Virginia Dental Journal

Volume 91, Number 4 • October, November & December 2014

In This Issue:

www.vadental.org/pro

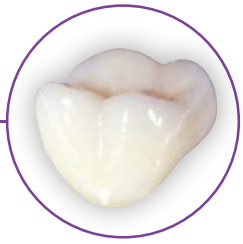
Use HENRY SCHEIN® to prescribe Zirlux® from Drake today!

Zirlux®
UNIVERSAL ALL CERAMIC SYSTEM

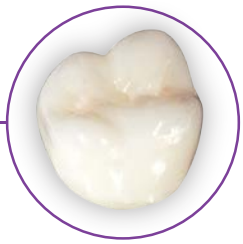
DRAKE LABORATORIES

Fracture and Chip Resistant

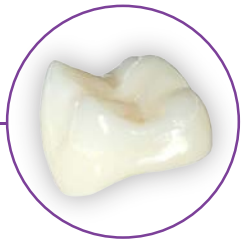
High Translucency for Increased Aesthetics



Low Wear to Opposing Enamel



Pre-Shaded, No White Spots from Adjusting



Mention ad VDA4Q for
$10 off
your first Zirlux crown!
expires 12.31.14

(800) 476 2771. 8510 Crown Crescent Ct. Charlotte, NC 28227. drakelab.com

Virginia Dental Journal

Contents

Oct-Dec 2014 - Vol. 91, NO 4

Columns

Features

Scientific (13-23)

Advocacy (32-33)

Outreach (40-47)

Virginia Meeting (48-51)

University Connections (52)

Membership (53-55)

VDA
Virginia Dental Association

AADE
Member Publication
American Association of Dental Editors

Virginia Dental Journal

REPRESENTING AND SERVING MEMBER DENTISTS BY FOSTERING QUALITY ORAL HEALTH CARE AND EDUCATION.

Volume 91, Number 4 • October, November & December 2014

VIRGINIA DENTAL JOURNAL (Periodical Permit #660-300, ISSN 0049 6472) is published quarterly (January-March, April-June, July-September, October-December) by the Virginia Dental Association, 3460 Mayland Ct, Unit 110, Henrico, VA 23233, Phone (804)288-5750.

SUBSCRIPTION RATES Members $6.00 included in your annual membership dues.
Members – Additional Copy: $3.00
Non-Members- Single Copy: $6.00
Non-Member outside the US: $12.00
Annual Subscriptions
in the US: $24.00
outside the US: $48.00

Second class postage paid at Richmond, Virginia.

POSTMASTER Send address changes to: Virginia Dental Journal, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

MANUSCRIPT & COMMUNICATION Editor, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

ADVERTISING Managing Editor, Shannon Jacobs, 3460 Mayland Ct, Unit 110, Henrico, VA 23233 or jacobs@vadental.org

On The Cover

Dr. Michael Link, VDA President
Photo credit: Linda Gilliam Photography
lgphoto@msn.com

President's Message

Wow, how did I get here? It seems not too long ago, I was sitting in this House as a guest not involved in organized dentistry. Then something incredible happened to me. Like most of us, we have mentors that help shape our values and vision. I have been very fortunate to have 6 mentors which helped shape my core values. I would like to tell you a brief story about my mentors so that you can better understand who I am and where I have come from.

I was in my office back in the early 1990's and I received a phone call from Dr. Ron Tankersley. (My first mentor)Dr. Tankersley asked me a simple question: Did I know Congressman Herbert Bateman? I informed him that "yes" I did know him on a personal level. I grew up with his son and daughter and spent a lot of time at his home. Ron then asked me to set up a meeting for him with Congressman Bateman, AND he asked me to attend this meeting as well. At this point in time, my feelings about organized dentistry were neutral. I was not involved and I did not intend to become involved. I was content to just grow my practice and remain in the background. I did not think there were many real issues facing dentistry and certainly nothing serious. Boy, was I wrong!!! What I learned during this meeting was that Dentistry had many problems on many different fronts, most stemming from outside organizations. Today, we are facing many of the same problems that we faced back in the 1980's and 90's but now there are more organizations and many more intense pressures. This one meeting, back in the early 90's, lit the fire to get me involved in organized dentistry. The question I kept asking myself was: Can I make a difference?

I was young and needed guidance. I wanted to learn how to be the best Dentist I could be while helping my profession. Ron taught me that the same personal touch used with our Congressman, should also be used with our members. Whether it is membership recruitment or retention, the personal touch enables us, The VDA to effectively convey our message better.

Two more of my mentors helped shape me in the art of listening. They are Drs. Richard Barnes and Mark Crabtree. These two individuals have led by example by demonstrating the skill of listening to others. Whether they are adversarial to or supportive of dentistry's issues, they listen first and THEN articulate a point to better communicate our position based on our core values.

My fourth and fifth mentors are family members. My brother-in law, Dr. George Jacobs, with whom I have practiced for over 29 years and my deceased father-in-law Willard Robinson, Jr., Esq. These two individuals taught me to think before reacting to challenges, and to ponder my response before delivering it. (Most of you who know me, know that I am still working on this issue and it's a work in progress or so my wife, Melissa says). Willard and George also taught me how to balance work life and family life – they led by example. At work and at home, George has always been a calming influence and he has helped me to remain composed while confronting many issues.

My last mentor was my Dad, Dr. Acree Link, with whom I practiced for over 20 years. He passed away 4 1/ 2 years ago; however the lessons he taught me still influence me today. One lesson that my Dad taught me was to use plain talk with all my patients. I had been in practice with him for about 2 weeks and I was discussing a treatment plan with a new patient. After the patient left, he told me this, "Son, that was the best technical description of what was wrong with that patient, however, she just left our office not knowing what the bleep bleep you just told her." Now he also used some very colorful words in that sentence that I don't care to repeat. However, the message was clear to me.

Another lesson that my father taught me was, "Treat every patient as though it was you." He said that by doing this I would never make the wrong treatment decision and I would always do what is right for my patients.

I am so grateful to all my mentors who have guided me and helped to shape my core values and beliefs. Asking, Listening, Thinking About Responses, Plain Talk, Treating People as I Would Treat Myself.

These are some of the main guiding principles in my life. Whether you know it or not, every one of you in this room is a mentor to someone. Your actions lead by example and influence others.

Now I would like to discuss my plans as President.

As ADA Executive Director, Dr. Kathy O'Loughlin, has so eloquently stated over the past year: A storm is coming. Dr. Chuck Norman, ADA President, said: "We must adapt to changing realities or face the prospect of becoming less relevant." I agree – adapting to realities is what we must do to stay relevant in today's world.

What keeps us from changing…..is it fear? Fear is not real, but a choice. Fear is a product of imagining a situation that is not currently present and may never exist. Dr. Albert Einstein stated that the definition of insanity is doing the same thing over and over and expecting different results.

We know we must change. Our past leadership has been outstanding in positioning our association in such a way to mitigate the effects of change. In particular, the last three Presidents of this Association have focused specifically on the management of environmental changes that are impacting our association in ways never seen before. Drs. Roger Wood, Kirk Norbo and Ted Sherwin have all focused our resources to address these troubling times we are facing. Without their vision, energy and commitment to this association and profession, we simply wouldn't be where we are today--stronger, more focused and committed to you, our members and to your success. Thanks to all our former presidents for your vision, leadership and message of change! I would now ask all past VDA presidents to stand and be recognized for committing your time and energy to our success.

The central theme of my presidency will be:
Navigating the Storm and Moving Forward
Here are my goals

Membership: With our declining membership, we realize that we need to focus our attention on our members' needs. The creation of the ADA's Center for Professional Success (CPS) is a major step forward, however, it is now time to focus specifically on our Virginia dentists. The VDA is implementing its own web-based solution customized to meet Virginia's needs. I believe that now, we need to focus our efforts on our newest initiative, the Membership Payment Plan. The plan will allow dentists to make 10 monthly payments towards their VDA membership with automatic renewal. I believe that this endeavor will go a long way in mitigating the financial concerns expressed by our younger members. Therefore, I will be appointing a task force to promote the 10 month payment plan with automatic-renewal to our newest members. I also plan to have this same task force help with membership retention. Their goal will be reaching out to non-renewals earlier than we did this past year. By using the personal touch, that Ron Tankersley has taught us, we hope to be able to gain insight and assist Members in their renewal process.

Continuity: This year, we were more focused on our goals than ever before. However, we cannot afford to lose that focus. Our environment is changing rapidly and if we do not concentrate on our

objectives, then we risk becoming an irrelevant association. Our Strategic Plan needs to be evaluated and modified each year to build on the tremendous efforts of previous leaders. Therefore, I am asking the House of Delegates for a by-laws change. This change would mandate that the Board of Directors and select individuals from the HOD create a Strategic Plan Committee. This committee will present a strategic plan every 3 years with specific and challenging goals. Its main function will be to develop a strategic plan to guide the efforts of the Board of Directors. The objectives can be changed or modified yearly by each new President, based upon the current challenges and ever-changing needs of our profession. The Board of Directors should view the monitoring of the Strategic Plan as its most important function, and should review the plan at each Board of Directors meeting. The development of a new Strategic Plan every third year will ensure that this Association's goals are relevant to the changing environment and will continue to serve our members' needs.

When asked why he was so good, the great hockey player Wayne Gretzky stated, "I move to where the puck is going to be, not where it is."Our goal will be the same--move to where our puck will be, not where it currently is. We will use our Strategic Plan as a vehicle that will help guide us so that we properly anticipate the changes that confront Dentistry.

Leadership Training: I would like everyone who has been out of dental school for 10 years or less to please stand. These individuals are our future leaders!! I applaud them for getting involved with organized dentistry early in their careers. In the past, our Association provided leadership training. I remember going to such training at the Boars Head Inn. We need to develop the necessary leadership training and education to provide leadership opportunities for our younger members. The title of this institute will be "Leadership for Tomorrow's Generation." The theme of the institute will be: Leadership is not a part time job; it's a full time commitment!

Let me explain: By choosing Dentistry as our profession, we have all chosen a path of leadership that is essential to our individual practices, our communities and the future of our profession.

By creating this opportunity for leadership education through our ongoing institute, we can help identify and train potential young leaders, who will lead our Association into a promising future.

Overall Business Resource Plan: As our Association has stated, the VDA needs to provide opportunities for its members to become successful in today's market. Our motto should be "How to maximize your business potential." As I mentioned earlier, the Center for Professional Service, or CPS, that the ADA created is an excellent source for business resources. However, we need to further custom fit the new resource center to help with the needs and objectives that are specific to Virginia.

For example, should we consider having a financial advisor located in Virginia that would be at our members' finger tips? The advisor could help with business decisions such as contract analysis, practice evaluation, buy/sell agreements, tax questions, and the list goes on.

This would add value to our membership by offering discounted business advice, which in turn would enhance the value of VDA membership and increase professional satisfaction. Thus the VDA would be seen as essential to member's professional success.

Therefore, I will be directing our Executive Director to explore this idea of negotiating with a financial advisor to come on board to better serve our members needs.

Board of Dentistry: What issues do we have concerning the Board of Dentistry in Virginia? Ownership of a dental practice, enforcement of advertising statutes, unannounced inspections of dental offices and the recent report from the Department of Health Professions, which suggests opening the Dental Practice Act to allow alternate providers in Dentistry. I believe we need more open communication with our Board of Dentistry and its members to discuss our differences. We should explore having at least one meeting between the two organizations on a yearly basis. This meeting will allow a healthy debate and exchange of ideas about our trepidations and our concerns, prior to implementation of policies.

Therefore, I will be directing our Executive Director to formally request that this meeting take place between the two Boards on an annual basis.

Practice Ownership: I believe the ownership of a dental practice needs to be clarified. Here is a little history. There was a state statute governing dentistry which, briefly stated that only a dentist could own a dental practice. During the re-codification process in 1988, this statute was eliminated because it was considered-- redundant. The question today is, "Who can control a dental practice?" Is there now a gray area? Questions regarding ownership and supervision of a dental practice have been answered by our attorney. The answer is: ONLY a dentist can own and control a dental practice, whether incorporated or non-incorporated. I feel very strongly about this issue. Who, other than dentists, can best determine the appropriate diagnostic and treatment options for their patients? Today, there are a number of different entities, PC's and PLLC's that control dental practices. Are these entities in violation of our statutes and/or regulations? There is a company that controls dental practices that is publically traded on the stock exchange. This company's major shareholder is the Canadian Teachers Pension Fund. Do they have the patient's best interests and needs at heart? Or are they more concerned with corporate profits? Do we have enemies in this fight? You bet we do! Do we have the necessary statutes and regulations in place to deal with this issue? I believe we do.
I am requesting a collaboration with the Board of Dentistry to look at closing these loop holes in ownership and control of a dental practice. I believe everyone in this room should have the slogan, "Only a dentist can own and control a dental practice." Period!

CDHC: I now want to share with you an idea whose time has come for us in Virginia. In the quest to promote oral health to underserved populations, as well as navigate people into a dental home, a new member of the dental team has emerged.

A Community Dental Health Coordinator or (CDHC) is a "connector" between populations of patients and a dental office. Their activities in connecting people to care have been documented both in the three year pilot program conducted by the American Dental Association, and in several studies that have been conducted across the country.

These professionals complete an online program and internship, both of which typically last a little over a year. CDHCs comply with the state Dental Practice Act and work under the supervision of a dentist. CDHCs may be dental hygienists, assistants or other health professionals.

Their duties may involve delivery of preventive services, such as dental sealants and fluoride varnish. However, experience with the pilot program has shown that case management and navigation are the significant areas where CDHCs have shown their tremendous value.

Based on the success we have seen in other states using the CDHC, I am going to appoint a task force headed by former ADA chairman of CAPIR, Dr. Mark Crabtree, to look into the possibility of Virginia adopting the ADA's training curriculum. I believe this is another piece of the solution in educating and getting patients into the oral health care system, as well as into your offices. I ask you to support me on this initiative.

I also want to share another concern I have along the lines of prevention. We are seeing a rise in activity by the anti-fluoridationists attempting to have water districts remove the fluoride from their water systems. This is concerning on a number of fronts. How can we stand by and allow a small vocal group to take away one of the great public health successes in history? If we are truly committed to prevention, we must not let this happen. I am appointing a task force headed up by Dr. Frank Iuorno and Dr. Paul Supan to work with other stakeholders on this issue to assure that we don't take a step backwards.

All Inclusive Organization: We need to work towards solidarity with other dental organizations and welcome them into our membership. We all share the same goal….to ensure the strength and relevance of our beloved profession, dentistry. Joining together as one inclusive organization, will only make us stronger. We gain strength in numbers and

PRES-MSG (Continued on pg 6)

Dr. Link (R) at the "Where's The Chair" event in August 2014

An Interview with: Dr. Michael Link

Virginia Dental Journal: Why do you want to be VDA President?

Dr. Michael Link: When I first went to the VDA House of Delegates, Dr. Ron Tankersley was elected VDA President. I kept saying to myself, "There's no way I could do this!" Then several months later, Ron asked me to call (US Representative) Herb Bateman and set up a meeting. After the meeting with Congressman Bateman, I asked myself "Can I really make a difference?" I wasn't sure I could because I was young and inexperienced and needed help to be more efficient in my practice. I then volunteered for a candidate for state senate. He ended up winning and at this point the newly elected senator asked me if I wanted to serve on the Board of Dentistry. After much thought, I agreed. All of a sudden, I was appointed to the Board of Dentistry. It was through my experiences with the Board of Dentistry that I found out that, yes, one person could make difference. The experience on the Board gave me the confidence I could do this job. I consider myself a consensus builder, and I want to build the association based on our core value for our members.

VDJ: In your opinion, what's the greatest threat to the dental profession today? Why?

Dr. Link: In my opinion, there are multiple threats to the dental profession that are equally damaging. A few major threats are government intervention into private practice, practice ownership/control of a dental practice, and apathetic or non-engaged members – the list goes on. Outside agencies under the guise of access to care are trying to change the Dental Practice Act to allow mid-level providers to practice dentistry. These agencies are trying to influence legislators to change the traditional dental care system. I do believe the traditional practice model will change somewhat over the next few years; however, the most important message here is that the dentist needs to be in charge of the team! This is of paramount importance.

VDJ: What will you do to stem the decline in association membership?

Dr. Link: Let me say first, the last three (VDA) presidents, Kirk (Norbo), Ted (Sherwin) and Roger (Wood), have done a yeoman's job to help to address this issue. I will continue the efforts of the prior administrations. Specifically, I will promote the 10-month payment plan with automatic renewal program and the PR Task Force. I will also do what I can to let members and potential members know that the VDA is here to help them succeed in their business. I believe this phrase is the key to stem the tide in the declining membership. Let me give you an example. When my dad started out in practice, until he went to file his taxes, he never realized you had to pay estimated taxes. He asked the assessor, how can I pay an estimate of what I might earn? He complained about this one incident for many years and even through retirement. We, as dentists, are not taught "business stuff" in dental school. It shows you just how naïve sometimes we dentists are. My idea of having a financial advisor at the VDA members' fingertips should really be a big help for our members. The CPS that the ADA started this year is a huge benefit as well, by helping our members with tax questions, business decisions, buy/sell agreements, etc. This will be an incredible benefit for our members which will help them succeed in business.

VDJ: Let's say I'm a recent graduate carrying a large student debt. Explain to me why I should join the VDA.

Dr. Link: Well, if I'm a student carrying a large student debt, I would want to get the lowest student loan rate in the country. I'm going to start a task force to look into this issue of trying to secure the lowest loan rates for our newest members. There are so many good reasons for a recent graduate to join us. The Leadership Institute that will start in November will offer young dentists the skills for leadership in their community, profession, and association. The Center for Professional Success offers web-based solutions. The VDA offers so many ways to help young dentists succeed in their careers. As Dr. Manny Michaels stated back in 1984, if you don't join your professional association, you have abdicated the control of your profession and given it to others. Organized dentistry is the only true organization that protects and cares for dentists.

VDJ: Your president's address mentioned six mentors. Tell us about them.

Dr. Link: There were (Doctors) Ron Tankersley, Richard Barnes, George Jacobs, Mark Crabtree, my dad (Dr. Acree Link) and my father in law, Willard Robinson, Jr., Esquire. My dad was my first mentor. He was an excellent dentist, and he was very caring and compassionate. He told me to treat each person as if he (or she) were you. He told me to always use plain talk to relate to my patients better. He said that people know you're intelligent, but if you can't explain the problem to the patient

Dr. Michael Link, Dr. George Jacobs and their staff, Newport News

An Interview with Dr. Michael Link

Continued

in understandable terms then you have failed your duty. George (Jacobs) is my brother-in-law. He has a calming influence on me. I'm hyper…I either go 110 percent or 0 percent (sleeping). George is more laid back than I so he lets many things roll off his shoulders. He has a lot of drive, but in a different way. Going at things at 110% may not always be the best way to do things. My father-in-law was a wonderful man. He was the Commonwealth's Attorney in Newport News and a very kind and caring man. He told me to always do what's right for people – treat people right and they will treat you right. Mark and Richard are two individuals that truly have a gift in that they listen to issues and can articulate a well reasoned point of based on their own set of core values. I have seen Mark and Richard in action and it is an art to be able to convey their messages after a disagreement. Ron, I believe has mentored more people than he realizes. He's the one who asked me to call (Congressman) Bateman because I knew him on a personal level. He is the one who really got me interested in organized dentistry and taught me the importance of the personal touch. Looking back, Ron made me realize how much we need help from all young members. I just wish our younger members could see the value in getting involved at an early age.

VDJ: Your father was a dentist. What did he teach you about practicing dentistry?

Dr. Link: My Dad taught me many things in life as a child and as a dentist, so it is a little hard to separate the two. However, he taught me the economics of dentistry, treating each patient as if they were you, the importance of plain talk to my patients, caring and compassion for patients. For example, when you see someone who has a lot of dental problems who can't afford dental care, what should you do? He believed that you give the patient a break. My dad's been gone now four and a half years and a lot of times I wish I could still talk to him. We had many discussions over the years about how we would do a procedure. Sometimes he would teach me a better way of doing thing, and sometimes I would explain new techniques to him. I believe we made each other a better dentist. It was a good collaboration. Also, I believe I have this situation with my brother-in-law, George Jacobs.

VDJ: What legislation will be brought before the General Assembly in 2015? What concerns will be discussed at the Virginia Board of Dentistry?

Dr. Link: There's no legislation planned as of now to go to the General Assembly. One of my priorities will be to form a task force to study practice ownership/ control and bring it before the Board of Dentistry. I'm not against DSOs, PCs, or PLLCs owning practices. I'm against these entities controlling dental practices and setting production quotas for dentists. This goes against every fiber in my body and everything I was taught as a healthcare provider. I believe that a dentist should do what is right for the patient and not oversell procedures because of a production quota; this does not benefit the patient. This is one reason why we need strong advocacy and why we need to support our VADPAC more to make sure our statutes are not changed to benefit unethical behavior. As Bruce Hutchison, our VDAPAC chairman, has stated so many times this year, VADPAC is our insurance to ensure we protect our profession.

VDJ: One last question: what would like to be doing five years from now?

Dr. Link: I will still be practicing dentistry. I love dentistry; however, I do not enjoy the constant regulations that have been encroaching on our profession over the past few years. I hope to travel some with my wife and I do plan to play more golf in senior/amateur events. My passion is dentistry but golf is an equal passion as well. I almost went into collegiate golf at (University of) Richmond. Over my first two years, I played with a few members on the golf team and beat them. At this point, the coach kept trying to get me to go out for the team. I kept asking the coach how long are you away from the school? Then I found out that the team would sometimes be away for a month. I remember explaining to him that I was a chemistry major, and there was no way I could make up classes, labs, etc. He kept telling me that they played at nice places like Augusta National. (This is my dream: to play Augusta National.) When I was in high school, I had been trained to be a dental assistant by my father. I believe this was my calling and this was something I wanted to be, a dentist. One of my friends ahead of me at U of R had warned that it is extremely difficult to be on the golf team and still be a chemistry or biology major. (I agree with him) So that was the decision I made that led me away from golf and into dentistry, and I know that I made the right choice.

Dr. Link at Virginia Meeting Putting Tournament

PRES-MSG (Continued from pg 4)

have a greater impact when we go to our legislators, either in Richmond or in Washington, DC.

In 1984, our past VDA President, Dr. Manny Michaels, wisely stated: "If you choose not to join your Association, you have abdicated the control of your destiny and given it to others." We need to stop the decline in membership by helping all of our fellow dentists and regaining control for our future.

Advocacy: I joined the VDA many years ago partly because of the statement made by Dr. Michaels. The other reason I joined is that one of my mentors told me that, organized dentistry is the only voice of the profession. It is truly the only organization that cares for the individual dentists. Over my many years of membership, I now realize how much of a voice we actually have. We must support our PACs or abandon our duty to leave the profession better off than when we started practicing.

Under the guise of access to care, many organizations are trying to influence legislators to accept policies that are not in the best interest of the patient, the public or our esteemed profession. To protect the quality of care that the public deserves and our professional interests, each of us needs to raise our commitment to our PAC. Therefore, today I am asking you to further our cause by increasing your contribution to VADPAC by at least one level! You can even make this pledge at our VADPAC booth today! This way, we can ensure that the control of our profession remains in our hands.

Student Debt is increasing at an unsustainable rate. Our newly-joined members are facing debt- some $200,000-300,000 out of dental school. The debt that these students face adversely impacts their ability to thrive professionally. Their student debt payments are more than many house payments! I feel empathy for these young dentists. We need to find a way to help!

