group practice. However, another very common option exists called the Associateship. There are many reasons for recent dental graduates to look into an associateship agreement. These agreements allow us to gain experience in a professional dental setting while minimizing the headaches of practice ownership as well as providing a reliable source of income. Associateships are in high demand because they provide us with stepping stones towards professional growth while allowing us to build a clinical track record under the observation of a more experienced clinician.

Conversely, there are many reasons why established dentists seek associates. Many dentists desire practice growth and feel that bringing on an associate is a good way increase billable patient hours without increasing his or her workload. Also many dentists who are looking for an associate have reached a point in their career where they are ready to reduce their time in the office so handing off some of their duties to another provider (like you for instance), is a great way to start stepping back. Once you have found your associateship it is time to start thinking about a contract. Associateship contracts can be very confusing, especially for the first time. Some terms to think about as you engage in your negotiations are: terms of employment (1099 or W-2), compensation rates (base and production based), restrictive covenants (geographic and time limits), non-competes, termination protocol (let's hope we don't need this one), lab fees (who covers them), advances on future earnings (try and avoid this one). Ultimately most associateship failures occur due to incompatibility with the host dentist, lack of business and unreal expectations of personal goals. We need to remember we are young, inexperienced and slow but we are still dentists and our time is valuable so there is a fair agreement to be found if we are methodical and selective.

In the end it is important to remember that we should always seek the help of an experienced advisor to manage our transition into private practice, no matter what route we choose. Most dentists want to find a fair and reasonable agreement but in most cases finding that common ground takes work and several rounds of contracts. These negotiations should be viewed as totally peaceful and transparent. Sometimes these important exercises reveal the practice we thought was perfect may not actually be able to sustain two dentists without large sacrifices by both parties. In that case, we may be frustrated but we should be thankful our due diligence revealed these issues before signing a contract.

Despite the cornucopia of issues to consider as we leap into the next phase of our professional careers, we need to enjoy our journey and remember to look out for ourselves and others. Creating a win-win agreement for yourself and the other party will almost always generate an equitable and fair contract. Now go out there and be great.

CONTINUED FROM PAGE 10

Patient VI; Slide #9
Infantile Hemangioma – age 16 – bleeds when brushing teeth - Maxillary muco-buccal fold and gingiva – sclerosing solution intra-lesional once a month for a period of four months – then surgery - Diagnosis: Capillary Hemangioma

Patient VII; Slide #10
Congenital Hemangioma – age 18 – no symptoms
Hard palate, large, with no regression – many years (possibly 8-10 years) – sclerosing solution intra-lesional once a month for four months – surgery
Diagnosis: Hemangioma with endothelial hyperplasia (endothelioma)

Patient VIII; Slide #11
Congenital Hemangioma – age 20 – asymptomatic
Upper lip – many years duration with no regression – surgery
Diagnosis – Hemangioma-endothelioma

Patient IX; Slide #12
Congenital Hemangioma – age 45 – dentist advised removal
Tongue – no changes noted in childhood – surgery
Diagnosis: Capillary Hemangioma

Patient X; Slide #13
Infantile Hemangioma – age 58 – removed by family physician
Buccal mucosa – noted entire life – no regression – surgery
Diagnosis: Capillary Hemangioma

THE VDA HOLDS 'ADVOCACY ACADEMY' AT THE VCU SCHOOL OF DENTISTRY

Laura Givens, Director of Legislative and Public Policy

The VDA held a 3-day lecture series at the VCU School of Dentistry in August. We modeled the series of lectures after a program that the Texas Dental Association had done for dental students in their state and gave ours the same title: The Advocacy Academy. This educational program promoted the importance of organized dentistry, dental advocacy and political action. Forty-four 2nd and 3rd year dental students attended and speakers included VDA members Drs. Justin Norbo and Dr. Bruce Hutchison; VDA lobbyists Chuck Duvall and Tripp Perrin; and special guest, Senator (and practicing physician) Siobhan Dunnavant. The speakers discussed both state and federal legislative/regulatory processes as well as specific issues that our members are currently focusing on, have faced in the past and foresee addressing in the future. Students also were informed of the opportunities for involvement in our advocacy efforts as a student and eventually as a new dentist. The program ended with a celebration at Hardywood Park Brewery, where the students, speakers, VDA staff and dentists gathered to mingle while enjoying some great food and refreshments. Due to the success and great feedback regarding this program, the VDA plans to do similar programs in the future. After spending all three days with the group, I can personally tell you – the future is bright for the profession so long as we actively engage graduates early and often.

40 UNDER 40

DR. MARK ARMANIOUS

Board Certified & Owner of Stone Ridge Oral & Facial Surgery, I am a father to the most energetic son-Daniel, husband to the most amazing wife-Basma, son to the most loving parents-Maged & Sohair, and brother to the most resilient sister-Mary...I am the most thankful man in the world.

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40 UNDER 40

DR. CHRISTINE KARAPETIAN

Christine Karapetian, DDS, board certified periodontist, is passionate about providing the highest level of care for patients' oral health to lead to better overall health. She has been practicing in Springfield since 2012 and received her DDS from NYU.

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