What if we partnered with a firm or a company to help ensure that our newly joined VDA members have the lowest student loan rates in the country? This would be a win-win situation for both our younger members and for our Association. Therefore, I will be appointing another task force to explore this idea and report back to the Board of Directors with its recommendations.

We have a significant agenda! And each year our needs are greater. Our success is dependent on our working together as a united profession with one voice.

As the great William Jennings Bryan stated: "Destiny is not a matter of chance; it is a matter of choice. It is not a thing to be waited for; it is a thing to be achieved." I believe our destiny is in our hands!! So let us act NOW!!

Letter to the Editor

Patients' Questions = Symptoms of Concern

By: Marvin E. Pizer, D.D.S., M.A., M.S.*

These are a few of the many questions asked by various patients on their initial visit to my office. My practice was limited to oral and maxillofacial surgery with a special interest in surgical oncology.

Some of the questions were:

1. I went to my medical doctor for this "thing" on my tongue. He sent me to my dentist who sent me to you. Who are you going to send me to?

2. I have had this black spot on my tongue for about two years. Should my dentist, who I see every four months, have sent me to you sooner?

3. Can my dentist do this biopsy? Does it hurt? Will I be put to sleep?

4. Do you think this is cancer?

5. If this mark on my tongue is removed, how will I eat and talk?

6. Do people die from mouth cancer?

7. If this is cancer, what kind of doctor will take care of me?

8. Will I have to go to the hospital?

9. Do dentists do this kind of work? Do they work in hospitals like medical doctors?

10. Will my insurance cover my visits to doctors, and if I have to go to the hospital?

A thoughtless answer could incite extreme fear, acute anxiety, and even anger at the referring doctor. At times, the manner in which some questions were asked implied a total lack of confidence in their referring doctor.

The answer to many of their questions was "Good, caring doctors are the ones who seek second opinions by referring and obtaining the best treatment for their patients. I do it frequently."

When listening to a patient's questions, I give an honest answer and at the same time reassuring the patient. Explaining to patients that what a doctor sees in the mouth or on the face are frequently variations of normal and that good medicine may require verification. Reassuring patients that they have had competent doctors generally reveals a content face.

Some of those questions could have been avoided if the following suggestions were applied:

1. All dental students should be thoroughly informed of the dental specialties and their scope. A general knowledge of the medical specialties is also beneficial.

2. The referring doctor should explain to the patient why they are being referred to a specialist and the qualifications of the specialist.

3. Communication should be made by the referring doctor to the specialist, as to precisely what this patient's problems are, that need to be resolved. The patient should know of this communication.

4. After radiographic studies and a biopsy – the referring doctor should have in his possession copies of lab work, biopsy report, and radiographic findings from the specialist. The proposed treatment should be discussed by both doctors. The specialist should inform the patient of all findings, and the discussion with the referring doctor as to the best treatment for this patient's condition.

5. The findings and results from treatment and prognosis should be explained to the patient as soon as the patient is receptive. The referring doctor should be informed as quickly as possible.

6. The specialist should follow the post-treatment care and the patient should be referred back to his or her primary doctor for continued general care.

The patients with "the questions" came from a variety of sources: some from my private practice, some from health departments, and even health fairs on university campuses.

When confidence is restored, patients are cooperative and appreciative. Communication with patients and fellow health professionals will result in excellent health care for patients and professional dignity for dentistry and medicine.

Formerly:

*Research Professor; Adjunct Professor Medical Physiology; Director Pre-professional Health Care Program, The American University, Washington, DC

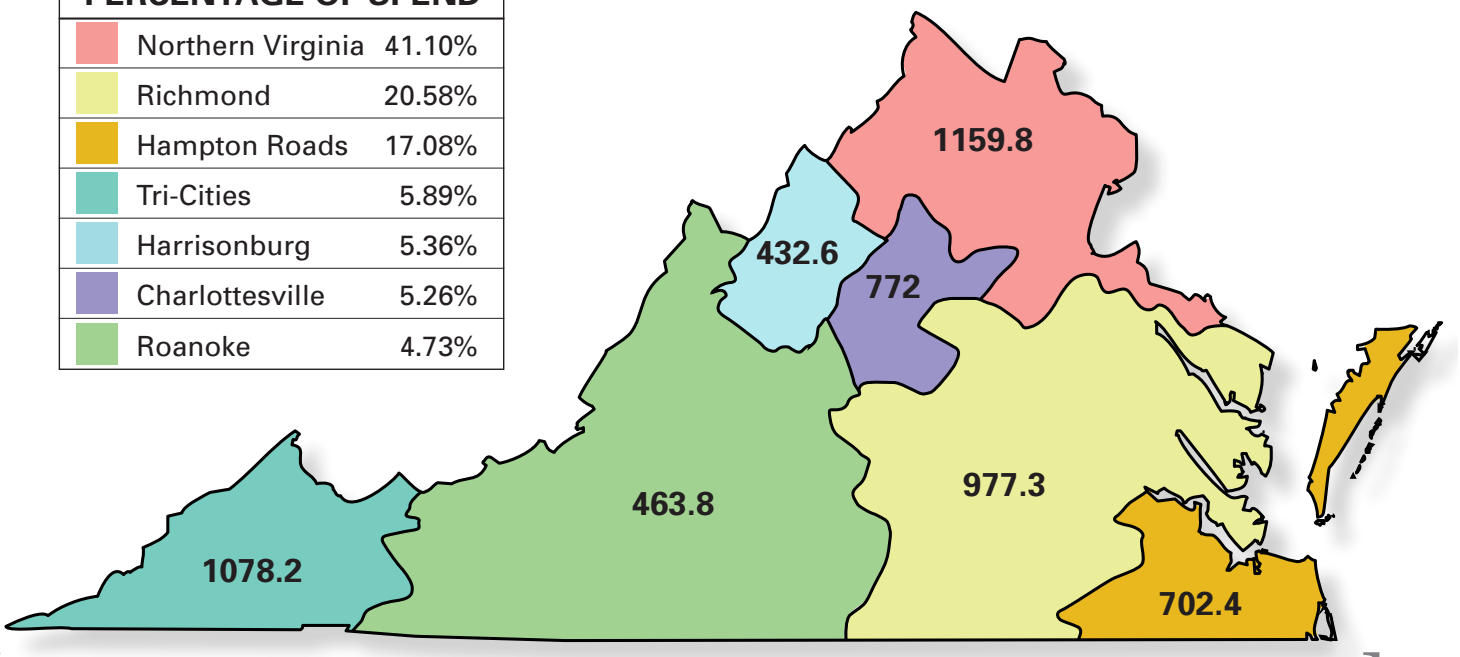
*Clinical Professor, Oral and Maxillofacial Surgery, Virginia Commonwealth University School of Dentistry, Richmond.

News from the VDA's Public Relations Task Force

Following the April television ad run (April 7-27, 2014), the VDA's Public Relations Task Force requested an update from the advertising agency (Seventh Point) on the results of the run. The map below shows the various media markets where the ad was shown and provides information about gross rating points (which measure the amount of media weight) in each region. Additionally, spending in each region is shown for this run of television only. Please note that this graphic only represents the first TV run -- the entire media spend for 2014 is carefully planned around the percentage of members in each region to ensure that spend correlates with the number of members in each region. At the bottom of the page please find some overall information about the first run of the ads in April 2014. Ads were also on television in September and results of that run will follow in a subsequent edition of the *Journal*.

Virginia Dental Association
TV Advertising Review for Spring 2014

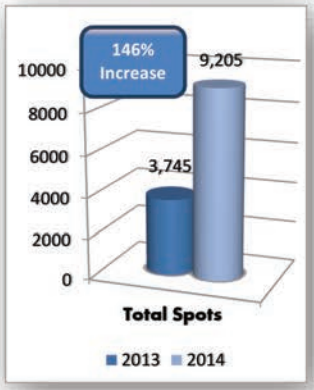
PERCENTAGE OF SPEND	
Northern Virginia	41.10%
Richmond	20.58%
Hampton Roads	17.08%
Tri-Cities	5.89%
Harrisonburg	5.36%
Charlottesville	5.26%
Roanoke	4.73%



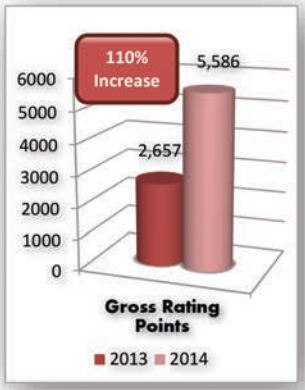
Total gross rating points (measure of media weight) per region during the month of April.

Television Summary-Spring Flight

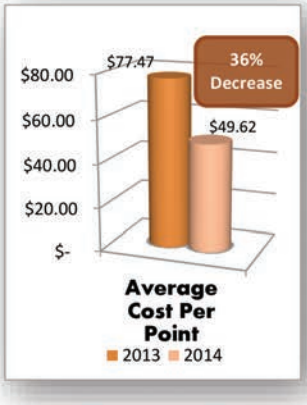
Planned increase in total spend



Addition of :15 spots to mix along with additional spend generated a 146% increase in total spots



More efficient buy and additional spend generated a 110% increase in weight



More efficient buying and negotiation resulted in a 36% decrease in cost per point

Trustee's Corner

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

Because we had June and July Board of Trustees meetings this year, my plan was to combine the two meetings into one report. However, I had to leave the July meeting early because of my father's illness. I want to take this opportunity to thank those of you who sent condolences and sympathy notes as a result of his passing. Our 16th District dental family is so very close and I appreciate all of your thoughts and prayers more than you know.

Most of the June BOT meeting work centered on development and preliminary approval of the draft of the 2015 Budget. The board received a draft of Board Report 2 earlier than in previous years, so the report is not final as there are a few open items that will be brought to the July BOT meeting for final approval with the resolutions to be sent as a final report to the House of Delegates. It is now available along with the first set of resolutions on ADA Connect . Please continue to check ADA Connect as new resolutions will continue to be posted.

In support of the new strategic plan, the proposed 2015 budget includes investments in membership growth, with a significant continued IT spending on accelerated Aptify implementation. Our goal is this will help state and local societies and the ADA better understand members and their needs.

As always is the case, the BOT continued the practice of devoting significant time to in-depth strategic discussions. At the June meeting, there was a discussion of the issue of adult Medicaid coverage. The discussion was data driven and revolved around what action the ADA can take in the Medicaid environment to help both our members and the public. We all understand that this is a difficult issue with no easy solutions. We have asked staff to develop a strategy and an action plan and to bring results back as quickly as possible.

As is the Board's custom, the chair of the Council on Dental Accreditation, Dr. John Williams, was invited to address the June BOT meeting. The total number of programs for which CODA is responsible has grown every year since 2006. Approximately 94% of these programs are currently in compliance with CODA accreditation standards. The relationship between ADA and CODA is both important and sensitive. Staff has been asked to work with four Board members to consider how to best promote ongoing dialogue with CODA and report back to us.

The initial focus of the July BOT meeting was on budget and related matters. The Board reviewed and accepted the recommendations of a work group to create a separate, dedicated reserve fund which would allow the Association to accumulate a targeted $100 million from royalties received from the ADA member insurance plans.

Board Report 2 was amended and passed and sent to the HOD via ADA Connect. The report proposed a budget that contained no dues increase with a significant surplus including royalty payments from the ADA Membership Insurance Plans.

Specifically, the BOT is recommending a 2015 operating budget of $134,877,000 in revenue and $128,728,000 in expenses and taxes.

Also at the July meeting, the BOT was pleased to have dinner with the American Student Dental Association Board. The ASDA President and Executive Director provided a presentation to the BOT on ASDA activities and ASDA-ADA interactions.

Our strategic discussion at the July BOT meeting revolved around the Millennial Generation. This strategic topic allowed those present to review detailed data on younger dentist and younger patients.

The discussions led to the conclusions that we need to act on data, not on the impressions of leaders. In addition to relying on data, we need to make room for younger dentists to actively participate in our leadership to make it more representative of our general membership.

The ASDA guests were asked how we could improve communication to their generation. The key is immediate, readily available information that is always available to them. There was discussion about the ADA web page. It needs to be more intuitive. This generation is very tech-capable which makes them impatient with technology shortcomings.

What do dental students want from us?

- Greater ADA constituent and local component presence at their schools
- More focus on each stage of their careers
- The ability to choose what they want and when they want it
- Students are anxious to learn from young dentists who have experienced what is in their immediate future.

The next generation is a very strong one. If we can succeed in serving their needs, the ADA will be a success now and in the future.

The VDA Welcomes Two New Staff Members

Jill Kelly

Director of Finance

Jill began her career in information technology and worked for various state agencies and Hanover County public schools for eighteen years. Jill decided to switch to a career in finance and in 2008 received a business degree with a major in accounting from Old Dominion University. She has worked as a Finance Officer for The Community Foundation (serving Richmond and Central Virginia) and as Director of Finance and Operations for The Partnership for Nonprofit Excellence. Jill looks forward to working with the board and staff to support the VDA's members. Contact Jill at jkelly@vadental.org.

Karen Clendenen

Membership & Meeting Coordinator

Karen worked as a Legal Assistant for 16 years before deciding to leave the work-force to focus her time on raising her daughter. Later, she began a position in retail at Hudson News, a retailer specializing in service to air travelers nationwide. Karen believes that serving others and bring a genuine smile to ones face, is the highest goal to which one can aspire. After four years of serving air travelers, she was offered the opportunity to join the VDA and believed it would be privilege to serve in that capacity. She now looks forward to serving and bringing a smile to the faces of those that help others flash their "pearly whites".
Contact Karen at staff@vadental.org.

for getting a loan from someone who understands your practice.

Business Borrowing | for the achiever in you®

Get financing from a banker who understands your practice and the importance of cash flow to help it succeed. PNC provides dedicated and experienced Healthcare Business Bankers who understand the financial needs of a successful practice, so you end up with more than just a loan, you end up with customized financing solutions.

For more information about how you can optimize your practice's cash flow, contact a Healthcare Business Banker at ***877-566-1355*** or go to ***pnc.com/hcprofessionals***

PNC | CFO℠
Cash Flow Optimized

PNC BANK

MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Dentists pride themselves on being scientific, objective, unbiased, and providing dental care that is based on the best clinical evidence available. Years of undergraduate and postgraduate training have inculcated these traits, which we all wear as a badge of honor. Yet, an activity that we perform on an almost daily basis falls prey to whimsy, prejudice, misconception, and personal preference. Like many aspects of dental practice, patient referrals are both an art and a science. We'd like to think that objective criteria and evidence-based (a fashionable word in dentistry these days) rationales guide our decision to place our patients' care in the hands of trusted colleagues, either specialists or other general dentists. But most studies show that referrals are dependent on doctors' personal (non-clinical) preferences and habituation.

Dentist-to-dentist referrals fall into three categories: 1) general dentists referring patients to specialists whose practice is limited to one of nine recognized dental specialties 2) dental specialists referring patients to other specialists and 3) dental specialists referring (often) self-referred patients to general dentists for further care and to establish a primary dental care provider. The first category is by far the most common of the three referral patterns, and the subject of most discussion both clinically and in dental literature. General dentists in their education are trained in and exposed to most procedures, yet in practice they routinely refer to specialists many of the most complex procedures.

What are some reasons for referral in Category One? This list may include the following: the doctor lacks training in a particular procedure; the doctor has been trained but is not confident in his or her clinical skills; the doctor feels a specialty referral is needed to meet the standard of care; or the doctor needs the specialist's opinion prior to proceeding with recommended dental treatment. General dentists know that they will be required to meet standards of care of that provided by specialists in that discipline. Having practiced for over thirty years, there are some procedures I will always decline to perform: orthodontics; removal of impacted third molars; implant placement; and periodontal surgery, to list a few. Also, I can say with certainty that there have been no referrals that I have regretted, but many that I wished I had foresight enough to make. It would be simple enough to have a written policy on referrals, e.g. no molar endodontics. But what about that maxillary second bicuspid: one canal or two? Or mandibular incisors, which always appear to have only one canal, but often have a second canal that if undiscovered will lead to failure, and ultimately lead to a referral that should have been made first. Or, what about children's dental care? We're urged from all quarters to treat young children, even those as young as two years of age. Again, we'll be held to a standard equivalent to care provided by a board-certified pediatric dentist. An arbitrary policy could be applied, such as referring all children under the age of six to a pedodontist. Years of practice have taught me that some four year-olds can be a delight, while others that age and even much older need to be seen by the specialist. A cynic will say we refer by intuition, but as Malcolm Gladwell has pointed out, intuition is merely a composite of our experience and training, and not merely a hunch or flight of fancy. "There can be as much value in the blink of an eye as in months of rational thinking." [1]

Science appears to have little or no bearing on the likelihood of dental referrals to a specialist. A study of Michigan dentists found that the patients' periodontal disease characteristics and diagnostic considerations had no influence on general dentists referring to periodontists.[2] A study of Virginia dentists found referrals were more likely if: the provider was female; in a group practice; and the nearest periodontist *was more than five miles* from the referring doctor.[3] In Nova Scotia, the satisfaction of previous patients and the personality of the periodontist were common criteria in general dentists' selection of a specialist.[4] What about other specialties? In Northern Ireland, a general dentist was most likely to refer to a specific endodontist if there was a short waiting time for an appointment.[5] In choosing an orthodontist, favorable past experience and oral hygiene monitoring *by the orthodontist* have been listed as most important factors when general dentists choose a specialist for their patients.[6] General dentists in Iowa were more likely to refer children to pedodontists if they had an increased percentage of children in the practice and they had received *additional training* beyond dental school.[7] Although most general dentists will deny it, clinical considerations are secondary when making a referral and choosing a specialist.

In the second category, dental specialists may refer to another recognized specialty if consultation is needed, if their treatment findings indicate it, or if the referring general dentist declines to perform the (agreed upon) procedure. Two examples: an endodontist finds a vertical fracture rendering the tooth hopeless, and necessitating a surgical extraction, perhaps by an oral and maxillofacial surgeon; an orthodontist contemplates orthognathic surgery as part of a treatment plan, and consults the oral surgeon. Specialist-to-specialist referrals should always be made in communication with, and the consent of, the referring general dentist. Quality communication is paramount in this instance.

The third category, whereby specialists, seeing the need for further care outside their recognized specialty, seek to find a general dentist for their self-referred patient. This can be a delicate process, as most specialists draw from a large number of referring dentists, and would hope to avoid offending other generalists in finding a "dental home" for their patient. Giving the patient more than one name based on the patient's geographic preference, would dispel any hint of favoritism on the part of the specialist. I've had new patients in the office tell me a local oral surgeon was their "regular dentist". And on the subject of self-referral, more than once a patient referred in writing to a specialist ends up in the office of another doctor in another specialty. The patient's explanation: "I've heard the name."

How do you make referrals? Doctor, do you put yourself or the patient first? What are your criteria for making a referral? Are you making clinical judgments, or subjective ones? If you're like most dentists, you fly by the seat of your (scrub) pants. But there's nothing unethical or unprofessional about referring patients to a local specialist who's on a first-name basis, and who you'll see once a quarter at a CE meeting. Communication may be the benchmark for a successful referral, both in clinical terms and in achieving patient satisfaction. We're more likely to refer to a colleague who'll listen, won't judge, and understands that success is not guaranteed. Our patients will be the greatest beneficiaries.

1 Malcolm Gladwell, *Blink – The Power of Thinking Without Thinking* (New York: Little, Brown and Company, 2005)

2 Bennett DE, Lee JH, Richards PS, Inglehart MR. General dentists and periodontal referrals. J Mich Dent Assoc 2010; 92(9): 46-51

3 Zemanovich MR et. al. Demographic variables affecting patient referrals from general practice dentists to periodontists. J Periodontol 2006; 77(3) 341-349

4 Ghiabi E, Matthews DC. Periodontal practice and referral profile of general dentists in Nova Scotia, Canada. J Can Dent Assoc 2012; 78:c55

5 Barnes JJ, Patel S, Mannocci F. Why do general practitioners refer to a specific specialist endodontist in practice? Int Endod J 2011; 44(1) 21-32. doi. 10.1111

6 de Bondt B, Aartman IH, Zentner, A. Referral patterns of Dutch general dental practitioners to orthodontic specialists. Eur J Orthod 2010; 32(5): 548-554

7 McQuistan MR, Kuthy RA, Daminano PC, Ward, MM. General dentists' referrals of 3- to 5-year-old children to pediatric dentists. JADA 2006; 137(5): 653-660

GET PAID FASTER!

Sign up for

FREE DIRECT DEPOSIT!

Get your claims payments transferred directly from Delta Dental to your checking or savings account.

Available to all dentists.

"I love Delta Dental's Direct Deposit; it's awesome! It's right there, right now! You get paid within a week. It's easy and simple! It makes my life easier and is one less thing I have to worry about!"

Melinda Marlow
Office Manager
Dr. William Hefele
Ashland, VA

To sign up, call

800.367.3531 EXT. 3328

or visit

DELTADENTALVA.COM/DENTISTS.ASPX

THE DENTAL COVERAGE EXPERTS

DELTA DENTAL®

Brought to you by Delta Dental of Virginia.

Is This Tooth Restorable?

John J. Boyle, Jr., DMD, MS*

Abstract

The overall treatment planning decision to extract a tooth involves criteria other than just the prosthodontic restorability. The esthetic concerns of the patient, the cost-benefit ratio, the strategic value of the tooth, and the adjunctive procedures required all play an important role. A discussion of all of these criteria is beyond the scope of this article. When formulating a treatment plan all teeth must first be diagnosed. Therefore, the purpose of this article is to review the clinical factors that determine the restorability of a single tooth.

Introduction

Dentists frequently face the treatment planning decision to restore or extract a tooth. Given the high success rate of implant treatment, dentists often now have a tendency to extract questionable teeth and treatment plan for implant replacement. However, implant restorations are not a panacea nor are they for everyone. A number of systemic conditions, such as acute infections, severe anemia or emphysema, uncontrolled diabetes, uncontrolled hypertension, abnormal kidney or liver function, severe risk of hemorrhage, severe immunocompromise, or the use of IV bisphosphonates, are considered to be contraindications (ref 1). The presence of chronic periodontitis is also a significant risk factor for implant failure (ref 2).

Our responsibility as dentists is not to judge the patient's desire to retain his or her natural teeth, but to provide sound treatment plan options with predictable prognoses. In a meta-analysis study of relative survival rates of single tooth implants versus endodontically treated and restored natural teeth, Iqbal and Kim reported equivalent outcomes (ref 3). In a review of outcomes study, Torabinejad et al. reported the survival of teeth with initial root canal therapy and the survival of single implants were comparable (ref 4).

Restorative Considerations

The first step in determining restorability of a questionable tooth is to excavate the carious lesion and assess the amount of remaining tooth structure. Also assess any pulpal involvement and the location of the final restoration margin. Extensive coronal destruction frequently requires endodontic therapy and/or periodontal crown lengthening therapy in addition to a full coverage crown restoration. Evaluation of restorability then proceeds to assessing the ferrule effect, periodontal restorability, the biologic width, periodontal crown lengthening or orthodontic extrusion, the final crown to root ratio, and potential furcation involvement.

One of the most accurate indicators of long term retention for an extensively damaged tooth is the amount of sound tooth structure encompassed by the final crown restoration. Eissman and Radke used the term ferrule effect to describe this 360 degree ring of crown material and recommended the definitive restoration extend at least two millimeters apical to the junction of the core and remaining tooth structure (Fig 1)(ref 5 and 6). The ferrule adds some retention, but primarily provides resistance form and enhances longevity (ref 7).

Sorensen and Engelman found that one millimeter of coronal tooth structure occlusal to the finish line significantly increased the fracture resistance of endodontically treated teeth (ref 8 and 9). Hoag and Dwyer determined that the amount of remaining tooth structure present is more important than the material from which the post and core is fabricated. They recommend retaining at least one to two millimeters of cervical tooth structure (Fig 2)(ref 9 and 10). A recent 3-dimensional finite element analysis study by Verissimo et al. confirmed that two millimeters of coronal dentin resulted in lower strains and higher fracture resistance regardless of the post and core restorative method (ref 11).

Periodontal Considerations

The health of the supporting periodontium must also be assessed when deciding to restore or extract a tooth. Pocket depth, bone loss, furcation involvement and mobility all play a vital role in the long term prognosis of the tooth.

Periodontal pocket depths greater than seven millimeters have been shown to be more difficult to maintain over time (ref 12).

Various authors have established written guidelines for the percentage of bone loss relative to the long term prognosis. Dentist should exercise caution and frequent maintenance when bone loss is 30% - 65%. When bone loss is greater than 65% extraction should be considered (ref 13 and 14).

The furcation involvement of posterior teeth should be evaluated and classified. Class II furcations have some bone loss and a periodontal probe will penetrate partially into the furca (ref 15). Class II defects can be treated successfully, but long-term maintenance is a concern (ref 16). Class III furcations will probe completely through the furcation and interradicular bone is absent (ref 15). Class III defects have been shown to have a poor long-term prognosis (ref 17).

Tooth mobility caused by inflammation and occlusal trauma can be corrected, but mobility caused by loss of alveolar bone support presents a greater problem. Teeth with a 50% loss of attachment and a grade two or three degree of mobility have a very guarded prognosis and should be considered for extraction (ref 18).

Often a tooth will have healthy periodontal support but lack the required ferrule effect. Gaining the two millimeters of tooth structure for an adequate ferrule by preparing the restoration margin beyond the gingival sulcus is contraindicated. It will violate the biologic width and result in a chronic periodontitis.

Figure 1. Ferrule effect with post & core

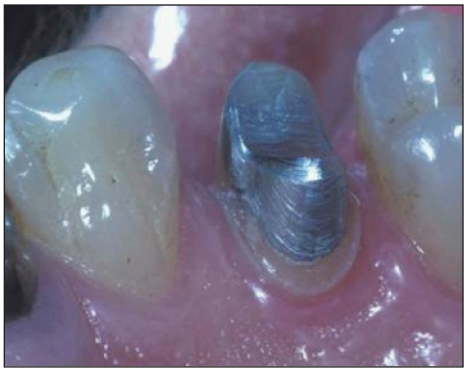


Figure 2. Ferrule effect with amalgam core

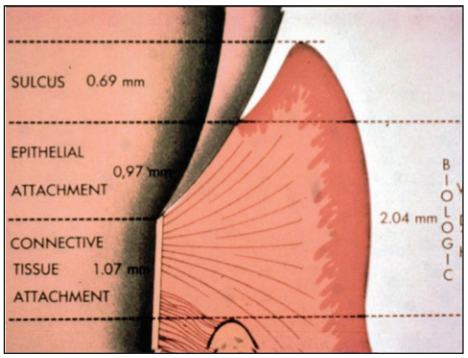


Figure 3. Biologic width dimensions

The biologic width is a term coined by Gargiulo et al. to define epithelial and connective tissue dimensions. The connective tissue attachment to the tooth averages 1.07 millimeters, the epithelial attachment 0.97 millimeters, and the gingival sulcus depth 0.69 millimeters (Fig 3)(ref 19). Crown margins may be placed into the gingival sulcus but

Continued from page 13

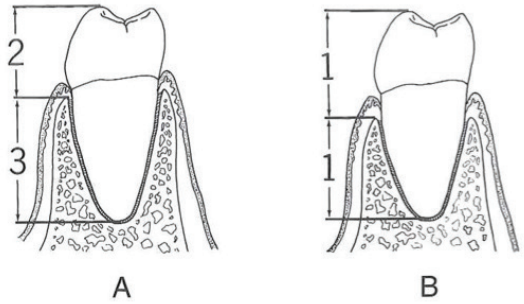


Figure 4. Crown:root ratio

no closer than 0.5 millimeters from the epithelial attachment. Extension of crown margins into the epithelial attachment and beyond will result in inflammation, bone loss, and apical migration of the tissue attachments (ref 20 and 21).

Adjunctive procedures are available to gain an adequate ferrule of tooth structure and avoid violating the biologic width. Periodontal crown lengthening or orthodontic extrusion are the most common.

Periodontal crown lengthening is a surgical procedure that intentionally exposes more tooth structure by apically repositioning the supporting tissues with or without osseous surgery. This procedure should be treatment planned carefully as crown lengthening may result in compromised periodontal support in the form of a less than ideal crown to root ratio and/or furcation involvement (ref 22).

The crown to root ratio is a measure of the length of tooth occlusal to the alveolar crest of bone compared with the length of root embedded in the bone. As the level of alveolar bone moves apically, the lever arm of the portion out of bone increases and the chance for harmful lateral forces increases. A crown to root ratio of 1:2 is ideal, 2:3 is realistic, and 1:1 is minimum (Fig 4) (ref 6). The more favorable the crown to root ratio, the better the tooth can withstand masticatory forces and the better the prognosis.

The periodontal crown lengthening procedure also has the potential to create a furcation that cannot be hygienically maintained. As previously discussed, Class II and Class III furcations may jeopardize long term success.

An alternative procedure to periodontal crown lengthening is orthodontic extrusion of the tooth. Using orthodontic wires and elastics the tooth is forcibly erupted to expose the needed tooth structure (ref 23 and 24). This procedure requires frequent patient visits to monitor the rate of eruption, change elastics, and adjust occlusion. It is a more complicated procedure and requires a longer period of time than crown lengthening (ref 18).

Conclusion

The decision to restore or extract a tooth is complex with many clinical factors influencing the decision. This paper has attempted to highlight the critical components to be evaluated when treatment planning a tooth with extensive coronal destruction. In summary, dentists must evaluate the restorative aspects of remaining tooth structure, pulpal involvement, and location of final restoration margin. Equally significant are the periodontal aspects of pocket depth, bone loss, furcation involvement, mobility, biologic width, and crown to root ratio. Once the restorability of each tooth is determined, dentists can then proceed to developing the overall treatment plan.

References

1. Bornstein MM, Cionca N, Mombelli A: Systemic conditions and treatments as risks for implant therapy. Int J Oral Maxillofac Implants 2009; 24:12-27
2. Garcia-Belosta S, Bravo M, Subira C, et al: Retrospective study of the long-term survival of 980 implants placed in a periodontal practice. Int J Oral Maxillofac Implants 2010; 25: 613-619
3. Iqbal M, Kim S: For teeth requiring endodontic treatment, what are the differences in outcome of restored endodontically teeth compared to implant supported restorations? Int J Maxillofac Implants 2007; 22:96-119
4. Torabinejad M, Anderson P, Bader J, et al: Outcomes of root canal treatment and restoration, implant supported single crowns, fixed partial dentures, and extraction without replacement: a systematic review. J Prosthet Dent 2007; 98:285-311
5. Eissman HF, Radke RA: Postendodontic restoration. In: Cohen S, Burns RC: Pathways of the Pulp. Saint Louis MO, C. V. Mosby Co 1976, p.540
6. Shillingburg HT: Fundamentals of Fixed Prosthodontics (Fourth Edition). Chicago IL, Quintessence Publishing Co 2012, p.212
7. Schwartz RS, Robbins JW: Post placement and restoration of endodontically treated teeth: a literature review. J Endodon 2004; 30:289-301
8. Sorensen JA, Engelman MJ: Ferrule design and fracture resistance of endodontically treated teeth. J Prosthet Dent 1990; 63:529-536
9. Goodacre CJ, Spolnik KJ: The prosthodontic management of endodontically treated teeth: a literature review. Part III. Tooth preparation considerations. J Prosthet Dent 1995; 4:122-128
10. Hoag EP, Dwyer TG: A comparative evaluation of three post and core techniques. J Prosthet Dent 1982; 47:177-181
11. Verissimo C, Simamoto PC, Soares CJ, et al: Effect of the crown, post, and remaining coronal dentin on the biomechanical behavior of endodontically treated maxillary central incisors. J Prosthet Dent 2014; 111:234-246
12. Renvert S, Persson GR: A systematic review on the use of residual probing depth, bleeding on probing, and furcation status following initial periodontal therapy to predict further attachment and tooth loss. J Clin Periodontol 2002; 29:82-89
13. Becker W, Becker BE, Berg LE: Periodontal treatment without maintenance. A retrospective study in 44 patients. J Periodontol 1984; 55:505-509
14. Lindhe J, Nyman S: Long-term maintenance of patients treated for periodontal disease. J Clin Periodontol 1984; 11:504-514
15. Malone WF, Koth DL, Cavazos E, et al: Tylman's Theory and Practice of Fixed Prosthodontics (Eighth Edition). Saint Louis MO, Ishiyaku Euoramerica Inc. 1989, p.91
16. Jepsen S, Eberhard J, Herrera D, et al: A systematic review of guided tissue regeneration for periodontal furcation defects. J Clin Periodontol 2002; 29:103-116
17. Palito DB, Joly JC, Delima AF, et al: Clinical and radiographic treatment evaluation of class III furcation defects using GTR with and without inorganic bone matrix. J Clin Periodontol 2003; 30:1-8
18. Harrison JW, Svec TA, Simon JF: The hopeless tooth: when is treatment futile? Quintessence International 1999; 30:1-6
19. Gargiulo AW, Wentz F, Orban B: Dimensions and relations of the dentinogingival junction in humans. J Periodontol 1961; 32:261-267
20. Maynard JG, Wilson RD: Physiologic dimensions of the periodontium significant to the restorative dentist. J Periodontol 1979; 50:170-174
21. Wilson RD, Maynard JG: Intracrevicular restorative dentistry. Int J Periodontol and Res Dent 1981; 1:35-49
22. Rose LF, Mealey BI, Genco RJ, Cohen DW: Periodontics: Medicine, Surgery, and Implants. Saint Louis MO, Elsevier Mosby 2004, p.546-549
23. Ingber JS: Forced eruption: Part II. A method of treating non-restorable teeth – periodontal and restorative considerations. J Periodontol 1976; 47:203-216
24. Cesar-Neto JB, Martos J, Artifon L, et al: Mandibular molar rehabilitation using orthodontic extrusion associated with odontoplasty. J Prosthodont 2012; 21:626-630

*Dr. John J. Boyle is Assistant Professor of Prosthodontics at Virginia Commonwealth University School of Dentistry. He may be contacted at jjboyle@vcu.edu.

PathologyPuzzler

with Dr. John Svirsky

A 56 year-old white male presented to the Virginia Commonwealth University School of Dentistry for dental care. During the initial head and neck examination a 1.8 by 1.4 cm ulcerated lesion of the right lateral tongue was found (Figure 1). It was non-painful with rolled indurated borders. It had been present for over four months with no appreciable change in size in the past month. The patient was blind with no history of smoking or drinking. His medications included Zoloft® (sertraline HCL), lisinopril, hydrochlorothiazide and Zocor® (simvastatin).

Your differential diagnosis would include which of the following?

1. Erythema multiforme
2. Oral carcinoma
3. Pemphigus
4. Traumatic ulceration
5. Viral ulceration

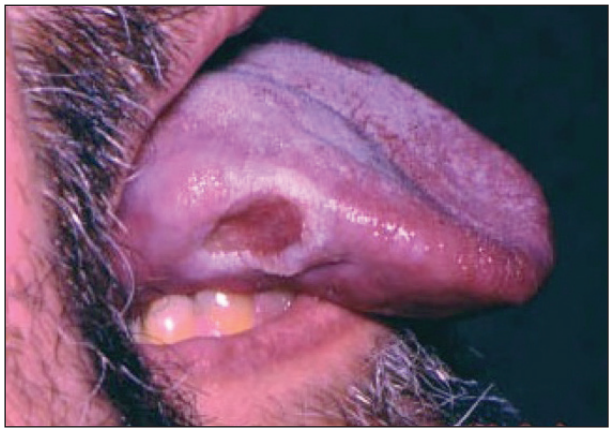


Figure 1

SVIRSKY (Continued on pg 16)

SVIRSKY (Continued from page 15)

PathologyPuzzler

with Dr. John Svirsky

The clinical appearance with rolled borders and induration was strongly suggestive of oral cancer (squamous cell carcinoma makes up 95% of oral cancers). There were no sharp teeth noted in the area and I was unable to elicit a traumatic origin. Erythema multiforme (EM), pemphigus, viral ulcerations and traumatic ulcerations would be painful. Additionally EM, pemphigus and viral ulcerations would have multiple lesions. Viral ulcerations are not this big and would go away in 7 to 10 days. I was left with a preliminary diagnosis of cancer and a diagnostic biopsy was performed. The histology was that of a non-specific ulceration. At the time I was surprised and asked more questions about the lesion with the patient and his sister. I found out that my history did not ask the right questions. Imagine that! Upon further questioning I found out that the patient was a "picker" being treated for obsessive compulsive disorder. He bit his tongue approximately four months previously which was the beginning of this lesion and commenced from that day to pick the granulation tissue out of the wound with his index fingernail. This of course did not allow the ulceration to heal. In looking back at figure 1 it would be unusual for a cancer to be a clean lesion. A cancer of that size would look like figure 2. This turned out to be a factitial injury.

I have included some additional cases:

In 1976, my first year on the faculty, a 28 year-old white male presented with a lesion of his face (figure 3) which was present for 4 to 5 months without healing and slowly increasing in size. The history was uneventful and the lesion appeared worrisome. We shaved around the lesion and did a diagnostic biopsy (figure 4) which came back as a facial granuloma with eosinophilia (usually eosinophils suggest an allergic origin). This made no sense at the time. We sent him to dermatology for a consultation and they were planning to radiate the unusual lesion. However, before this could be done, his wife came to the next appointment and told us that he sat in front of a mirror and picked the lesion with tweezers for an hour a day. At that time in my career, I would not have considered a self-induced lesion. I assumed a patient would tell me he picked it before being radiated. Of course now I am older and wiser and would suspect, or at least ask, about a factitial lesion. This lesion looked like the first lesion (figure 1) and was too clean to be considered as cancer. We had the lesion taped over and it started to heal over the next month (figure 5).

The third case was a factitial lesion in a 28 year-old white female with "issues" (figure 6). In this case I "got it right" because I suspected it and asked the right questions. The lesion again was clean and the patient admitted to picking the area daily.

The last picker case came in two weeks ago and by that time I was an expert on pickers. This 51 year-old male presented due to pieces of bone being picked out of his right maxilla and marked gingival recession near the area (figure 7). There was no recession of any magnitude in other areas. This time I asked him right away if he was picking the area. He was. I guess you can teach "old dogs" new tricks.

From these four cases if you see a lesion that is broken down with a clean appearance and makes no sense, consider a picking etiology. You should at least ask!!!

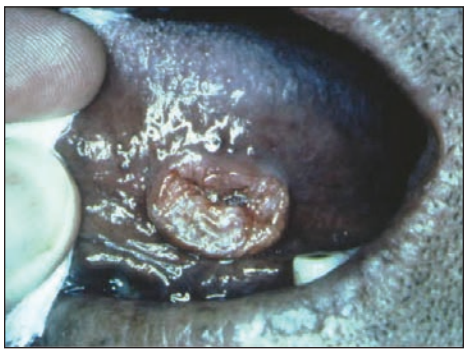


Figure 2

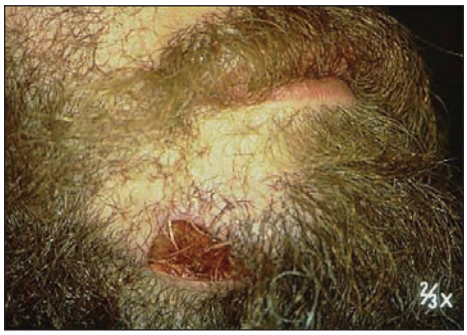


Figure 3

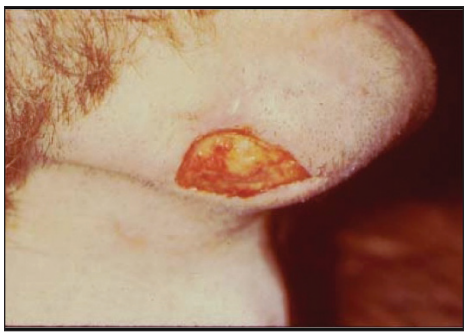


Figure 4

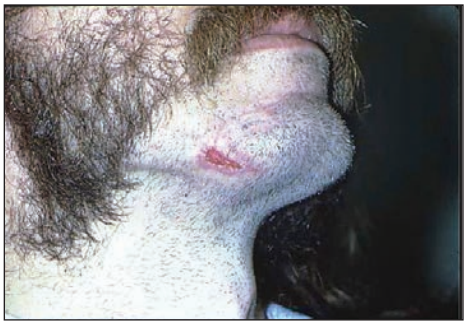


Figure 5

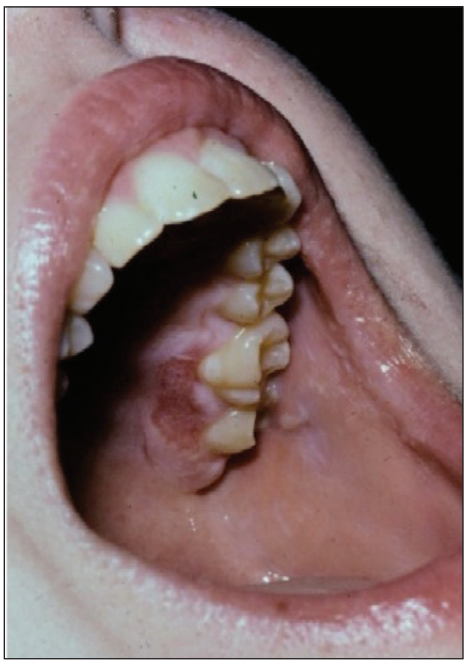


Figure 6

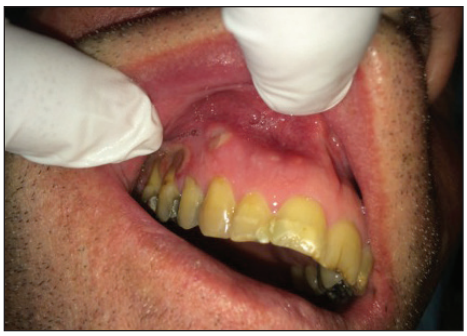


Figure 7

AAOMS Position Paper: Medication-Related Osteonecrosis of the Jaw- 2014 Update[1]

Osteonecrosis of the jaws (ONJ) is a phenomenon that has potentially severe detrimental effects to dental patients. It can arise from invasive dental procedures such as extractions, implant placement, periodontal surgery, apical endodontic treatment, or, in rare cases, appear spontaneously. The American Association of Oral and Maxillofacial Surgeons (AAOMS) released a position paper in 2014, which provides recommendations for prevention and management of ONJ. The paper includes analysis of recent studies (since 2009) that have the highest level of evidence available for the topic. This information is beneficial in aiding the medical decision making of the entire dental community.

A major change that AAOMS recommends is changing the nomenclature from the previously used "bisphosphonate-related osteonecrosis of the jaw" (BRONJ) to "medication-related osteonecrosis of the jaw" (MRONJ). Medications in addition to bisphosphonates (BPs) have been shown to pose a comparable risk for ONJ. Receptor activator of nuclear factor-kappaB ligand (RANKL) inhibitors such as denosumab (Prolia®, Xgeva®) work as antibodies to RANKL to inhibit osteoclast function and bone resorption. According to a recent landmark study, "the risk for ONJ among cancer patients exposed to denosumab is comparable to the risk of ONJ in patients exposed to zolendronate". This risk is not benign. Cancer patients exposed to zolendronate have a 50-100 times greater risk ONJ than patients treated with a placebo. Anti-angiogenic medications such as Tyrosine Kinase Inhibitors and VEGF inhibitors are also thought to pose an increased risk for ONJ. Several studies have shown that dental screening and appropriate dental measures initiated prior to therapy with these medications have been shown to reduce the risk of ONJ. Risk for developing MRONJ varies more based on the drug dosage/disease process than it does with the type of drug. In osteoporotic patients exposed to IV-BPs, "the risk for ONJ among patients treated with either zolendronate or denosumab approximates the risk for ONJ of patients enrolled in placebo groups." The paper concludes that the risk for developing ONJ among osteoporotic patients exposed to oral or IV BPs, or denosumab "is real but remains very low". When compared to cancer patients, this risk is 100 times smaller. Of note, however is that the duration of therapy, regardless of drug type or disease process increases the risk for development of ONJ significantly. In multiple studies, the risk of developing ONJ among cancer patients was shown to escalate with duration and plateau between years 2 and 3 of therapy. The prevalence of ONJ in patients receiving oral BP therapy is greatest in those receiving four or more years of exposure. AAOMS also concluded in this paper that "the best current estimate for the risk of ONJ among patients exposed to oral BPs following tooth extraction is 0.5%." This risk in cancer patients exposed to IV BPs ranges from 1.6-14.8%. The current risk of developing ONJ from other procedures involving bone in these patients is unknown.

In order to prevent MRONJ in our patients, AAOMS recommends a multi-disciplinary approach that includes an important role of dental screening and preventive care in patients before initiating drug therapy. Several recent studies have demonstrated a significantly lower risk (up to 50%) of developing MRONJ when patients received screening and preventive dental care prior to therapy. Patients and clinicians must also be aware that the potential risks of MRONJ development extend beyond the scope of active therapy, in many cases the risks remain over four years after. Several management strategies have been shown to be effective for patients that are currently taking medications that pose a risk for development of MRONJ. Asymptomatic patients that are receiving IV bisphosphonates or antiangiogenic drugs for cancer should avoid all procedures that involve direct osseous surgery, including implant placement.

Dr. Bryan Wheeler, Resident, Oral and Maxillofacial Surgery, Virginia Commonwealth University

1 http://www.aaoms.org/docs/position_papers/mronj_position_paper.pdf?pdf=MRONJ-Position-Paper

Filo K, Schneider T, Locher M, Kruse A, Lübbers H. The inferior alveolar nerve's loop at the mental foramen and its implications for surgery. JADA 2014; 145 (3): 260-269.

With constantly improving dental implant and radiographic imaging technologies, there has been a dramatic increase in the amount of dentoalveolar surgery completed by general dentists. Naturally with this increase in surgery comes an increased incidence of complications, one being nerve damage, which is one of the reasons this study was completed. One of the most significant considerations when planning surgery at the anterior mandible is taking into account the local anatomy, which includes the inferior alveolar nerve (IAN) and its respective branches. When the mental nerve branch breaks off from the IAN, there is an anterior loop (known as the anterior extension of the alveolar loop), and a caudal extension of the alveolar loop.
The purpose of this study was to identify and present the variation in dimensions and presence of the anterior extension of the alveolar loop (aAL) and the caudal extension of the alveolar loop (cAL) of the inferior alveolar nerve through the use of cone beam computed tomography. In doing so, the authors hoped to demonstrate the significance of obtaining a CBCT (versus panoramic radiograph) prior to surgery, present average dimensions of the aAL and cAL, and also provide recommendations for surgery in the anterior mandible region (implants, genioplasty, bone harvesting, etc.). The study hoped to address the inconsistent findings in the literature for the mental nerve anatomical path, and to prevent future iatrogenic nerve damage.

This retrospective case study was completed by quantifiably analyzing 1,384 mandibular sites in 694 CBCT scans, looking at the frequency and dimensions of the aAL and cAL. The CBCT scans were of both dentate and edentulous patients, and were taken between January 2009 to February 2013, most of which were taken to diagnose any pathology prior to removal of third molars. The extensions were measured using a multiplaned grid system which involved the occlusal plane, mental foramen, and the furthest extent of the aAL and cAL. The study also looked at frequency of cAL and aAL, and took into account sex, age, and dentate status. The results showed a frequency of cAL of 100%, and 69.73% for aAL. The mean value for cAL was 4.11 mm, with a range of 0.25mm to 8.87mm, and the mean value for aAL was 1.16mm, with a range of 0.3mm to 5.6mm. For cAL, 93.78% of the sample sites showed 0.25mm to 6.0mm, and 95.81% of the aAL dimensions were within a range of 0mm to 3mm. The results showed that the dentate patients had a statistically significant higher cAL average than the partially edentulous patients, and also that the higher the resolution of the CBCT, the higher the measurements of the cAL dimensions were. Overall, the study successfully proved the significance of obtaining a CBCT prior to anterior mandible surgery, due to the high variation of dimensions and frequency of aAL and cAL. The study also was able to provide a range of dimensions for aAL and cAL, which can be utilized by surgeons for future operations to minimize iatrogenic nerve damage.

Charlie Boxx, DDS; Intern, Oral and Maxillofacial Surgery, Virginia Commonwealth University

Troeltzsch M, Eichinger C, Knosel T, et al. Clinicopathologic Features of Oral Squamous Cell Carcinoma: Do They Vary in Different Age Groups? J Oral Maxillofac Surg 2014; 72 (7): 1291-1300.

Oral Squamous Cell Carcinoma (OSCC) is a very prevalent and serious malignancy worldwide. It is most common between the fifth and seventh decades of life. The mortality rate for OSCC, according to the American Cancer Society, is around 40%. A retrospective study evaluating the manifestations of primary OSCC was performed by Troelzsch, et al. The study's objective was to determine if there was a clinicopathological difference in primary OSCC in various age groups and determine the association with human papillomavirus (HPV).
The age groups evaluated were divided as follows: young (0-40 years), middle age (40-80 years), and elderly (>80 years). The following variables were taken into account during the study: demographics, classic risk factors, location and size, neck node involvement, histopathology, and association with HPV.

The authors reviewed 739 patients, identifying 11 as young, 17 as elderly, and the remaining as middle age. The results of the data revealed several statistically significant findings. The predilection site for each age group varied. The very young patient's predilection site was the tongue, whereas the predilection site for the elderly was the alveolar process. The floor of the mouth was the site most common in the middle age group. Another significant finding was that very few of the young and elderly had been exposed to risk factors (i.e., smoking, alcohol consumption), whereas all of the middle age group had been exposed to risk factors.

Several negative findings were also noted. The pathological characteristics did not differ between the age groups. HPV, which was found in 20% of the OSCC, was distributed equally among the age groups, with no predilection. Based on these results, one can begin to understand and better screen for OSCC as there is a predilection in the site among age groups; however, HPV association could not be concluded.

Dr. Trevor Holleman, Resident; Oral and Maxillofacial Surgery, Virginia Commonwealth University

Dicus-Brookes C, Partrick M, et al. Removal of symptomatic third molars may improve periodontal status of remaining dentition. J Oral Maxillofac Surg 2013; 71(10): 1639-1646

Pericoronitis is a periodontal inflammatory condition most commonly associated with mandibular third molars and is frequently cited as the reason for third molar removal. Whether and when third molars should be extracted because of pericoronitis is still controversial. Some studies guidelines state that one episode of pericoronitis is not an indication for extraction unless the episode is severe; while others state that you should strongly consider removal of third molars after even one episode of pericoronitis. The impact of third molar removal on the periodontal status of the adjacent second molar is also controversial.

The objective of this prospective, exploratory, and longitudinal clinical study was to compare the periodontal status of second molars and the remaining dentition after third molar removal in patients with mild symptoms of pericoronitis. Inclusion criteria for this study included patients ages 18 to 35 with signs or symptoms of mild pericoronitis without major signs and symptoms. Patients with fever, reduced opening or severe periodontal disease were excluded. Full mouth periodontal probing depths (PD) were collected at enrollment and at postsurgical follow up. A periodontal PD of at least 4mm (PD 4+) was considered an indicator of periodontal inflammation. The association between patients' enrollment and postsurgical periodontal status was analyzed with the McNemar exact test. Overall, 69 patients were included in the study. Forty-five percent (45%) were male, 57% were Caucasian, and 90% had at least some college education.

Results showed that the proportion of patients with at least one PD 4+ on the distal of the second molar at enrollment decreased significantly after surgery (from 88% of patients to 46% of patients). Of the patients that did have PD 4+ at the distal of the second molar at enrollment, 54% showed improvement after third molar removal. However, of the eight patients that had all PD less than 4mm at enrollment, 4 of them developed at least 1 PD4+ at the distal of the second molar after third molar removal. The study also showed that the percentage of patients with at least 1 PD4+ anterior to the distal of the second molar decreased significantly from enrollment to follow up. 64% of patients with PD4+ showed improvement after surgery, but 19% of people with no PD4+ developed at least 1 PD4+ anteriorly after third molar removal. Based on the data, this study suggests that removal of third molars significantly improves the periodontal condition of second molars and teeth more anterior in the mouth. At enrollment, most patients had PD4+ on the distal of the second molars, but postoperatively significantly fewer patients had PD4+. Previous studies have shown that patients with deeper PDs in the third molar region have increased levels of pathogenic anaerobic bacteria with higher bacteria counts. This data suggests that removal of third molars may be beneficial in symptomatic patients because it decreases the surface area for bacteria to create biofilm layers and decreases the bacterial load. Decreasing the quantity of pathogens colonizing at the third molar site may also decrease bacterial loads throughout the mouth, which would account for improvement in PD anterior to the distal of the second molar. Despite the need for further research, this study does suggest that most patients with mild symptoms of pericoronitis have clinical evidence of early periodontal inflammation and that the periodontal health is overall improved after third molar removal.

Amber Johnson, D.M.D.; Resident, Oral and Maxillofacial Surgery, Virginia Commonwealth University

Laviv A, Jensen OT, Tarazi E, Casap N. Alveolar Sandwich Osteotomy in Resorbed Alveolar Ridge for Dental Implants: A 4-Year Prospective Study. J Oral Maxillofac Surg 2014; 72(2): 292-303

Management of vertical alveolar ridge defects has been the most challenging condition for implant surgeons. Various procedures have been developed to solve the problem, including onlay bone grafting, guided bone regeneration, distraction osteogenesis or use of short implants, each of which have limitations and complications. A relatively modern technique, with promising long term success, is the sandwich osteotomy presented in this study. The technique is executed by making a horizontal osteotomy on the ridge with two mesial and distal osteotomies through a vestibular incision and segmenting the crestal alveolar ridge, while maintaining its attachment to the crestal and lingual/palatal tissue. The segment is then positioned in the desired location and secured with plates and screws. The remaining gap is filled with a xenograft material. In this study 10 ridges with alveolar defects, requiring bone gain between 4-10mm, were included. To assess success of the procedure, bone gain was measured immediately postoperatively, and compared with bone height after 4-6 months of healing with a CT scan. Also a time of implant placement a trephine histological specimen was obtained to assess bone viability at one or all of the sites. Bone height remained the same at all the sites, and except for one patient who had the 10mm gain, only 1mm was lost. Setbacks with the cases included two patients requiring horizontal augmentation at time of implant placement. One patient required a soft tissue graft and another required pink

porcelain added to the final prosthesis. Two patients had bone exposure two weeks postoperatively, which spontaneously resolved in one month. Histological review of the bone sample showed healthy viable bone. Some of important technical points made by the authors focused on the free alveolar segments, which are needed to maintain attachment to lingual/palatal tissue for blood supply. Also the segment must not be placed higher than the level of adjacent cemento-enamel junctions, or otherwise it will resorb. And finally, that segment should at least be 5mm in thickness. All cases had an esthetic final prosthesis and all patients were pleased with the outcome. The conclusion was that the sandwich osteotomy technique can be very successful in managing vertically deficient ridges, and should be considered when managing such defects.

Fahad Alsaad, DDS; Resident, Oral and Maxillofacial Surgery, Virginia Commonwealth University

Shiratori K, Nakamori M, Ueda T, Sonoda H, Dehari, K. Assessment of the Shape of the Inferior Alveolar Canal as a Marker for Increased Risk of Injury to the Inferior Alveolar Nerve at Third Molar Surgery: A Prospective Study. J Oral Maxillofac Surg 2013; 71(12): 2012-2019.

Surgical removal of mandibular third molars is a common oral and maxillofacial surgery procedure. Due to the close anatomical approximation of the mandibular third molar to the inferior alveolar canal, injury to the inferior alveolar nerve is a known complication, which can result in significant patient morbidity and open the surgeon to medico-legal litigation. Computed tomography can be used to three dimensionally evaluate the anatomical relationship between the mandibular third molar and the inferior alveolar canal.

The objective of this prospective study was to evaluate whether cortication status of the inferior alveolar canal and inferior alveolar canal shape noted on pre-operative computed tomography are reliable predictors of inferior alveolar nerve injury during surgical removal mandibular third molars. The authors evaluated the hypothesis by analyzing 169 mandibular third molars on 115 patients, which were determined to be high risk of inferior alveolar nerve injury based on pre-operative orthopantographic examination. All patients then underwent pre-operative computed tomography to allow for three dimensional evaluation of the anatomic relationship of the mandibular third molar and the inferior alveolar canal. Patients were excluded from the study if he/she had an additional impacted mandibular tooth or a lesion associated with the impacted mandibular third molar (cyst/tumor). The predictor variables tested were demographics (age and gender), angulation of the mandibular third molar, and radiographic factors (inferior alveolar canal cortication status, buccolingual position, shape of the inferior alveolar nerve canal, number of roots, and root shape). The outcome variable tested was inferior alveolar nerve paresthesia, which was assumed to be associated with surgical trauma.

Postoperative inferior alveolar nerve paresthesia was observed in 12 of the 115 patients and 13 of the 169 mandibular third molars. All 13 cases of inferior alveolar nerve injury exhibited lack of cortication of the inferior alveolar canal on the pre-operative CT scan, but 58 cases showing lack of cortication did not have any noted inferior alveolar nerve deficit upon post-operative follow up. It was also found that a dumbbell shaped inferior alveolar nerve canal is a useful anatomic predictor for inferior alveolar nerve injury with a sensitivity of 69.2% and a specificity of 84.6%. This study shows that cortication status and the shape of the inferior alveolar nerve canal are reliable predictors for inferior alveolar nerve injury in surgical removal of mandibular third molars.

Nicholas Kain, D.D.S.; Chief Resident, Oral and Maxillofacial Surgery, Virginia Commonwealth University

Phillips C, Gelesko S, Proffit WR, White RP. Recovery after Third-Molar Surgery: The Effects of Age and Sex. Am J Orthodont Dentofac Orthopedics. 2010; 138(6):700.e1-8; discussion 700-1

Almost all young adults have at least one third molar (95%), and 75% have four third molars. Despite third molar crown development usually being complete by age 14 and root development by age 18, the third molars might or might not be in function at the occlusal plane by age 18. This failure to erupt to the occlusal plane has been attributed to lack of space resulting from growth patterns of the jaw. Predicting which third molars will erupt into a functional location or remain impacted has been shown to be difficult. Many clinicians advise their patients to have third molars removed before or just after teeth are visible in the mouth, especially if they are deemed unlikely to erupt to the occlusal plane.

The general perception of clinicians and the public is that recovery time after third molar removal is shorter in younger patients. However, data supporting this perception is somewhat limited and has not controlled for the increased complexity of the surgery in older patients.

In this study, quality of life (QOL) was assessed after removal of four third molars in 958 healthy patients from 9 academic centers and 12 community practices from 1997-2009. Healthy patients age 14-40 were stratified into three groups: <18, 18-21, >21 years. Third molars were categorized preoperatively relative to the occlusal plane using a panoramic radiograph. Standard procedure for removal of mandibular third molars consisted of intravenous anesthesia, buccal access, and bone removal using rotary instrumentation. Extensiveness of surgery was indicated by length of surgery and surgeon's estimate of degree of difficulty (scale of 0-7 with 7 being maximal difficulty). Each patient was given a QOL diary to be completed each postsurgery day for 14 days. Three QOL domains were assessed: lifestyle, oral function, and pain. A 5-point Likert-type scale was used to assess oral function and lifestyle. Impact on lifestyle included social interaction, recreation, and daily activities. Oral function assessed difficulty with mouth opening, chewing, and eating a regular diet. Patients also recorded pain medications taken, including over-the-counter ones, and recovery was defined as number of days until no pain medications were taken. For each QOL item, Kaplan-Meier estimates of values for recovery for the three age groups and for sexes were calculated and Cox regression time to event analysis performed to assess effects of age and sex on recovery. Hazard functions were calculated after controlling for clinical and surgical predictor variables (position of third molars, length of surgery and surgical difficulty).

Except for ability to open the mouth, recovery for QOL items for subjects 21years of age and older lagged behind younger subjects. Recovery from pain was prolonged on average 2.5 days in the older age group. On average, male subjects reported no or little trouble with lifestyle and oral function 1 day earlier than females. Male subjects also demonstrated recovery from pain 2 days earlier than female subjects.

Oral function, lifestyle, and pain recovery was demonstrated in this study to be prolonged in patients who are older than 21 years, and those who are female. These patients should be informed of this prior to removal of third molars.

Graham H. Wilson, DDS; Resident, Oral and Maxillofacial Surgery, Virginia Commonwealth University

Majid OW, Al-Mashhadani BA. Perioperative Bromelain Reduces Pain and Swelling and Improves Quality of Life Measures After Mandibular Third Molar Surgery: A Randomized, Double-Blind, Placebo-Controlled Clinical Trial. J Oral Maxillofac Surg 2014; 72 (6): 1043-1048

Purpose: To compare the effect of oral bromelain (250 mg) versus oral diclofenac sodium (25 mg) on pain, swelling, trismus, and quality of life (QOL) after surgical removal of lower third molars. Bromelain is a mixture of enzymes derived from the stem of the pineapple plant, Ananas comosus. Several animal and human studies have demonstrated anti-inflammatory and analgesic properties of oral administered bromelain, which results from its ability to block bradykinin and modulate prostaglandin synthesis. Bromelain has gained particular interest in the plastic surgery community because of its apparent anti-edemic, anti-inflammatory, and analgesic properties.

Materials and Methods: In this randomized, double-blind, placebo-controlled study (conducted at the Department of Oral and Maxillofacial Surgery, College of Dentistry, University of Mosul, Nineveh, Iraq), patients requiring extraction under local anesthesia of a single partial bony impacted mandibular third molar were randomly distributed into 1 of 3 groups: bromelain, diclofenac, and placebo. Patients included in the study sample had to be: healthy, have a partial bony impacted mandibular third molar free of pericoronitis and infection at time of surgery, and to not have received any medication during the previous 2 weeks. Patients were instructed to take 1 capsule of their assigned study medication every 6 hours starting the morning before the day of surgery and continued for a total of 4 days. All surgical procedures were performed using a standardized procedure by the same operator; post-operatively, all patients received oral erythromycin 250 mg q6h x 5d and oral paracetamol 500 mg as a rescue analgesic. Primary outcome variables were pain, swelling, trismus which were measured at post-op days 1, 3, and 7. QOL scores were measured to assess the patients' perception regarding the effect of surgery on their well-being and daily activities using a validated questionnaire completed on day 4 after surgery. Data were analyzed using analysis of variance, multiple measures analysis of variance, or Pearson's $\chi 2$ test. $P < 0.05$ was considered significant.

Results: A total of 45 subjects requiring surgical removal of a single impacted mandibular third molar under local anesthesia were included in this study. The bromelain and diclofenac groups both showed a significant reduction in pain compared with the placebo group at all intervals ($P < .05$). Diclofenac also resulted in a statistically significant reduction in swelling at post-op days 3 and 7, while bromelain resulted in an insignificant reduction. An insignificant reduction in trismus occurred in both treatment groups compared with the placebo group. Both treatment groups also showed a significant difference in the effect on total QOL score and most subscale scores (social isolation, working isolation, eating ability and diet variations, speaking ability, sleep impairment, physical appearance).

Conclusion: Oral bromelain showed a significant analgesic and anti-edemic effect in the early post-operative period for patients who underwent surgical removal of impacted lower third molars, and is an effective therapy to improve QOL and reduce post-operative sequelae. Bromelain's effect was comparable to that of diclofenac sodium in all parameters, making it a good alternative to NSAIDs to improve patients' post-operative QOL. Bromelain offers a natural, effective, and safe alternative treatment of sequelae after third molar surgery, and it lacks the undesired (gastrointestinal, hematologic, and renal) side effects commonly associated with NSAIDs.

Dr. George Y. Soung; Resident, Oral and Maxillofacial Surgery, Virginia Commonwealth University

Bortoluzzi MC, Capella DL, Barbieri T, Marchetti S, Dresch C, Tirello C. Does smoking increase the incidence of postoperative complications in simple exodontia? International Dent J 2012; 62(2): 106-108

Tobacco smoking has long been attributed to adverse outcomes and implicated in several diseases involving the cardiovascular and respiratory system. It has also been associated with poor surgical outcomes and development of complications in the perioperative and postoperative period among many different surgeries.

The purpose of this single-center, prospective study was to determine the risk of postoperative inflammatory complications in simple exodontia of erupted teeth in patients that smoke tobacco. The study excluded impacted third molars that were classified as difficult and/or unerupted. Patients who underwent extractions performed questionnaires before, immediately after and 7 days after surgery, in addition to having a post-operative assessment at day 7 or prior if needed. All procedures were performed under sterile conditions. The study included 793 patients and ultimately performed a total of 1,022 extractions of erupted teeth. Of these patients, 23.3% were smokers, and 160 smoked less than one pack per day, and 15 smoked over one pack per day. Overall 10 patients (1.3%) developed postoperative complications: alveolar osteitis in four and alveolar infection in six patients. Half of these patients were smokers.

The study also looked at other factors which could increase the complication rate of routine extractions such as gender, sectioning of teeth, oral contraceptive use, duration of surgery, intraoperative root fracture, age and if an ostectomy was required.

This study concluded that smokers who underwent routine dental extractions are at a higher risk for postoperative complications, especially those who smoke over one pack per day. Teeth that required sectioning and length of surgery also increased the risk of complications.

Roman G. Meyliker, DMD; Resident, Oral and Maxillofacial Surgery, Virginia Commonwealth University

An Alternative Treatment Method for a Large Apical Lesion: A Case Report

Fawaz AlForaih, D.D.S., M.S.D.; Richard Archer, D.D.S., M.S.; Karan Replogle, D.D.S., M.S.

The treatment of large persistent apical lesions presents a problem in endodontics. These persistent lesions are often radicular cysts. Historically, it has been reported that when histologically evaluating periapical lesions, the incidence of cysts is 40 to 50 percent (1,2,3). Studies by Nair (4,5) have shown that the incidence of cysts may actually be much lower. These reports indicate that the occurrence of apical lesions that are cystic is 15 percent. Nair's findings also indicate that these cysts are less likely to heal without surgical intervention. This assertion also has been supported by Natkin et al. (6) who found that larger periapical lesions are more likely to be cysts and are less likely to heal with non-surgical endodontic therapy. When non-surgical endodontic treatment is not successful and a large lesion persists, alternative treatment regimens must be considered.

When attempting surgical root canal treatment on a large periapical lesion, several potential complications are present. Surgery in these cases can lead to damage of adjacent teeth or anatomical structures in the area as well as the inability to enucleate the entire lesion. An alternative treatment is decompression (aka externalization or marsupualization) by placement of a drain into the lesion. In 1964, Sommer et al. (7) described the use of rubber dam sections as a drain material. In later reports, Colquhoun (8) and Freedland (9) used polyvinyl or polyethylene drainage tubes. In a more recent case report, Martin (10) used #10Fr radiopaque latex tubing as a drain.

When doing a decompression or marsupualization procedure peripheral ingrowth of bone occurs as the lesion diminishes in size. As the growth of bone progresses, the normal bony contours in the area of the lesion are maintained. The procedure is less invasive than surgical root canal treatment. Even if surgical treatment is necessary at a later date, the lesion will be smaller, and the surgery will have fewer potential complications. Decompression also offers an alternative treatment to those patients for whom surgery is contraindicated due to medical reasons. The following case report describes treatment of a large lesion using apical decompression.

Case Report

A 69-year-old female presented to the Graduate Endodontic Practice at Virginia Commonwealth University (VCU) School of Dentistry with a chief complaint of mild discomfort in the maxillary anterior region (pointing to tooth #10) associated with intermittent swelling of the facial and palatal tissues around that tooth. She reported that the symptoms had persisted since the tooth was endodontically treated approximately one year ago. The patient also was concerned about the mobility associated with the tooth.

A dental history revealed that tooth #10 had been treated endodontically for the first time by a predoctoral dental student during the previous year and restored with an interim restoration. Extraoral examination revealed no swelling, lymphadenopathy, or TMJ dysfunction. Intraoral examination revealed no significant pathosis, and a hard tissue exam in that area showed an existing distal resin restoration closing a diastema between teeth #s 10 and 11. Furthermore, there appeared to be an interim restoration in the lingual endodontic access opening. Teeth #s 7, 8 and 11 responded normally to endodontic diagnostic testing. Tooth #9 was slightly symptomatic to percussion while tooth #10 was more symptomatic to percussion. Moreover, there was mild vestibular swelling noted labial to tooth #10. Teeth #s 6-8 and 11 had normal physiologic mobility whereas tooth #s 9 and 10 exhibited class I and class II mobility respectively. Preoperative periapical (PA) radiographs of tooth #10 demonstrated previous NSRCT and a coronal restoration sealing the access in addition to a DIFL restoration with defective margins. Bone loss distal to tooth #10 also was noted and is most likely caused by an overcontoured distal restoration. An extensive periapical radiolucency (PARL) was noted around the apices of teeth #s 9 and 10 that was about 15 x 15 mm in size (Fig. 1). A diagnosis of Previously Treated with Acute Apical Abscess was made consistent with the American Board of Endodontics (ABE) terminology. A recommendation of nonsurgical retreatment (NsReTx) on tooth #10 was made followed by surgical intervention (apicoectomy or decompression) due to the size of the existing lesion and the questionable probability of healing with only nonsurgical treatment. Treatment options, risks, benefits and costs were discussed with the patient. Moreover, the patient was in-

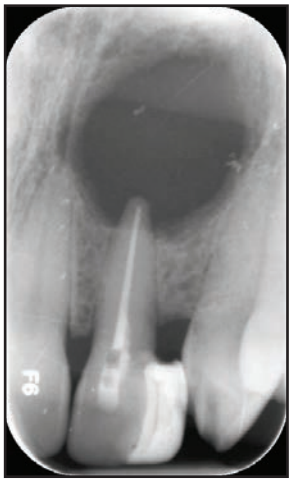


Figure 1

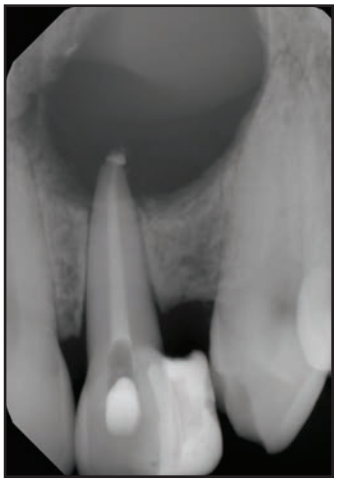


Figure 2

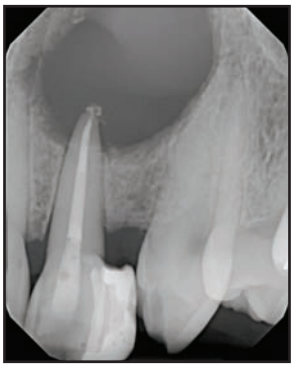


Figure 3

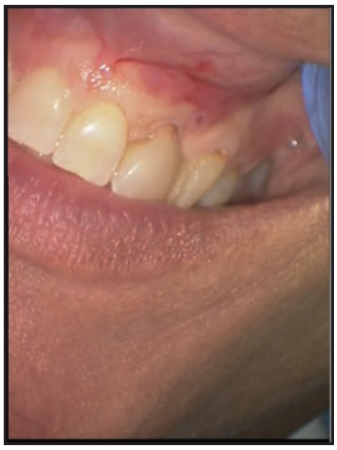


Figure 4

Figure 5

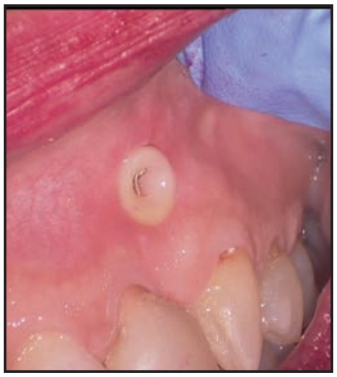


Figure 6A

AlForaih (Continued on pg 22)

AlForaih (Continued from pg 21)

structed to have the distal restoration replaced. Upon reviewing the medical history, it was noted that the patient was hypertensive, had emphysema and ulcerative colitis. She also had a history of mini-strokes with the most recent in July 2010. She was taking atenolol (Tenormin®) 50mg qd, hydrochlorothiazide 75mg, Plavix® (clopidogrel) 75mg, and aspirin 325mg. She reported that she no longer needed medication for the ulcerative colitis and emphysema. She was allergic to penicillin and tetanus, both having caused a rash, and lip and hand swelling several years ago. A medical consult was requested from her physician and received with the recommendation of discontinuing both aspirin and Plavix® for one week prior to any surgical intervention.

Informed consent was obtained for the NsReTx of tooth #10 in the VCU Graduate Endodontics Practice. Local anesthesia of 2 percent lidocaine with 1:100,000 epinephrine was administered buccal to tooth #10. Rubber dam isolation was used for asepsis and contamination control. The existing interim restoration was removed, exposing gutta percha that was removed with EndoSequence rotary files (Brasseler, Savannah, Ga.). An electronic apex locator, Root ZX II (J. Morita USA) was used in addition to a PA radiograph to confirm desired length. The canal was instrumented to size 50 with a taper of 0.06 using EndoSequence rotary files. Pyogenic exudate drainage was established through the canal space. The canal was irrigated with 5.25 percent sodium hypochlorite, 17 percent EDTA, and 2 percent chlorhexidine (Endo-CHX, Essential Dental Systems) and dried with paper points. Intracanal calcium hydroxide (Ultracal XS, Ultradent, South Jordan, Utah) was placed in the canal space, and the access was sealed provisionally with Cavit (3M ESPE, Germany) on top of a cotton pellet (Fig. 2). The patient returned after seven days for completion of the procedure and reported some "soreness" since the previous appointment. Local anesthesia (type, dosage and location identical to that used in the previous appointment) was administered as well as rubber dam isolation. The interim restoration, cotton pellet and calcium hydroxide were removed. The canal was irrigated with 5.25 percent sodium hypochlorite and 17 percent EDTA, each with ultrasonic acoustic streaming via Sonifile (Satelec, Aceton Group) for one minute. The canal was dried with paper points and obturated with gutta percha and Roth's sealer via the continuous wave warm vertical method (Fig. 2). The access was restored with a composite resin Z250 (3M ESPE) shade A2 and adjusted accordingly (Fig. 3). The patient was instructed to return in six months to assess healing, unless symptoms or swelling developed. It was explained that the chances of healing were questionable due to the size of the existing PARL and the fact that it appeared to be a through-and-through lesion involving both cortical plates.

The patient presented to the clinic four months later complaining of swelling (both extra- and intraoral) in the maxillary anterior region, along with discomfort mainly provoked by chewing. Clindamycin (300 mg capsules tid) was prescribed to address the swelling. Furthermore, the authors made a recommendation of surgical decompression rather than an apicoectomy to physically address the periapical granuloma/cyst due to its extensive size and borders.

The patient consented to the proposed treatment and the procedure was started one month later in the VCU Graduate Endodontics Practice. At that time, the patient had intraoral labial and palatal swelling around tooth #10 and a sinus tract on the labial attached gingiva adjacent to tooth #10 (Fig. 4). Local anesthesia of 2 percent lidocaine with 1:100,000 epinephrine was administered. A vertical incision of approximately 10 mm was made on the buccal attached gingiva and alveolar mucosa between teeth #s 10 and 11. Pyogenic exudate drainage was noted and aspirated until hemorrhage was established. The site was irrigated with both saline (0.9 percent) and 2 percent chlorhexidine. A drain was fabricated that consisted of IV tubing with double ended flanges (Fig. 5) and securely placed without sutures. Patient was shown how to irrigate the site with a 3ml syringe and a 23 gauge needle using 0.12 percent CHX (Colgate Periogard®) (11). She was given strict instructions to irrigate the site twice daily for a period of 4 weeks.

After four weeks, the patient presented to clinic with no symptoms and reported that the swelling had resolved. Extra and intraoral examination revealed absence of swelling and sinus tracts. Teeth #s 6-11 were normal to palpation and percussion and were free of mobility. Probing depths were all less than 3 mm. The drain was removed and the patient was instructed to return after two weeks for evaluation of the site (Fig. 6A and 6B).

A two-week recall showed closure of the drain site and normal gingival tissue architecture as well as findings similar to the previous appointment (Fig. 7). At eight and 12 months, there was continued absence of symptoms, swellings and sinus tracts as well as absence of mobility. A periapical radiograph at each of these appointments revealed significant healing consistent with radiographic bone fill (Fig. 8A and 8B).

Further 6 and 12 months recalls were recommended to assess radiographic healing, and the continued absence of symptoms and/or swellings. It was explained to the patient, however, that due to the labial-lingual extent of the pre-operative lesion, there was the possibility of healing with a fibrous scar due to ingrowth of connective tissue. Furthermore, it was stressed to the patient, the need for replacement of the existing DIFL restoration on tooth #10 to prevent further bone loss destruction in that area.

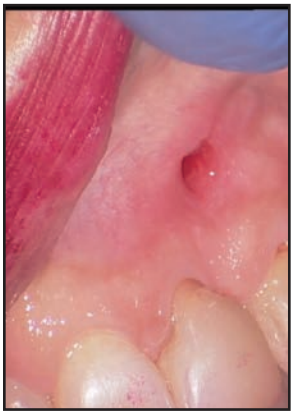


Figure 6B

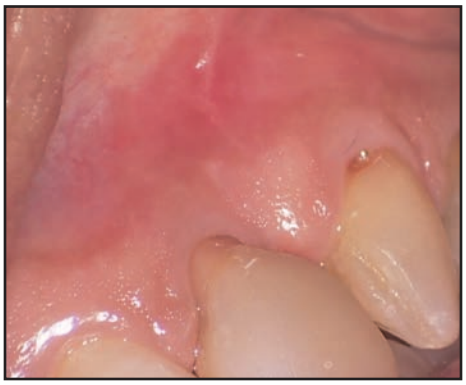


Figure 7

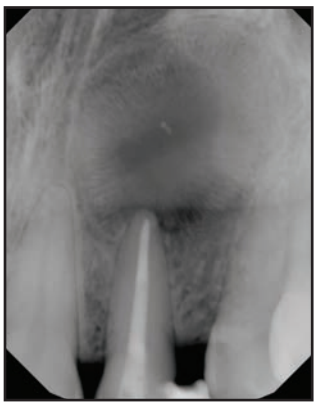


Figure 8A

The patient was recalled to the practice 27 months later. She was asymptomatic but complained of staining of tooth #10. Clinical examination showed staining of the composite resin in the distal interproximal area. All diagnostic tests were negative, and a periapical radiograph showed complete bone fill with no pathosis (Fig. 9). The patient was informed of the findings and instructed to have the resin evaluated for replacement by her general dentist.

Patient recalls exhibited excellent healing. Although the histologic diagnosis was not determined, this case shows the possible resolution of a large periapical lesion without apical surgery.

Continued on page 23

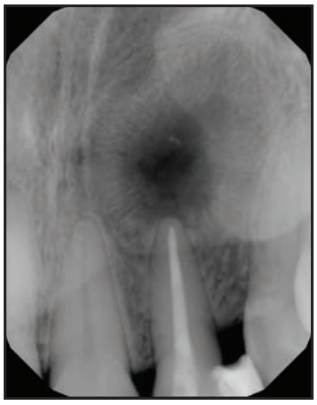


Figure 8B

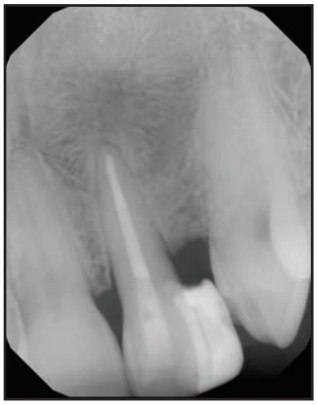


Figure 9

Bibliography

1. Bhaskar SN. Periapical lesion-types, incidence and clinical features. Oral Surg 1966;21: 657-72.
2. Lalonde ER, Luebke RG. The frequency and distribution of periapical cysts and granulomas. Oral Surg 1968;25: 861-8.
3. Spatafore CM, Griffin JA Jr., Keyes GG, Wearden, S, Skidmore AE. Periapical biopsy report: an analysis over a 10 year period. J Endod 1990;16: 239-41.
4. Nair PNR. New perspectives on radicular cysts: do they heal? Int Endod J 1998;31:155-60.
5. Nair PNR. Apical periodontitis: a dynamic encounter between root canal infection and host response. Periodontology 2000 1997;13:121-48.
6. Natkin E, Oswald RJ, Carnes LI. The relationship of lesion size to diagnosis, incidence, and treatment of periapical cysts and granulomas. Oral Surg 1984;57:82-94.
7. Sommer RF, Ostrander FD, Crowley MC. Clinical Endodontics, 2nd ed. Philadelphia: W.B. Saunders & Co. 1964.
8. Colquhoun NK. Treatment of large periapical lesions by an indwelling tube. J Br Endod Soc 1969;3:14-16.
9. Freedland JB. Conservative reduction of large periapical lesions. Oral Surg 1970;29:455-64.
10. Martin SA. Conventional endodontic therapy of upper central incisor combined with cyst decompression: a case report. J Endod 2007;33:753-57.
11. Brondum N, Jensen VJ. Recurrence of keratocysts and decompression treatment. Oral Surg Oral Med Oral Pathol. 1991;72:265–269.

Editor's Note: Dr. AlForaih is currently employed as an endodontist by the Kuwait Ministry of Health. Dr. Archer is Assistant Dean for Clinical Affairs and Interim Chair, Department of Endodontics, Virginia Commonwealth University (VCU) School of Dentistry. Dr. Replogle is Program Director for Advanced Education in Endodontics at VCU School of Dentistry. Readers may contact Dr. Archer, (804) 828-0784, rdarcher@vcu.edu.

The authors wish to thank Dr. Robert Strauss, Department of Oral and Maxillofacial Surgery, Virginia Commonwealth University.

Affordable Care Act 2015
For individuals and their families

The Open Enrollment period for 2015 coverage is November 15, 2014 to February 15, 2015.

Open enrollment is a period of time when you can sign up for health insurance more easily and with fewer restrictions than at other times of the year. If you already have health insurance, you can change the plan you have or drop your coverage during open enrollment.

If you are eligible and apply for health insurance during open enrollment, the health insurance company has to insure you.

During Open Enrollment, if you enroll:

- Between the 1st and 15th days of the month, your coverage starts the first day of the next month.
- Between the 16th and the last day of the month, your coverage starts the first day of the second following month. So if you enroll on March 16, your coverage starts on May 1.

If you do not have health coverage during 2015, you may have to pay a fee. The fee in 2015 is higher than it was in 2014 — 2% of your income or $325 per adult/$162.50 per child, whichever is more.

For additional information please contact Jackie Holloman at 1-877-832-9113 X 283 or Jackie@bb-insurance.com.

Full Service Personal & Business Insurance Agency

B&B

B&B Insurance Associates, Inc.

1-877-832-9113 • www.bb-insurance.com

The Growing Gap Between Communicating and Understanding

By: Dr. James R. Schroeder

Have you ever attended a CE course and returned to the office excited to implement a change, only to discover thirty days later, your office is back to business as usual?

Have you ever introduced an idea to your organization and received tremendous resistance or push back, resulting in an aborted launch of your great plan?

New ideas and growth plans are imperative to your long-term success. Unfortunately, they are often sabotaged — not because they weren't excellent ideas — but because the people in charge fail to understand the tools and dynamics required for the "Change Process" to be effective.

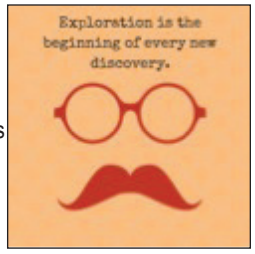
Allow me to walk you through a series of steps and principles to enhance team ownership and improve the successful launch of your next effort to change.

Often as the dentist, we are so busy working *in the practice*, we do not take time to work *on the practice*. Focusing on patients and strengthening our skill sets consume our energy…and we fail to maximize the potential business growth at hand. Let's change that!

Here are the steps to implement a major or minor adjustment in your office:

1. **The first step to implement effective, lasting change is to prioritize quality planning time.** Try to start out with as many facts regarding the change as possible. Avoid "I feel or I think" being the main drivers. Depending on the issue you may need to consult with your attorney, accountant or other outside expertise. Schedule time in your calendar as though it were a patient. Start with an objective assessment of the NOW.
2. **Define the area you want to change or grow, and outline the steps needed to reach that goal.** Often change is implemented without a plan, generated from a gut feeling. In the initial stages before planning, that is okay — but through the implementation process, a mere gut feeling will fail you as the details get jumbled. Conversations with staff in the early stages must be done with caution as rumors can spread on half developed ideas and negativity develops before the launch takes place. Keep a written journal to track your thinking, input and progression. You may revise this plan as you receive feedback, but it will keep you from losing your momentum to the wrong details that arise.
3. **Create an objective fact sheet with a timeline to keep track of where you are and what needs to happen next.** As the journey begins to the summit adjustments are needed, but the leader must keep his eye on the target. Sometimes we forget where we were going!
4. **Prepare your staff. Dedicate a special meeting time to explain what is happening and why it's happening.** The number one concern a staff member has when change is about to occur is "How will this affect me?" More work, longer hours, new skills with no training are all thoughts being considered by your team members. As a leader you must be able to **frame the change** proposed in terms the staff will value. Expect and understand that **resistance will develop** when first presented by different team members. Whether a small change (incremental) or a sweeping change (transformational) — there will almost always be some resistance. Depending on your leadership style this can be a difficult stage to navigate. Be prepared not to turn back to business as usual because it is uncomfortable to go through the change process. Can you think of things you have wanted to change over the past years that have remained "status quo"? Instead of allowing resistance to hinder your plan — realize the great asset it is to accomplishing your goal, and harness it! Listen to what your staff has to say. The feedback will be helpful in elevating your awareness. In this stage your staff develops ownership over their assigned roles, even if you do not agree to their suggestions. What's even more important is that Respectful Listening is the greatest respect you can pay your employees. Not only do they realize you care — some of their ideas may be pertinent to your business's sustained growth, which you will only learn about when you are listening. This step is imperative. I label it as CHA-ORDER (chaos +order) and is one of your greatest assets as you move forward: team cohesion.

Resistance can have a stronger effect on your plan than you think. Be prepared.



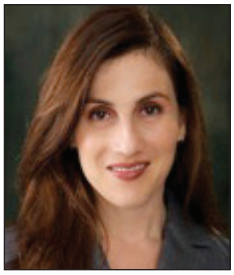
5. **Exploration.** Allow the proposed changes to sink in with your staff. While you have been thinking about this change for months, it's brand new to them. When the adjustments begin to sink in, they can identify which details are of most concern to their roles in your organization. They'll have questions — enlightening some aspects of the process you may not have even thought about (and you'll have to revise your plan). As they begin to understand the specifics of the change and that you care about their role, the fear of the unknown reduces, and the plan becomes more readily acceptable.
6. **Understand that each person on your team has a different "Change Style."** It shapes how each individual approaches issues and creates solutions. Without preparation and the understanding that each person on your team will have different expectations, your plan can fail. Don't let it knock you off your feet! With understanding, you can prepare to respectfully handle each different perspective and channel the momentum in the right direction.
7. **Create a platform for ongoing, open communication.** As you move forward, keep all staff members included in the discussions of why each minor adjustment is occurring, and listen to how it will impact their position. Again, you do not have to implement each piece of feedback you receive. Listening intrinsically provides value and helps you understand how the changes affect each person. Also, the team can embrace the changes more when they hear why each specific effect or result of the overall change is necessary.
8. **Stick to the plan.** Enough said. Universities, corporations and small businesses all have plans and strategies that were never executed. Understanding the change process and the people dynamics can greatly enhance your chances of success!

Change in dental offices is an "all hands on deck" operation. It takes planning, strategy, and an understanding of the big picture followed up by the details. Be comforted knowing that resistance is part of the refining process — it's a crucial step in the process of accomplishing the greater goal. With the right tools, your practice will be better prepared to navigate the external changes taking place in our profession.

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.

For Online Success: Make it Easy for Patients –New and Existing – to Find You Online

By Naomi Cooper – Chief Marketing Consultant, Pride Institute



Coca-Cola, McDonald's, and Nike are three of the most iconic American companies. Just the mention of their names brings an image to mind – the red and white soda can; the Golden Arches; the Swoosh. In dentistry, Crest, CareCredit and Zoom are companies that have consistently presented their product in a way that has clearly communicated who they are, what they offer and what they stand for – their promise. What do these all these companies have to do with your dental practice? Branding.

Jeff Bezos, founder and CEO of Amazon.com, said: "A brand for a company is like a reputation for a person." Because dental practices thrive on patient retention and rely on word-of-mouth referrals to reach new patients, a good reputation is of utmost importance. It is critically important for dental practice owners to have a clear vision of who they are as professionals and local healthcare providers – and what their practices have to offer the community. That's where branding comes in. Branding gives your practice an identity. It helps patients differentiate your practice from others in your community. In addition to your practice identity, branding also conveys the reputation of your dental practice to the community.

Often, solo practitioners minimize the importance of branding their dental practice. They may think that branding is only for big corporations or retail stores. The mindset is that branding is not necessary. On the contrary, branding is just as important, if not more so, for a small dental practice as it is for a large company. Employing a branding strategy, especially online, puts the dentist in the driver's seat in establishing the identity and reputation of the practice. And if there is no strategy in place, it leaves the practice vulnerable to patient "reviews" and competition.

According to Pew Internet Research, 93 percent of Americans ages 30-49 years use the Internet, and 72 percent of users looked online for health information within the past year. Your dental patients are online now more than ever, and to reach them most effectively, they need to be able to easily find your practice. The key to success is consistency.

Here are five important elements of a consistent online branding strategy:

Practice name: It is not uncommon that a practice's business cards read "Joe B. Smith, DMD," while its website uses the moniker "Smith Family Dentistry." One name should be used across all marketing platforms, including your website, online profiles, practice signage and printed materials.

Social media: Today, consumers can significantly impact a brand and company's reputation by posting their comments, good and bad, online. So, social media should no longer be considered a passing trend. Sites such as Facebook, Twitter and Google+ give dentists the opportunity to connect with patients and to manage your online reputation. It is ideal to set up your dental practice's social media profiles under the same name as the practice. It may seem more natural to build the profiles in the name of an individual dentist, but in order to be as consistent as possible, use the practice name on each profile.

Website: Along with having the same name across all online platforms, it is smart to link your online profiles to your website. The homepage of your practice website should include links to your social media profiles and your blog. Likewise, your profiles on social media and patient review sites should also link to your practice website. This will form a consistent – and cohesive – online presence.

Patient review sites: As mentioned above, word-of-mouth has shifted online via sites such as Yelp!, Healthgrades.com and Google+ Local. Consumer review sites play a large part in a patient's online research when seeking a new dentist. Many of these sites often automatically create a profile for your business. It is up to you to log on and claim your practice's profile on each of these sites, making sure your business name is correct and contact information is current. After you claim your profiles, encourage patients to share their positive experiences, so that when prospective patients are doing their online research, they can get a complete picture of what your practice has to offer.

Search Engine Optimization (SEO): Keeping your online brand consistent aids your SEO, or search engine optimization. SEO is the process of improving a website's visibility in search engine results. The higher a website ranks in the list of search results of Google, for example, the more people will click through to the site. Since search engines are robots, not humans, it is not recognized that a website for Joe B. Smith, DMD, should be associated with patient reviews for Smith Family Dentistry. Another way to improve your SEO is to link to other relevant websites that generate a lot of online traffic. For instance, if you accept CareCredit, you can add a link to your website on their online Provider Locator, which is searched up to 560,000 times per month. Consistency in your branding will aid your SEO while providing a solid online presence for your dental practice.

Once the important online elements are in place, it's a good habit to take periodic inventory to make sure everything is up-to-date, and that all digital efforts mirror the more traditional marketing components: business cards, letterhead, signage, patient forms, flyers and brochures. The ultimate goal is to have branding consistency across all marketing channels — both online and offline.

Naomi Cooper is Chief Marketing Consultant for Pride Institute. She can be reached via email at naomi@minoamarketing.com, and she blogs regularly at www.minoamarketing.com. For regular updates from Naomi, including dental marketing & social media tips & tricks, follow her on Twitter (@naomi_cooper) or "Like" Naomi Cooper – Minoa Marketing on Facebook at www.fb.com/minoamarketing.

Get More From Your VDA Membership!

VDA CLASSIFIEDS
vdaclassifieds.org

VDA Classifieds offers four ad types:
JOBS, Products and Services, Practice Transitions and RESUMES

VDA Member Pricing: FREE ads (start posting today)
Hassle-Free Pricing: $50 a month per ad
(Resumes are free for everyone)

Go to www.vdaclassifieds.org to place your ad today!

Need Help? Contact, Shannon Jacobs at jacobs@vadeental.org or 804-523-2186

LAX INFECTION CONTROL INCREASES LIABILITY RISKS

By: Laura Cascella, The Medical Protective Company

Recent National Practitioner Data Bank reports indicate that healthcare-acquired infections (HCIs) have increased in ambulatory care settings. According to a guideline published by the American Academy of Pediatrics (AAP), "most outbreaks reported in outpatient settings were associated with noncompliance with infection control procedures."[1]

Dentists have a duty to protect their patients from infection. To assist them in doing this, the Centers for Disease Control and Prevention (CDC) provides several infection control resources for ambulatory care providers. Every office should seek out these resources and consider implementing them as part of office practice.

As business owners or administrative leaders, dentists also have a duty to ensure the safety of their employees. According to the AAP, "all employees should be educated regarding the route of transmission and techniques used to prevent transmission of infectious agents."[2]

It is incorrect to assume that sterilization requirements are less important in private dental practices. In its infection control guideline, the AAP states that "in general, the standards for infection prevention and control are the same in all healthcare delivery settings, whether inpatient or outpatient, hospital or freestanding ambulatory facility."[3] It would be safe to assume that deviation from infection control procedures may increase the risk of infection — and the potential for malpractice litigation — for all ambulatory care venues.

However, in many ambulatory care settings, a casual attitude toward infection control often weakens office policies and procedures. Although equipment sterilization processes might be followed, the likelihood of contamination is unabated if clinical staff don't wash their hands in accordance with the guidelines. One noncompliant individual can undo the faithful compliance of all the other employees.

Public awareness of the increased risk of infection should heighten practitioners' oversight of infection control in their offices. Patients are becoming more demanding and less forgiving when they note obvious breaches. Some offices are taking direct action, placing hand cleaning stations at entrances and placing hand disinfectant products throughout the offices. Signs noted include:

- "Ask us to wash our hands before we start."
- "Clean gloves require clean hands first."
- "Please ask us for more information about infection control."

Malpractice MINUTE

Brought to you by:

VDA SERVICES

Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Additional efforts to encourage the active participation of patients are supported by the WAVE Campaign, introduced by the Office of Healthcare Quality and the Centers for Medicare & Medicaid Services (CMS) and endorsed by the Association for Professionals in Infection Control and Epidemiology (APIC). Together, these organizations encourage families to be more involved in fighting healthcare-associated infections.

The WAVE campaign asks patients and their family members to:

- Wash hands
- Ask questions
- Vaccinate
- Ensure safety

1 American Academy of Pediatrics. (2000, June). Infection control in physicians' offices. Committee on Infectious Diseases and Committee on Practice and Ambulatory Medicine. Pediatrics, 105(6), 1361–1369. Retrieved from http://pediatrics.aappublications.org/ content/105/6/1361.full

2 Ibid.

3 Ibid.

Get the remainder of this article on the NEW VDA Resource Center

www.vadental.org/pro/3186

Other articles you might be intersted in on the Resource Center:

- Responding to Claims Rejection
- How important is exercise to preventing back and shoulder pain? Do I need a personal trainer, or is what I know about ergonomic positions sufficient?
- Responsibilities of the ADA President during Turbulent Times

WHAT'S THE SAYING?

There's strength in a group committing to its community?




That's our experience at least.

When Great Expressions Dental Centers is affiliating with new offices we focus on the whole community, affiliating with several local offices including your own, concentrating our resources there, and building a support network for our doctors. So that you and the community you serve have all the support you need.

Help is a call away: Contact Kurt Harvey, vice president of business development, to discuss affiliating your practice with Great Expressions Dental Centers.

affiliate@greatexpressions.com
248-203-1110

Great Expressions® DENTAL CENTERS

Children's Book Raises Funds for RDS

By: Dr. W. Graham Gardner

"How will Santa find us, Daddy?" That's how it all started. On the way to see my mom in Martinsville for Christmas, my daughter had asked me this question. Unfortunately I did not have a good answer. After a couple of days, I had an answer, which led to a story, which led to a book. Soon I had a story book that was to be a present for my daughter. However, after some friends read the book and liked it, I decided to make it official! Next thing we knew, *The Santa Beacon* had been born!

My office has a lot of fun paintings done by a local artist, Nancy LeBlanc. She had never illustrated a children's book before, but her work is so whimsical and fun. After making a Snapfish© version of the book, I sent it to several publishers. Words cannot explain how excited I was when the letter came in the mail from Brandylane Publishing offering to publish the book! Throughout the long, fun, production process, we decided to add the Christmas ornament as a keepsake. After many book signings and promotional events, I was looking forward to a good, long rest. My boys had other plans, however. It wasn't long before they were asking "When are you going to make a book for me, Daddy?"

I temporarily skipped my middle child because I had a story that seemed perfect for my younger son. We have often had the problem in our house about the tooth fairy not showing up the first night. After speaking with parents and patients, it became apparent that almost all of them had the same problem. This led to the idea for the second book, *What Happened to the Tooth Fairy?* While the book was going through publication, Dr. Kit Sullivan, President of Richmond Dental Society, asked if I would write a book to raise money for them. Luckily, the book going through publication at that time was about teeth. I agreed to donate a bunch of books and sell them to help raise funds for the RDS. During the Virginia Meeting at the Homestead, we raised $2000 for the Society solely through sales of *What Happened to the Tooth Fairy?* Thanks to everyone who bought books! Linda Simon at RDS, (804) 323-5191, can still get books for you if you missed your chance, and I will be happy to sign them to someone special, if you would like. All profits of books sold through RDS will continue to go towards the Society.

If you want to learn more about the books, feel free to visit my website (www.grahamgardnerbooks.com) or our Facebook® page. The next book will be out in about 6 months and is called *Finn Finds Fun!* It is about choosing fun by choosing to be positive. I hope you like the books!!!

Editor's Note: Dr. Gardner practices orthodontics in Richmond.

New Dentist Conference Held in Kansas City

By: Sayward E. Duggan, DDS, MS

The ADA-sponsored New Dentist Conference was held July 17-19, 2014 in Kansas City, Missouri. For those of you who made the trip to Kansas City, I know you got a lot out of this well-attended and exciting conference! For those of you who were not able to make the trip, but would like to see what was offered and learn of future opportunities to become involved, please read on!

The first day of the Conference was Thursday, July 17, and it was a day devoted to leadership skills and training. The day started with a question and answer period with members of the ADA Board of Trustees regarding new dentist concerns and issues ranging from student debt to practice transitions and practice management. Following this session, there were two break-out sessions one of which focused on leadership development. This session was full of ideas and strategies on how to become an effective and efficient leader. Moreover, there was information on techniques for becoming an outstanding leader, as well as developing a pathway to leadership and how to pursue leadership opportunities.

A networking luncheon was also provided for all attendees; this offered a time where we could meet and converse with other new dentists around the country and trade notes about what we see as the challenges and the opportunities that we face both from an organized dentistry standpoint and, closer to home, what we experience every day in our own dental practices. The afternoon provided another opportunity, within a small focus group venue, to discuss new dentist outreach efforts and tools to increase new dentist membership and create member value. At the end of the first day, we reconvened with the ADA Board of Trustees and discussed ways in which our own components are developing strategies for improving new and renewed membership in organized dentistry.

Friday, July 18 included an all-day continuing education course devoted to practice management. The speaker provided the attendees with many solid ideas on everyday practice strategies and patient treatment, including incorporation of clinical photography in treatment planning and presentation. Additionally, practice teamwork between all members of the dental team was stressed as were ideas on how to implement systems to ensure team work is developed and maintained.

The Conference was truly a great way to have fun and earn CE credits. Clinical presentations, practice management, and hands-on workshops were available for participants to enhance their skills and abilities for their practices. Moreover, attendees had the opportunity to meet members of the ADA Board of Trustees to discuss current dental issues and learn about opportunities for further involvement. This was certainly the type of event that provided the perfect setting for meeting new dental professionals as they begin, or continue with, the transition from dental school to the first steps of their professional careers. As you may know, the New Dentist Conference in 2015 will be part of the annual ADA Session in Washington, DC. This joint format should provide even greater visibility to this worthwhile objective of the VDA which is to exert the type of efforts that are conducive to ensuring our newer colleagues are part of organized dentistry from the very beginning of their professional career. Ensuring these opportunities and resources are available to dental students and dentists, at the earliest stages of their careers, underscores and enhances the importance of organized dentistry involvement along every step and stage.

Editor's Note: Dr. Sayward Duggan is a member of the New Dentist Committee and practices periodontics in Yorktown.

VADPAC

The Virginia Dental Political Action Committee

See Where Your Component is and What You Need to Do to Meet Your Goal

Component	% of Members Contributing to Date	2014 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	39%	$45,500	$31,034	$246	68%
2 (Peninsula)	45%	$27,500	$24,482	$288	89%
3 (Southside)	46%	$14,000	$15,905	$254	114%
4 (Richmond)	39%	$67,750	$65,313	$325	96%
5 (Piedmont)	42%	$30,000	$24,148	$244	80%
6 (Southwest VA)	55%	$25,250	$23,406	$325	93%
7 (Shenandoah Valley)	35%	$30,000	$22,829	$282	76%
8 (Northern VA)	33%	$135,000	$109,644	$300	81%
Other Contributions			$500		
TOTAL	**42%**	**$375,000**	**$317,261**	**$283**	**85%**

Total Contributions: $317,261

2014 Goal: $375,000

WE NEED YOUR CONTRIBUTION TO RAISE $57,739

Thanks so very much to all members who have made generous contributions this year! We are nearing the end of this year's cycle and would like to see that the goal is reached. If you have not yet sent your contribution for 2014, please do so today by going to https://vadental.org/pro/vadpac or contacting Laura Givens at givens@vadental.org or 804-523-2185.

VDA Dues for 2015 will be arriving in your mailboxes next month and we urge members to submit contributions when sending your dues payment. 2015 is an election year and your contributions are essential to securing the livelihood of the practice of dentistry.

Your VADPAC contribution helps the voice of dentistry to be heard on Capitol Hill!




VDA's Legislative Day on the Hill:

Mark Your Calendar for January 16, 2015

- **It's going to be cold.**
- **It's going to be dark and raining.**
- **Or snowing….**

All in all, a great day to talk dentistry with the folks who have more to say about your profession than you do: The Virginia General Assembly.

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

Policy-makers really do want to see us; after all, what do they really know about our profession and our practice challenges? Who better to tell them than you!

Breakfast is free and our Day on the Hill is over before lunch.

Mark your calendar now: January 16, 2015

AFTCO

TRANSITION CONSULTANTS

WWW.AFTCO.NET

Helping dentists buy & sell practices for over 40 years.

AFTCO is the oldest and largest dental practice transition consulting firm in the United States. AFTCO assists dentists with associateships, purchasing and selling of practices, and retirement plans. We are there to serve you through all stages of your career.

Irama L. Forbes, D.D.S.
has acquired the practice of
Felisha D. Kimble-Tanks, D.D.S.
Annandale, Virginia

Brian O. Burke, D.D.S.
has acquired the practice of
Michael D. Webb, D.D.S.
Chester, Virginia

Brian J. McAvoy, D.D.S.
has acquired the practice of
Edwin A. Torrey, D.D.S.
Fredericksburg, Virginia

AFTCO is pleased to have represented all parties in these transitions.

Call 1-800-232-3826 today for a free practice appraisal, a $5,000 value!

"Are you sure that's safe?" Providing patients with answers and resources

By: Jeremy Jordan, Associate Editor; Class of 2015, VCU School of Dentistry

As Bob Dylan once wrote, "the times they are a-changin'." It used to be that dentists were considered the go-to experts in oral health, but it's increasingly common for patients to consult the internet, instead of their dentist, when questions arise. Likewise, it's becoming more common for patients to question or deny the use of certain dental materials and recommended procedures. Why the sudden change? Our patients are concerned with the potential effects of radiographs, amalgam, fluoride, and root canals on their systemic health. Some patients have even decided to turn to 'holistic' methods, like oil pulling, to avoid seeing the dentist altogether. But what can we do? As oral health care providers, it's our responsibility to assuage their fears by answering their questions and providing scientifically sound evidence as support for our clinical decisions and recommendations.

Radiographs

In 2012, an article published in Cancer, the scientific journal of the American Cancer Society, suggested that exposure to dental radiographs was associated with the risk of developing meningioma and received widespread media coverage. This study, in addition to others, alarmed patients and raised suspicions about the need and frequency of dental radiographs. The media reports weren't clear, however, that the study's results were based on memories of radiographs taken and that other risk factors are involved. According to the American Dental Association, dentists are encouraged to use the ALARA principle (as low as reasonably achievable), recommendations based on individual risk, and clinical examination in determining the need and frequency of radiographs as a diagnostic tool. The ADA also reports that radiation exposure is significantly lower than ever before, thanks to digital x-ray technology, faster x-ray speeds, and collimation. What's important is that patients know they can talk to their dentists about why radiographs are being taken and the risk of radiation exposure. For patients with concerns, an explanation of the relative risk and the reason the radiographs are needed for treatment is usually enough. In the most extreme instances, if patients deny radiographs necessary for diagnosis and treatment, dentists can refuse treatment.

Fluoride

Search the internet for fluoride, and you'll certainly find two strong opposing views. On one side, oral health care providers celebrate the known benefits of water fluoridation and its role in reducing the instance of caries. On the other, you'll find blogs, websites, and newsletters dedicated to exposing fluoride as an evil toxin linked to a long list of disorders and diseases. Fortunately, science is on our side, and the ADA remains an advocate for water fluoridation, along with the use of fluoride tooth pastes and mouth rinses. In fact, according to the ADA's Fluoridation Facts packet, "of the thousands of credible scientific studies on fluoridation, none has shown health problems associated with the consumption of optimally fluoridated water." When patients question the use of fluoride, share the facts and point them in the direction of more scientifically based information.

Amalgam

When it comes to dental restorative materials, amalgam often gets the short end of the stick—either patients don't like it because it doesn't provide the same esthetics as composite, or they're concerned with mercury poisoning. It's hard to argue that amalgam is esthetic; however, science doesn't support the notion of amalgam being unsafe. In fact, the FDA, FDI World Dental Federation, WHO, and the ADA's Council on Scientific Affairs, and other organizations, have all conducted extensive studies to determine amalgam's safety. Barring the year published and choice of words, they all published essentially the same findings—there's no evidence to suggest that amalgam has negative effects on systemic health, is linked to diseases, or should be discontinued. Amalgam continues to have indications for large restorations, high caries risk patients, in areas with heavy occlusion, when proper isolation can't be achieved, and is often noted for its longevity.

Root canals

Social media sites like Facebook and Pinterest are littered with articles that suggest that root canals aren't necessary and either cause cancer, or are linked to other diseases. According to AAE President, Dr. Gary R. Hartwell, "as dental professionals, we know there is no evidence of a link between root canal treatment and cancer or other diseases." In an ADA press release, Dr. Hartwell goes on to say that "unfortunately, claims to the contrary, with sensational headlines, continue to make their way through social media and can be persuasive to a small portion of the public." This past spring, the AAE published a new page for patients on their website, aae.org/rootcanalsafety, to help patients better understand root canals and their indications. The website also clearly explains that there are no valid scientifically based articles that link endodontically treated teeth with systemic diseases.

Unconventional dentistry

Like radiographs, fluoride, amalgam, and root canals, a number of websites suggest alternative treatments to help patients achieve optimal oral health. One of the most popular right now is the process of oil pulling, in which patients swish coconut, sunflower, or sesame oils in their mouth for twenty minutes a day. Fans of this treatment rave that it removes plaque, whitens teeth, improves breath, reverses decay, and heals toothaches. Although those that practice oil pulling cite ancient Indian traditions, and articles that prove its benefits, there's no valid, scientifically based article that's been able to prove its effectiveness. As oral health care providers, we ask our patients to brush two minutes, twice a day, and to floss every day. If you ask me, that's a lot easier than blocking out twenty minutes in your daily schedule to swish a mouth full of oil. What's even better than that? We know that brushing and flossing is effective at reducing plaque, bad breath, and decreases the risk of dental decay and periodontal disease. It's not that dentists want patients to avoid new trends because they may put us out of our jobs, it's that these alternative methods don't have the research to support their efficacy. According to the ADA's statement on unconventional dentistry, "the ADA supports the scientific exploration needed to discover new diagnostic and treatment approaches and techniques, and encourages advocates of unconventional dentistry to pursue scientifically valid, systematic assessment of diagnostic and treatment efficacy and safety."

At some time or another—maybe even every day—patients are going to question recommendations, or ask our opinions on alternative treatments. It can seem silly, but it's our responsibility to keep up with evidence based dentistry, answer our patients' questions, and help them find the information for which they're looking. Patient autonomy is the key. It's not always enough to just be the dentist. Sometimes we need to guide our patients through the process and help them make their own informed decisions. Fortunately, the ADA and other dental organizations provide a plethora of resources for both dentists and patients. Membership in organized dentistry ensures access to those resources, and makes your voice part of something greater. When patients come with questions, you can cite the ADA's statements and research and provide facts instead of opinions. Do you have any tips for talking with patients about 'controversial' procedures or materials? What have you found to be the most effective, and how did your patients respond?

When it's time to start thinking about tomorrow...

Practice Sales
Practice Appraisals
Transition Consultation

We customize a plan FOR YOU to maximize patient and staff retention, minimize your tax liability, and ensure a smooth and successful transition.
Call us today for a free initial consultation!

Amanda Christy
Regional Representative
a.christy@NPTdental.com
877.365.6786, x230

F: 877.641.0808
www.NPTdental.com
info@NPTdental.com

Trust your dental practice with a brokerage firm that has...

- ***Successfully transitioned hundreds of dental practices over the past decade.***
- ***An impeccable reputation for experience, service & results.***
- ***Achieved its success with unparalleled service & a face-to-face approach.***
- ***A 100% success rate post-closing; we've never had a buyer fail or default.***

Peace Of Mind Knowing Your Practice & Family Are Protected
NPT's Practice Protection Plan (PPP)

In general, following the unexpected death or disability of a dentist, practice value immediately begins to decline approximately 25% per month until a transition occurs. Unfortunately though, it could be weeks before a grieving loved one contacts the appropriate professionals to begin the search; and then additional weeks if not months before a proper transition is completed. By then, the practice could have little to no value remaining.

Contact us for more details or to start protecting your practice & family today!

We may not be the biggest, but we are committed to being the BEST!

DATING YOUR PATIENT: IS IT O.K.?

By: Dr. Sarah Friend, Ethics and Judicial Affairs Committee

Many of you will not disagree with me: dentistry is an up-close and personal profession. But what happens when interactions between dental professionals and patients get a little too personal? Perhaps you've had a patient ask you out on a date. Maybe you've asked a patient to a romantic outing. The purpose of this article is to provide you with some guidance on what behavior is considered to be acceptable and ethical when choosing to date a patient.

The **ADA Principles of Ethics and Professional Conduct** states the following:

> "Dentists should avoid interpersonal relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient."

The **Ethics Handbook for Dentists** published by the American College of Dentists states:

> "Dentists should not use their position of influence to solicit or develop romantic relationships with patients. Romantic interests with current patients may exploit patients' vulnerability and detrimentally affect the objective judgment of the clinician. In such a case, the dentist should consider terminating the dentist-patient relationship in an arrangement mutually agreeable to the patient. Dentists should avoid creating perceptions of inappropriate behavior."

So you've read the guidance quotes above and you still really want to date that patient? What do you do? What do you do if your hygienist or other team member wants to date a patient? What are the potential negative outcomes?

Any patient you or your team member desires to romantically pursue should be referred to another dental practitioner and his or her care should be well-established with the new practitioner before any romantic encounter occurs. You should have a written office policy outlining this procedure. If you don't terminate the professional relationship first and something goes wrong with the romantic relationship, you could face a variety of problems. Some states can seek professional disciplinary action against you if their code has a specific statement against dating patients. The patient may become litigious at a later date and/or may argue that you or your team member in question has unauthorized access to his or her private health information. In some cases, account balances may be forgiven or unauthorized credit given to the patient as a favor from the person they are dating. The public may also view these types of relationships as inappropriate.

It is your choice when choosing to enter into a more personal relationship with a patient. Always remember to refer first and date second in order to protect your integrity and that of the profession!

References:

1. Ethics Handbook for Dentists, American College of Dentists, p. 13. acd.org
2. Chiodo GT, Toile SW. Sexual boundaries in dental practice: Part 1. Pub Med.
3. ADA Principles of Ethics and Professional Conduct, Section 2.G., p.6. ada.org

I'm a new dentist...what does the ADA do for me?

By: Dr. John "Cappy" Sinclair

With about 1000 new dentists graduating from dental school in Virginia alone over the past 10 years, the future of dentistry looks very bright. The hopes of the VDA new dentist committee is to keep all of our recent graduates abreast of what is happening nationally as well as in our state and local ADA components.

I am a fairly new dentist; I graduated from VCU in 2009 and can hardly believe that I just had my five-year reunion a few months ago. It was great to visit with my fellow classmates and see just how many different paths had been taken; however, many of us were thriving in general dentistry.

Once you leave the doors of dental school, you quickly realize how many career paths are available. You can specialize, attend a residency, become an associate, enter public service or the military, and even start your own practice! I have experienced several of those areas myself starting with public health, working as an associate, and finally starting my own practice a few years ago. Did you know that the ADA can help in almost all of these areas? student to practice owner, the ADA has been a great resource for me in almost every segment. In the next few issues, I will highlight some of these areas that the ADA has helped out along the way and show a few of the various ways the ADA may be able to help you, the new dentist.

ADA Sponsored Insurance Policies

-Did you ever think what would happen if you had some life altering issue while you were in school? How would you pay your loans? What would happen if you injured your hand(s), which disabled you and prevented you from practicing dentistry? I was a young dental student and none of these ideas ever crossed my mind; however, I didn't need to worry about it! The ADA had taken care if it for me as they currently do for all dental student members. When you are student member in the ADA, you are covered in an ADA sponsored policy that not only includes a $500,000 life insurance policy, but also a $2,000 a month disability plan with $150,000 coverage in student loan protection. There is even a chance to continue on with the policies as your career advances and your need for coverage increases. https://insurance.ada.org/dental-student.aspx

Licensure Maps

-Where do you want to practice? One of the main hurdles for many dental students is deciding what regional board is going to be the best one to take. The ADA has a great informational website that lists all of the regional board exams and the states that accept that exam for licensure. There are also links to contact the state's individual boards as well as state dental components if there are any further questions. http://www.asdanet.org/licensuremap.aspx

CV Development

-How do you distinguish yourself among your peers for that perfect job? Not everyone graduating dental schools wants to do the same thing, but how do you get that first interview for your first associateship? As an ADA member, you have access to the group at the Career Transitions Center of Chicago (CTC). The team at CTC can provide you with general tips for having a successful resume all the way to co-writing that perfect CV to help you land your dream job. http://www.ctcchicago.org/PDP1.asp?MPid=29

As a student, you can see that there are several areas that the ADA can be beneficial and most of them come at no cost to you. In the next issue I'll be discussing some ADA resources that are available to the associate dentist such as reviewing of employment contracts, where to find the best continuing education for you, how to be a great team member and more!

Editor's Note: Dr. Cappy Sinclair, a VDA member dentist, practices in Virginia Beach. The Journal welcomes him as a new columnist. He will write on subjects relating to dentists who are beginning their careers.

Not Just Toys: Technology Makes You a Better Dentist

By: Dr. Jonathan Ellis

As dentists, we are lucky to work in a field where we are constantly introduced to new and exciting toys. It's the kind of stuff little kids dream about getting to play with: titanium implants, digital x-ray guns, CAD/CAM machines, 3D imaging, and lasers. The list goes on and on. While all of this is great because it's very "cool," the best part is that these advances are not just toys. Technology enables us to become better dentists from patient management and charting, diagnosis and treatment planning, patient education and treatment acceptance, to quality control. Combined with compassion and good technique, dental technology helps us be the best dentists we can be.

In this article I will focus on digital x-rays. *Dental Economics* recently said that even though digital radiography has been available since 1987, only around 25% of dentists are using this powerful tool. Whether you are fresh out of dental school or have been in practice for 30 years, there is no reason why you should not be implementing digital x-rays in your practice.

First of all, the diagnostic quality and functionality of digital radiography is undeniably better, hands down. You can enlarge images to analyze much smaller areas. You can apply contrast to the images to better evaluate light and dark areas. You can instantly calibrate measurements. You can send images to a specialist for immediate phone consult. You can put images on a monitor to educate patients and talk them through why you are treating certain areas. You can do side-to-side comparison with previous years' x-rays. You can take images during treatment and post-operatively in order to evaluate your own performance and fix any problems before the patient leaves. Digital x-rays are extremely beneficial during endodontic procedures and implant placement to continually check positioning. Post-delivery digital PA's quickly tell you if crowns are fully seated and clear of residual cement. *Dentaltown* recently published an article saying that approximately 50% of film x-rays don't show what they are intended to show. With digital x-rays, you can immediately see the quality of the image and take it again if needed.

Another perk of digital x-rays is that they have been shown to expose the patient to 80-90% less radiation than film x-rays. For patients out there who deny x-rays based on radiation exposure, this is a huge comfort which increases acceptance. Also, you and your staff are decreasing your radiation exposure day in and day out. So to sum up, digital x-rays allow us to take better quality x-rays that we can use in more ways with less exposure to ourselves and our patients.

The only downside to digital x-rays is the initial investment, which will quickly prove its worth as the quality of your care improves and the value of your practice increases. It's not just about return on investment and how many images you need to take in order to pay off the equipment. You will pay off your investment by performing better dentistry and being more confident in your work. Your patients will be able to directly see why you are recommending certain procedures, and they will be reassured that their dentist is performing good work for the right reasons.

For younger dentists, digital x-rays will allow you to hit the ground running and know that you are starting into practice with the best possible technology. For dentists closer to retirement, digital x-rays will make your practice much more attractive to someone looking to buy in. Wherever you are on the spectrum, this technology will improve your dentistry. And it's cool too.

Editor's Note: Dr. Ellis, a VDA member dentist, practices in Hopewell.

MOM Provides Critical Care and Relief for 15th Year

- *$1.4 million in high quality dental care delivered at 2014 Wise project*
- *1,299 adults and children served over two-and-a-half days*

Dr. Terry Dickinson with grateful patient

"They made my life less painful!" These words describing the dental volunteers came from a young man who walked 20 miles to the Wise County Fairgrounds to get care at the Mission of Mercy (MOM) project held July 18th through 20th. He was one of nearly 1,300 adults and children who received free preventative, restorative and surgical dental treatments valued at $1.4 million during the event.

Two days of rain and temperatures in the low 60s did not keep volunteers and patients away from this year's MOM project in Wise. Governor Terry McAuliffe toured the dental area on Friday, July 18th, and presented the Virginia Dental Association (VDA) and Foundation with a proclamation in honor of the program's 15th anniversary.

MOM was created in 2000 by VDA executive director Dr. Terry Dickinson. The very first project was held in Wise in the hangar of the Lonesome Pine airport. "When we began this journey almost 15 years ago, we had no idea of the long-term impact it would have," says Patrick Finnerty, VDA Foundation President. "Since then, this organization has had the privilege of partnering with thousands of dentists and volunteers to provide over $35 million in free dental care to more than 55,000 patients and families across the Commonwealth. In fact, the MOM program is so successful that more than 25 other states have implemented similar models."

For many individuals living in rural areas – particularly uninsured adults -- MOM projects play a critical role in providing access to dental care. As one patient shared, "It's great for the people that don't have insurance. It helps us get by."

MOM is a program of the Virginia Dental Association Foundation. Founded in 1996 as the charitable and outreach arm of the Virginia Dental Association, the Foundation is a 501(c)(3) nonprofit organization whose mission is to provide access to dental care to underserved Virginians. Learn more at www.vdaf.org. The Virginia Dental Association is a member-driven organization representing the interests of over 3,500 Virginia dentists, and it provides a wealth of clinical expertise and hundreds of volunteers annually for dental outreach programs. Visit www.vadental.org to learn more.

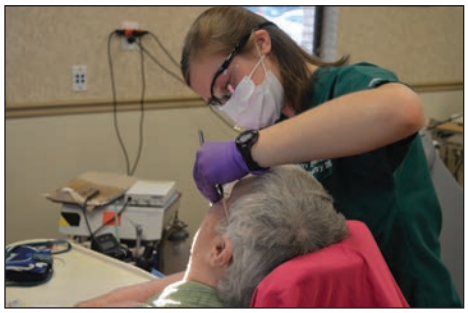
For more information, contact Beth Vann-Turnbull, Virginia Dental Association Foundation, at 804-523-2181 or vannturnbull@vadental.org.

L-R: Dr. Ted Sherwin, Dr. Charles Norman, and Mr. Pat Finnerty

L-R: Dr. Terry Dickinson, Gov. Terry McAuliffe, and Dr. Ted Sherwin

VDA Volunteers Demonstrate the Value of Ongoing Oral Care in Nursing Homes

By: Joel Rubin, President, Rubin Communications Group



It's been called an "epidemic," the poor state of teeth and gums among the nearly 1.4-million nursing home residents in the United States. Research supports links between oral health and cardiovascular disease, diabetes, mental health, arthritis, and pneumonia. These chronic conditions are particularly prevalent in the long-term care population.

That's why the Virginia Dental Association, in partnership with the Virginia Dental Hygienists Association and Virginia's nursing homes, is urging the state to consider funding a study that could lead to financing oral health care for Medicaid patients, who represent 60% of the 28,000 skilled care facility residents in Virginia. Currently Medicaid provides little or no coverage for these procedures, which the VDA believes is shortsighted since poor oral health can lead to more complicated conditions requiring expensive hospital stays.

The VDA and its partners shined a light on the problem during a screening June 20 at the Envoy of Westover Hills nursing home in south Richmond. In half a day, 12 volunteer oral health care specialists, including VDA dentists, hygienists, assistants and a VCU dental student, screened and in some cases treated 52 residents, providing $6,000.00 worth of dental services.

Prevention, claim organizers, is the key to keeping residents healthy. "We've known for a long time that water fluoridation and sealants keep kids from getting cavities and decreases the overall cost of dental care," says Richmond area orthodontist Dr. Frank Iuorno, who heads up a special VDA Access to Care Task Force. "So it's the same principle. You just carry it to the geriatric population."

The VDA contends a study would not only demonstrate the extent of the problem but also suggest options. "What if we had a dental coordinator in every nursing home who could help people keep their teeth clean, assist the staff in coordinating care that's beyond what can be delivered on site and then either get a provider in or take that person to a nearby VDA dentist," says Dr. Ted Sherwin, President of the VDA. "It would save the state quite a bit of money in the long run and bring important relief to some of our most vulnerable citizens."

For Dr. Patricia Bonwell, who has a PhD in gerontology and is a dental hygienist at Lucy Corr Village in Chesterfield County, the goal is help nursing home residents "get healthy and stay healthy for the remaining time of their lives."

Make A Visible Difference: Start A New M.O.M. Project

By: Tracy van Marcke; Dental Opportunities Champion, Virginia Health Care Foundation

Are hardworking people where you live going without dental care because they can't afford it? Do you want to make a difference?

If so, you could be the spark your community needs to begin planning a Missions of Mercy (MOM) project in your area. Often, one dentist is the impetus for bringing the many facets of a MOM project to a new area.

Nothing is more rewarding than the satisfaction of implementing a successful MOM and experiencing the gratitude and joy of the many people who receive dental care there.

Money to Get You Started

To encourage MOMs in localities that have never had them, the Virginia Health Care Foundation (VHCF) is making $10,000 in seed grants available for up to five new MOMs.

The first of these grants was awarded to the Suffolk MOM, where Dr. Ralph Howell assembled a team of local dentists and other leaders to provide much needed dental care to 500 people one Saturday last March.

A typical MOM project requires about $50,000 in cash and in-kind contributions. Seed money from VHCF can make a significant dent in the amount needed and be an effective stimulus for local giving.

Lots of Help At Every Step

Local MOM projects are led by an organizing group in each community. They get lots of help from the Virginia Dental Association Foundation (VDAF), which provides the necessary mobile dental equipment and supplies; helps recruit dentists to volunteer; coordinates with Virginia Commonwealth University's School of Dentistry to provide dental students; assists with vetting possible sites; and gives overall guidance and great advice.

It can take 9-18 months for an organizing group to plan and prepare for a MOM, depending on the pace of the local leadership team. To inform your efforts, VHCF and VDAF have written a detailed guidebook that lays out all that it takes to put on a MOM. There's even a corresponding booklet with all of the sample forms and protocols you might need. These are available at www.vhcf.org or in hard copy from VHCF.

A Visible Difference

Since the VDAF launched the first MOM 15 years ago, hundreds of volunteer dentists from the VDA have provided more than $3.8 million in donated care and treated more than 54,000 patients via 75 MOMs.

Each MOM project has generated great visibility locally. In some communities, like Martinsville, Orange County, the Eastern Shore, Gloucester and Mathews counties, and the City of Roanoke, they have even become a springboard to establish dental safety net clinics.

Interested in giving back to your community?

Learn more by contacting Beth Vann-Turnbull at VDAF (804-523-2181) or Tracey van Marcke at VHCF (804-828-5804). You can also review the MOM implementation guide and seed money information at www.vhcf.org.

An Interview with: Stan Brock

Virginia Dental Journal: How has your career in television and movies prepared you for Remote Area Medical®?

Mr. Stan Brock: It actually had nothing to do with it. It all goes back to 1953 when I was living in British Guiana. I get asked this question all the time. I was helping run a 4,000 square mile cattle ranch there. I was given a wild horse to ride who had already killed two *vaqueros* (cowboys). In my attempt I was badly injured, and the cowboys told me it was 26 days on foot to the nearest doctor. A couple years ago I was talking with astronaut Ed Mitchell. Well you know, when we sent men to the moon they were only 3 days from the nearest doctor. Some parts of the US might as well be on the moon when it comes to seeing a doctor. RAM® is now a full-time operation. I later took my saddle and lasso skills to Africa as a young cowboy.

VDJ: What draws volunteers to a RAM® event?

Mr. Brock: We've had over 84,000 volunteers, and out of 84,000 volunteers they've been inspired one or two times more to do other volunteer work. RAM® has spawned several other organizations, particularly in the dental field. Right now we'll do 30 projects a year. We're going to be doing this for a long time. The experience is an inspiration. The patients are great – they're overwhelmed with gratitude. The patients are always great – we have no need for police or anything like that. They are so appreciative. You see them hug a doctor or dentist and say things like "Wow! I never had a pair of eyeglasses before." Patients like the fact that we don't ask any damn silly questions like "What is your job?" or "What kind of insurance do you have?"

VDJ: What's the number one reason for lack of medical care in the US?

Mr. Brock: I testified before the (US) Senate this April, and I told them now as I have two times before that the greatest country in the world is #37 on the W.H.O. list for healthcare for its citizens. Think about it: the richest country is #37. What is France doing right? France is Number One! I'm British, so I'm sort of familiar with the National Health Service (NHS) which started in 1944. The system has been successful, but lately it's had a lot of problems and it's running out of money. Dr. Claire Gerarda, a prominent physician who is also the chair of the Royal College of General Practitioners, came over and saw what we were doing and was impressed, but she doesn't want a RAM® event in England. She's afraid it will deter the government from doing anything about healthcare. I told her a story about my childhood in South Wales. Growing up we'd see thousands of starfish stranded on the beach. Every now and then I pick one up and throw it back. My friend would ask why it mattered – there were still thousands left on the beach. I'd say, "Well, it matters to that starfish!" Our patient base here at this event (Wise) is 29 to 64 years old. This morning, at 5:00 a.m., I asked1500 people standing in line how many are here to the dentist? All the hands went up! I asked about the eye doctor, and the all the hands went up! Then I told them we had specialists in medicine and asked how many wanted to see a physician and only 12 hands went up.
The reality is in the triage figures: when many of them have blood pressures (systolic) of 250-300 it's obvious they all need to see the MD, but they are preoccupied with teeth pain, or they can't see.
At an event like this about 71% will see the dentist, and the eye doctor is a close second. Only 1 or 2 percent want to see the MD, but we urge them to see them when they get a chance. When I was as the US Senate two weeks ago I met Senator McConnell and Representative Dunn and asked them to support our patients. McConnell has a stack of photocopy paper in his office 10 feet tall – this represents the Affordable Care Act. The message is: who knows what's in there? What it doesn't show is where dental and vision care will come from. A *London Times* reporter told me that people recognize the "ACA" term, and they don't know anything about it, but they don't like it. The word "socialism" gets in the way.

VDJ: Have you ever encountered resistance from the local medical community? If so, why?

Mr. Brock: We never have, but I guarantee if I asked a casual question - would you mind if the person working alongside you was licensed in another state – no one would raise an objection. The real objections come from the state boards. In 2009 we held an event in California, and although we had 100 dental chairs, we ended up with only 30 dentists, and 70 vacant chairs. We could have filled the chairs with dentists from other states. The California Board of Medicine even mentioned in a column in the *Los Angeles* Times saying that they didn't want MDs from Texas and Alaska in California, saying that "we have very high standards". My question to them would be, what would you do if you were in a car accident in Dallas? There was great resistance to changing the law in California. There you have to give 60 days' notice, be fingerprinted, and pay a fee. The Tennessee model is very simple – the doctors work under the auspices of a charitable organization. The form they fill out is on one sheet of paper. Why can American doctors cross some international borders, but we can't let them cross state lines? Our critics raise the specter of "lawsuits" and "child molesters", but we've never had a problem with either one.

VDJ: If you could share one favorite story from RAM®, what would it be?

Mr. Brock: Well, there are a lot of favorite stories, maybe a thousand. Here's a couple. A seven-year-old kid was here two years ago, and he had several bad teeth. He told the dentist: "If I start yelling, you keep pulling, because I can't stand the pain!" In Tennessee, a very pregnant lady in her thirties was in the eye line, and the contractions were 3 minutes apart. She was #92 in line. As the van pulled out to take her to the hospital, she pointed to a lady on the curb and said "I want a pair of glasses just like hers!" The baby was delivered that afternoon, and we delivered her glasses the same day. Here's another. A lady failed an eyesight test to get a job at a mill. She came to our RAM® event, got new glasses, and the mill re-tested her and gave her the job.

VDJ: According to press reports, you lead a Spartan lifestyle. How would you describe it?

Mr. Brock: *60 Minutes* reported it that way, and they do their research. When I started RAM®, we were all volunteers, and nobody got paid. Thirty years later we are the biggest medical outreach of its kind in the US, and I'm still not getting paid, and this is all I do, 365 days a year. I'm essentially a penniless person who runs the organization. This is no hardship to me. My dependents are the patients. I don't have any family. I lived with the Wapishana Indians as a teenager in British Guiana. When I worked on the cattle ranch, I supposedly got paid $20 a month. At 4,000 square miles, it was the largest cattle ranch in the world in terms of acreage

– no fences! After 10 years I learned to fly a plane, and I would fly into Georgetown (British Guiana) for medical supplies. I still didn't need any money. But after I left my work there, I owed them $700. I've never gotten into the culture of this money thing. *Wild Kingdom* always gave me my ticket. I've never had to worry about money, and that carried through to the rest of my life.

VDJ: How does a RAM® event change the opinions of policymakers?

Mr. Brock: That's a good question. In DC testifying I met Senator Harry Reid. We had something in common. In Nevada he had an interest in boxing, and I was keen on boxing as schoolboy. I told him, "You know, Senator, we've done over 700 events around the US, and only 12 members of Congress have ever been there." He said, "Make that 13!" I told him we would be in Reno the next day, and he said "I'll be there." He showed up at our Reno event, and he was so impressed. He stayed a couple of hours. I told him the law was changed in Nevada to allow doctors from other states to participate, and there needs to be a federal law on that. In May of this year (2014) he and Senator Boxer (California) sponsored a bill to do just that. I told him Tennessee changed its law in 1997, and ten states have made changes in the last three years.

VDJ: What are some sources of funding?

Mr. Brock: Mainly those $5 and $10 donations from the general public. Never from patients. We don't accept government funds. On rare occasions, we do get unsolicited support from foundations. The *60 Minutes* story gave us a huge response. This Internet thing has made a big difference. FedEx gave us an airplane, but we get no corporate support of any significance. Our biggest expense is fuel – what we really need is an oil company donation. We have seven airplanes, and a huge bill for fuel.

VDJ: Have you ever turned away patients? Volunteers?

Mr. Brock: Yes, we've turned away patients, but it was due to a shortage of time or doctors. But we've never turned away dental or vision care volunteers. We're always short of dentists and eye doctors. We're going to do an event in Lee County (Virginia). This is an airborne operation; we'll fly into the Lee County airport. Lee County is the poorest county in the state. The poverty rate is three times the state average. There are only two or three dentists in the county. Yes, it's possible to have too many MDs. The patients are seeking dental and vision care. Sometimes we tell the MDs the event is closed. Volunteers do not like to stand around with nothing to do, or no patients to see.

VDJ: What can dentists do to better collaborate with other healthcare professionals at similar projects?

Mr. Brock: That's a very good question. At a Motorola convention in Las Vegas, I heard a speech from Chris Hill, the president of a corporation that does business with Motorola. We talked about this same question. What about a dentist's patient who goes to the MD next with a mouthful of gauze, such as what happens at a RAM® clinic? At the site, we always try to make sure a patient sees the MD first if that's what they need. We know that bad teeth can cause all kinds of medical problems. They were talking about a wristband device that can communicate what the dentist has done and pass it on to the other practitioners. The MD often doesn't know that patient has been to another doctor. What they are trying to develop is something that the doctor can download off the Internet. The name of this company is "Mobile Epiphany", and they are developing application for smart phone, so that this information can be shared on cell phones. Of course, there are going to be some costs for this, such as cost for design, and the cost for software licenses.

Editor's Note: Mr. Brock was interviewed for the Journal on July 18, 2014.

Harvest Foundation Honored by Dental Groups

From a press release

At the September 16, 2014 annual Leadership Recognition reception at the New College Institute, the Foundation and the Dental School presented the Harvest Foundation with the "Platinum Award for Exceptional Leadership in Improving Oral Health."

The Harvest Foundation has committed more than $1 million in grants to the Piedmont Virginia Dental Health Foundation in nine years. "The Harvest Foundation has supported us from the beginning, and the Community Dental Clinic would not be in existence today without the generosity of the Harvest Foundation," said Dr. Mark Crabtree, president of the Foundation.

The Platinum Award was presented jointly by the Dental Foundation and the VCU School of Dentistry. The Dental Foundation also recognized Dr. and Mrs. Mervyn King and Debra Green with Dental Health Hero awards. The Kings are generous financial supporters of the Foundation. Green joined the Community Dental Clinic as coordinator in 2006 and teaches dental assisting and trains interns.

"The educational experience our dental students receive in Martinsville is exceptional," said Dr. David Sarrett, Dean of the School of Dentistry at the reception. "The community-based clinical program is considered one of the best, if not the best, extramural site for VCU dental students in the entire Commonwealth. Our students consistently point to this part of their training as vital to their development as dentists."

Fourth year students from the School of Dentistry come to Martinsville to provide dental care to patients at the Clinic. They are supervised by the Clinic Dentist and dentists in the Martinsville community who volunteer their time. Dental students stay in housing provided by the Foundation with furnishings donated by community businesses.

"The educational experience our students receive in Martinsville gives them a realistic perspective of the practice of dentistry," added Sarrett. "They come away from their experiences with a deeper understanding of the day-to-day operation of a dental office and the oral health needs of all citizens."

Both Henry County and the City of Martinsville recognized Dean Sarrett and the Virginia Commonwealth School of Dentistry for their commitment to the oral health of our community. Henry County presented a resolution honoring the Dental School, and the City gave him a Key to the City.

Crabtree also recognized the County and City for their financial contributions to the Foundation. "Our local governments understand that the Foundation is contributing to the oral health of the entire community," he said.

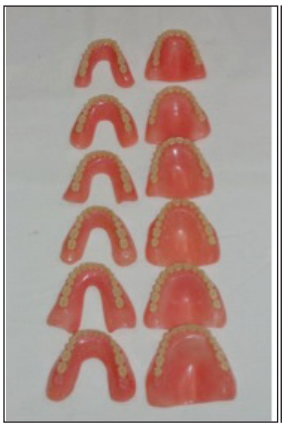
"The Foundation relies on financial support from the community," said Dr. Edward Snyder, Vice-President of the Foundation. "Approximately half of our expenses are reimbursed, so we must have continuing support from the Harvest Foundation, governments, businesses and individuals to operate the Clinic."

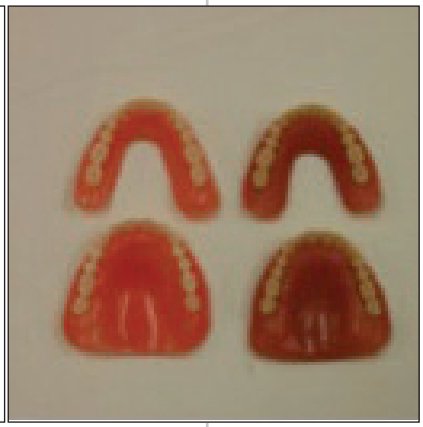
Anyone interested in donating to the Foundation should call 276 632-7727 and visit www.dentalfoundation.org. The Foundation is a tax-exempt organization.

A SINGLE VISIT ALTERNATIVE DENTURE BUILT ON CLASSIC PRINCIPLES

By: Scott R. Miller, D.D.S.

Boucher, Pound, Turbyfill, Massad, Crabtree, Ward, Unger and McAndrew are the people that come to my mind when I think of denture fabrication. They are the clinicians that set up the acrylic stage for what you are about to question and consider as

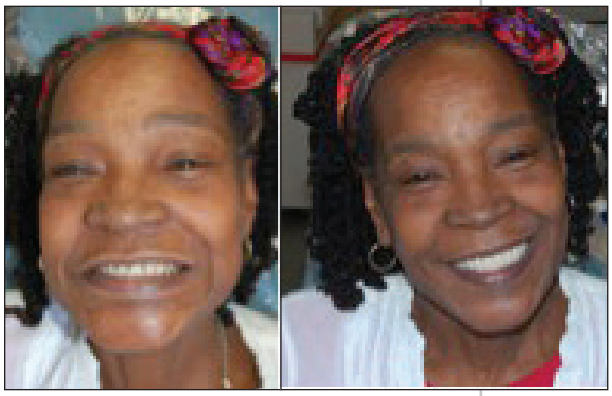




an alternative approach to dentures. No matter the instructor or the patient, dentures must meet basic principles to be successful. Carl Boucher in 1963 described the "Criteria for Success" to include "Support and Retention"[1] Support is defined as the quality of a denture to resist displacement by functional stresses and Retention being the resistance of a denture to removal in a direction opposite that of its insertion. Dr. Boucher stated the obvious when he said that making a denture is a technically demanding task. To him the ability to make a final impression is one of the most critical steps in the entire process. As a dentist, you were taught the importance of incorporating anatomical landmarks required to have a successful impression. Some of us can likely flash back to dental school and remember how much impression material that we wasted in an attempt to get our instructor's approval and now we know why they were so demanding.

A conventional denture typically requires five office visits in the private practice. The initial visit requires an impression to be made to begin the conventional denture treatment process. Following the fabrication of custom trays the patient returns for a border molded final impression at a second appointment. The third appointment then records a jaw relation record and tooth selection. A fourth appointment is for tooth try-in and hopefully a happy patient that will consent to denture processing. The conventional denture is typically delivered on the fifth appointment. The fabrication of dentures includes not only a clinically demanding task of impressions but then the correct positioning of wax for proper arch form, smile design and occlusion. These demands are why I feel many dentists do not make dentures or dread seeing them on their office schedule. As the office CEO, we are all concerned with our overhead percentage and know that chair time utilization is a critical factor and is likely another reason that some practices do not want to offer denture treatment. Dr. Joseph Massad developed a series of impression trays that incorporate the use of Polyvinyl Siloxane Impression Material to make a master cast impression on the first visit. I have used this procedure and found it to save a step in the conventional denture process. There are not many ways of shortening the conventional denture process and having a predictable result. As one of the directors of the Mission of Mercy denture team, the need to fabricate and deliver a denture in a timely manner has been the mother of invention. This article is about another alternative denture product that incorporates all the conventional denture appointments into one single visit.

The Benchmark Denture is an Alternative Denture that can be fabricated in one visit. The Benchmark Denture is a preformed denture that is available in six arch sizes (A-F), two tooth shades (A-3 and A-O), and two denture base shades (original and ethnic).



Suffolk Missions of Mercy Patient 2014: L - Before, R - After

The process begins with an alginate impression of the edentulous arch which is poured in a quick set stone (Whipmix). The stone model is then used to select the denture that best places the teeth over the arch. The denture base is then trimmed in any area that may be overextended. The denture is placed in boiling water for at least 50 seconds then placed on the model and molded to the edentulous model. Your questions at this point are the ones we have already answered for you in the development of this alternative denture. The denture base material is only thermoplastic and moldable at extremely high temperatures and will not deform in the mouth. The first step is to convert the alternative denture into a custom tray. The maxillary denture is then placed in the patient's mouth to evaluate the plane of occlusion, tooth show, and lip support just as you would with a record base and wax rim. The mandibular denture is tried in next to evaluate the vertical dimension. One of the most critical steps in any occlusal rehabilitation is ensuring a proper freeway space exists. The dental literature describes this process using various procedures.[2] Establishing a mandibular rest position 2-3mm short of the occlusal contact position (centric occlusion) is the goal in this procedure. The denture base and denture teeth can be adjusted on the stone model to ensure this position is obtained. One of the goals of a denture try-in is to evaluate the tooth position, midline and occlusion. All the classical denture principles are unchanged in this alternative denture process. A hard chairside reline is then placed in the maxillary denture while ensuring the plane of occlusion and lip to tooth position are correct. Functional border movements are then performed as with a final impression and a custom tray. The reline material is then trimmed as with any other conventional denture reline. The mandibular denture is relined in the same fashion and the delivery is completed as on the fifth appointment for a conventional denture. The dentures are evaluated with pressure indicating paste and articulating paper. The dentures are then polished and post-delivery instruction given. The monoplane denture is the easiest to adjust for the clinician and has advantages for the patient with minimal alveolar ridge height.[3]

A successful treatment is one that meets the patient's expectations. The Benchmark Denture is an alternative treatment option that should be part of the treatment plan consult appointment. The first treatment option in my office for the edentulous patient includes an oral rehabilitation with dental implants restored with a screw-retained prosthesis in both arches. Unfortunately, the number of patients with the ability to elect

1 Zarb, George A., Boucher Carl O., et al (1997). Boucher's Prosthodontic Treatment for Edentulous Patients. Saint Louis: Mosby.

2 Olsen, E. S. Vertical Dimension of the Face. DCNA. 1964; 611-622.

3 Jones, Phillip M. The monoplane occlusion for complete dentures. JADA. 1972; 85: 94-100.

WHEN FACED WITH A MALPRACTICE CLAIM, WHO DO YOU WANT IN YOUR CORNER?

When your career and reputation are on the line, you want the strongest dog in your corner. Many dentists don't realize how important their dental malpractice insurance is until they need it most. Medical Protective has over 100 years of proven experience, national expertise and a balanced defense that focuses on ***your best interest***. And, today, more than ever, the big financial strength, integrity and powerful backing of a Warren Buffett Berkshire Hathaway Company are crucial to the quality of your dental malpractice protection.

One company has strength and experience that towers over the others.

Contact us today for a Protection & Price Check-Up

PROTECTION & PRICE CHECK-UP

Email: dental@medpro.com
Visit: www.medpro.com/dental
Call: 800-4MEDPRO ext.3536

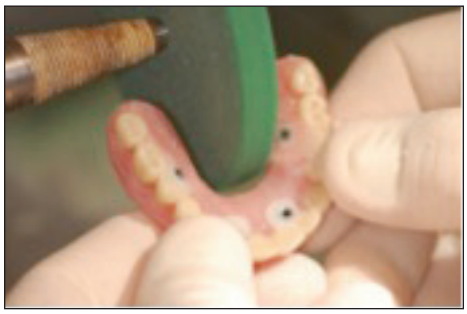
Trust the dental malpractice experts.

Medical Protective
a Berkshire Hathaway company

Strength. Defense. Solutions. Since 1899.

this option today in my demographic area continues to decrease as the economy declines. The next treatment plan option usually includes conventional custom made dentures with two mandibular implants for retention. The final treatment option does not have to be a referral to "Affordable Dentures" when an Alternative Denture can be fabricated in your office in about 60-90 minutes with the staff assisting with the steps they are allowed by law to complete.

Dr. Stephen Alouf and I have watched the oral surgery area at every MOM project continue to expand every year with the need for complete dentures growing rapidly. Currently there are 752 people on the denture waiting list for Southwest Virginia. The Mission of Mercy project in Wise, VA is the first place that a denture was made for those less fortunate. Dr. Karen McAndrew and her team of dentists and laboratory technicians provided conventional denture care for 25-35 patients yearly. This process required a second visit to deliver the dentures once they were processed at a dental laboratory. I believe the current economy in Coal Country and the lack of oral health education in the school system are the driving forces in the "Access to Care" dilemma in my area. As these factors remain unchanged, the necessity for a denture process that can keep up with the demand has been one of the driving forces in the development of the Benchmark Denture. Dr. Alouf, myself and our denture team have delivered over 1000 arches of single visit dentures. The Benchmark Denture is a product we use in our private offices on a daily basis. It is a denture designed by dentists and a certified dental lab technician to meet the standards of care and principles required for successful complete denture treatment. This denture is the only denture of its kind developed by clinicians that use it in their private practices. Benchmark Dentures were developed out of the necessity for patients to have a single visit alternative denture that would provide years of trouble free service.

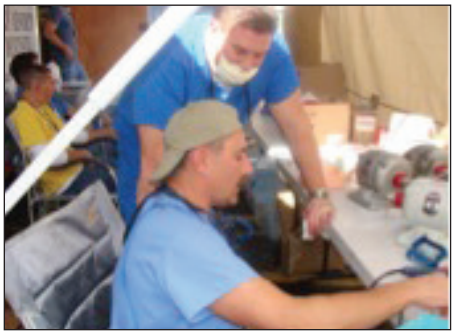


Dr. Stephen Alouf adjusts a Benchmark Denture for use as an immediate fixed interim prosthesis.

Benchmark Dentures are used consistently for immediate interim dentures, immediate load fixed implant interims, a definitive prosthesis option and emergency situations when time is a factor for the patient. Having these dentures as part of the dental treatment armamentarium has been a benefit in my office for our patients. The single visit denture has allowed us to deliver dentures to as many as 80 patients in 3 days with our current denture team. This denture is fabricated with materials used in dental offices every day. It does require knowledge of classic denture principles and it can meet the expectation of your patients and provide an excellent treatment option.

The Benchmark Denture is manufactured in Virginia and is designed by the dentists that use it routinely. A training video is also available with purchase and hands-on training is always free at the next MOM project. Please visit www.VDAF.org for more information on the MOM project schedules.

Dr. Scott Miller is a Prosthodontist in Bristol, VA. He and Dr. Steve Alouf are the co-directors of the Mission of Mercy Denture Team. They are also two of four partners in the Benchmark Dental Manufacturing Company, L.L.C. All have been involved with the single visit denture research and development since its inception. To learn more about this product please visit www.Benchmarkdentures.com or Benchmark Dentures on Facebook.



Meeting Highlights

Photos • Attendee Feedback • Sponsors • Exhibitors

September 17–21, 2014
Hot Springs, Virginia

Continuing Education

Attendees participated in hands-on and lecture courses led by dentistry's top instructors.

Association Governance

Moments from the Annual Business Meeting and The House of Delegates.

Social Events

And of course, a good time was had by all in between education and business proceedings!

Meeting Sponsors

We thank the following people and companies for their generous support!

American College of Dentists
Anthem Blue Cross and Blue Shield
Associated Printing
Atkins, Maestrello, Miller & Assoc.
Pediatric Dentistry
Axis/Sybron Endo
B&B Insurance
Bank of America Practice Solutions
Bayview Dental Lab
Bivins Orthodontics
Blue Ridge Endodontics
CareCredit
Carl P Roy, DDS, MS, PLC
Central Virginia Oral & Facial Surgery
Colgate Oral Pharmaceuticals, Inc.
Commonwealth Endodontics
Commonwealth Oral and Facial Surgery
Cordell Medical
Creative Dental Ceramics
Cynthia M. Southern, DDS
Delta Dental of Virginia
DentaQuest-Commercial Product
DentaQuest-Smiles for Children
Doctors Morris & Taylor, LTD.
Dr. Alonzo Bell
Dr. Andrew Zimmer
Dr. Brian Midgette
Dr. David Konikoff
Dr. Frank Iuorno
Dr. Roger Wood
Drs. Brown, Reynolds, & Snow Drs. Kaugars & Miller
Drs. Kirk and Justin Norbo
Drs. Ralph and Leroy Howell
Drs. Shivar, Peluso, and Andersen
Drs. Whiston, Patterson, Corcoran
Dynamic Dental Partners Group
Elliott Davis
Endodontic Partners
Fairfax Oral & Maxillofacial Surgery
First Citizens Bank
Fitz Vital Dental Laboratory
Fortress/Asset Protection Group
Gardner Orthodontics
Goodwin Dental Lab
Gus Vlahos, DDS
Hampton Roads Oral and Maxillofacial Surgery
Hancock, Daniel, Johnson, & Nagle
Harris, Hardy, & Johnstone
Henry R. Hortenstien, III, CPA, P.C.
Henry Schein Dental
Hilton Virginia Beach Oceanfront
HNGRI Labs
Hutchison & Gorman, DDS, PLLC
Implant Direct
International College of Dentists
Jacobson Brotman PC
Jeffrey Friend, DDS
Jeffrey N. Kenney, DDS
Lab One
LifeNet
Link, Jacobs, & Link
McPhillips, Roberts, and Deans
Meares Bernier Endodontics
Medical Protective
Michael Miller, DDS
Morgan Stanley
Morgan Stanley PC Wealth Management
National Practice Transitions
New England Handpiece Repair
Nobel Biocare
Northern Virginia Dental Society
OneMind Health
Oyster Point Oral & Facial
Paddle Palace Table Tennis Co.
Past Presidents' Council
Patrick D. King, DDS
Patterson Dental-Richmond
Pincrafters
PNC Bank
Practice Booster, LLC
Premier Dental
Proctor & Gamble
Richardson, DMD, Overstreet DDS, Ltd
Richmond Dental Society
RK Tongue Co., Inc/Tongue/Gerner Financial Services
Saunders Dental Lab
Seaboard Dental Study Club
Shenandoah Valley Dental Association
Southwest Virginia Dental Society
Steven G. Forte, DDS - Practice Limited to Endodontics
Suntrust Bank Medical Specialty Group
Ted Sherwin, DDS
Tidewater Dental Association/ Ferris-Donne Foundation
VDA Services
Vera Bradley
Vince Dougherty, DDS
Virginia Academy of Endodontists
Virginia Academy of General Dentistry
Virginia Association of Orthodontists
Virginia Dental Assistants Association
Virginia Dental Lab
Virginia Family Dentistry
Virginia Oral and Facial Surgery
Virginia Society of Oral and Maxillofacial Surgeons
WorldPay
Yorktown Periodontics
Virginia Hot Springs Realty

Meeting Exhibitors

We thank the following people and companies for their generous support!

3M ESPE
A-dec
ADS South
AFTCO
American Express Open
Asset Protection Group, Inc./ Fortress Insurance Co.
Axis/Sybron Endo
B&B Insurance Assoc., Inc.
Bank of America Practice Solutions
Benchmark Dental Manufacturing Co., LLC
Benco Dental
BioHorizons
Brasseler USA
CareCredit
Carestream Dental
Chas. Lunsford Sons & Associates
Colgate
Delta Dental of Virginia
Demandforce
DentaQuest
Dentegra Insurance Company
DENTSPLY Implants
DENTSPLY North America
Dentsply Tulsa Dental Specialties
Designs for Vision, Inc.
Digital Doc, LLC
Doral Refining Corp
Drake Dental Laboratories
Dynamic Dental Partners Group
Elliott Davis
Enovative Technologies
First Citizens Bank
Gateway Healthcare Professionals
Gephart Marketing Solutions
GlaxoSmithKline
Great Expressions Dental Centers
Healthcare Professional Funding
Henry Schein Dental
Implant Direct International
IT Practice, Inc.
Ivoclar Vivadent
Johnson & Johnson
Kerr Corporation
Leadership By Design - Practice Transitions
LumaDent, Inc.
McPhillips, Roberts, & Deans, PLC
Medical Protective
Miles Global
Morgan Stanley Wealth Management
National Practice Transitions
NIH Federal Credit Union
Nobel Biocare
Norfolk Waterside Marriott
North East Dental Management
OneMind Health
Pan-Am Dental Lab
Patterson Dental Supply, Inc.
Philips Sonicare/Philips Zoom
Porter Royal Sales
Proctor and Gamble Professional Oral Health
ProSites
R. Webb Interior Design Firm RK
Tongue Co., Inc./ Tongue/Gerner Financial Services, LLC Sabika Austrian Crystal Jewelry
Saunders Dental Laboratory, LLC
SciCan, Inc.
Solmetex
Solutionreach
State Corporation Commission - Bureau of Insurance
Straumann USA
Sunstar
Surgi-Tel/General Scientific Corp.
The Gideons International
Transworld Systems
Ultradent Products, Inc.
Ultralight Optics, Inc.
VADPAC
VDA Services
Association Gloves
Virginia Academy of Dental Sleep Medicine
Virginia Dental Assistants Association
Virginia Dental Association Foundation
Virginia Dental Sleep Solutions
Virginia Department of Health, Office of Family Health Services - Dental Health Program
Virginia Oral Health Coalition
VOCO America, Inc.
Wildtree
WorldPay
Zimmer Dental
Zoll Medical Corporation

The Real World Tour, 2014

By: Leslie Pinkston; Director of Membership, VDA

On August 20, 2014, 23 VCU dental students participated in the VDA New Dentist Committee "Real World Tour". The students visited the offices of Drs. Londrey, Gardner, and McMunn.

What great insight and advice the students received from each office! They learned about insurance, office design, sleep apnea, were given reading suggestions (for personal growth), received as gifts the book, *FISH!*, and terrific advice from all the dentists!

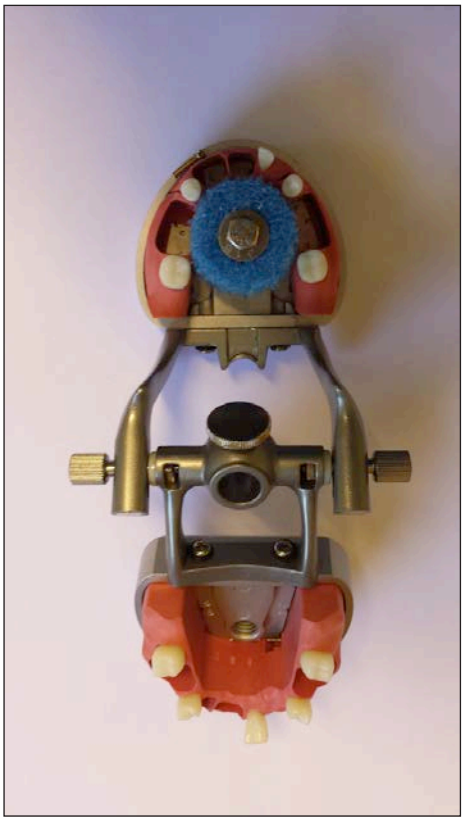
The VDA thanks Kristin Coffield (D-3) for all her help in organizing this event with her classmates. We also thank Dr. Londrey, Dr. Gardner, and Dr. McMunn, for sharing their offices, their time, and their insight with the dental students.

Innovation in Undergraduate Endodontics

Virginia N. East, D.D.S., Assistant Professor, Department of Endodontics, VCU School of Dentistry

Dr. Ginny East joined the VCU School of Dentistry faculty in the Department of Endodontics in 2012. She had been in private practice in the Richmond area for more than 20 years. One of her early experiences at the school was getting involved with a course given to third year dental students that followed a basic lab course in the principles of endodontics. In this course they work on a patient typodont called a Modupro, which simulates the upper and lower arches with a metal head attached. It helps students make a transition from a lab course, which they take earlier that year, to a more clinical situation. It is a great way to learn techniques in a more realistic setting.

East was shown a technique that was developed for taking radiographs with the ModuPro. It did not work well, and students spent a great deal of time trying to get good films. This was a constant problem in the course. She noticed there was a screw hole in the middle of each metal ModuPro. East developed a device that consisted of round plastic foam that attached to the screw held in position with washers and nuts. It allows the film to be placed anywhere in the arch. The film is placed in front of the sponge wheel. Below is a picture of this device and one with a student having positioned her film and getting ready to take a radiograph with a modified endo angling device.



The device allows for great positioning with a consistent outcome, and students rarely miss the root apices. Students now spend more time learning to do root canals, and it saves the school money on dental materials. We are in our second year of use and have approached a company in to have these wheels mass produced so other schools will be able to take advantage of this system that was developed at the VCU School of Dentistry.

VDA - Board of Directors - Actions in Brief

June 20, 2013

The following Bylaw amendments and Policy changes were considered:

1. Approved: Background: To clarify who makes appointments to the ADA Delegation.

Resolution: In cases of emergency appointments the following Bylaw change be made: Article V – Section 2, B.a

a. After the ADA certifies the Delegation, ~~in cases of emergencies of short duration when a Delegate or Alternate Delegate cannot fulfill his duties~~, the Chair of the VDA Delegation may appoint any member of the Virginia Dental Association temporarily to fill the vacancy. All such appointments must conform to the rules of the House of Delegates of the American Dental Association.

2. Approved: Background: To clarify who makes appointments to the ADA Delegation.

Resolution: In cases of reasonable notice the following Bylaw change be made: Article V – Section 2, B.b

a. Before the ADA certifies the Delegation ~~in cases of reasonable notice~~: when any Delegate cannot complete his term of office because of resignation, death or other reason, the President of this Association shall appoint his successor from the Alternate Delegates to serve until the next election, subject to the approval of the Board of Directors. When any Alternate Delegate cannot complete his term of office because of resignation, death or other reason, the President of this Association shall appoint his successor from the Association membership to serve until the next election, subject to the approval of the Board of Directors.

3. Approved: A resolution that electronic, voting for VDA elected offices, begin July 1 and policy be a minimum of 60 days before the Annual Meeting. (Policy)

Board of Directors recommends the House of Delegates vote yes on the above Bylaw amendments and Policy change.

The following were considered and the noted action taken:

4. Approved: A resolution to approve the 2015 Budget as presented.

5. Approved: A resolution to make Linda Gilliam an honorary member of the VDA.

6. Approved: The members eligible for life membership in 2014.

Component 1: Robert T. Banes, John I. Barney, Marshall S. Bonnie, Townsend Brown, Jr., Thomas O. Dusek, Alan G. Forbes, Arthur C. Hendricks, Grover C. Hill, Jr., Thomas J. Ishom, Jan E. Milner, Demetrios P. Milonas, Robert A. Pope, A. J. Weisberg.
Component 2: William J. Bennett, Donald D. Cooke, McKinley L. Price, Richard W. Toth, Kenneth A. Yorgey, James D. Watkins.
Component 3: Thomas M. Coghill, David L. Ellis, James P. Webb.
Component 4: William D. Crockett, Harold M. Cruse, Nicholas Germane, James O. Glaser, Lindsay M. Hunt, Charles K. Johnson, Fred N.Kessler, Gene C. Mears, Jonathan D. Perkinson, John B. Rose III, James R. Schroeder, Kevin C. Sweeney.
Component 5: Gregory T. Gendron, George D. Morris, Marvin E. Perdue, James H. Priest, William C. Richardson, John W. Rhoday, Mark P. Smith.
Component 6: Douglas W. Chambers, W. S. Glascock, Henry K. Higginbotham, Neil D. Hollyfield, Joe A. Paget, Jr.
Component 7: D. C. Devening, Jr., W. J. Faircloth, Jr., David C. Hall, Robert S. Knierim, Allen D. McCorkle.
Component 8: David C. Anderson, Gary V. Avakian, David Bertman, Alvin W. Breeden, Theron L. Dikeman III, Steven Fuchs, James L. Gyuricza, Gerald A. Hoffman, John J. Krygowski, Brian A. Mahler, Paul H. Patterson, James A. Pell, Clark W. Rogers, Peter J. Scelfo, Richard G. Tami, Jack Weil.

Board of Directors recommends the House of Delegates vote yes on the above resolutions.

The following actions are reported as information only:

1. Approved: A resolution that Terry Dickinson, Ted Sherwin and Mike Link are authorized to meet with the Department of Health Professions' attorney and Sandy Reen to share the VDA attorney's opinion the issue of practice ownership.

2. Approved: The following resolution: Background: VDA legal opinion indicates that in the VA Code the practice of dentistry in sole proprietorships must be governed by the dentist owner. In the event of the dentist owner's death, all diagnosis and treatment by volunteer dentists, whose purpose is to "keep the practice active" until proper disposition (sale) of the practice by the deceased dentist's heir cannot occur. Volunteer dentists might be prosecuted due to their altruism. This resolution would direct the VA Board of Dentistry to establish a regulation and/or ask the VA Legislature to change the VA Code to make these humanitarian efforts by the dentists of Virginia legal.

Resolution: The VDA will ask that the Virginia Board of Dentistry establish a regulation and/or ask the VA Legislature to change the VA Code to allow the practice of dentistry by volunteer dentists in sole proprietor practices where the dentist has succumbed. The regulation should define a period of time, not less than six months, for the disposition of any practice in question.

3. Referred: To the Council on Legislative Affairs - The Board of Dentistry's fee splitting language for rewording (use ADA Code of Ethics as a guide).

4. Defeated: A resolution that the Internal Image Task Force is authorized to spend up to $2,500.00 on a "Year in Review" video that would be on the VDA website.

5. Approved: A resolution that a subcommittee be appointed to monitor dental school admission numbers.

6. Referred: To the VDA Ethics Committee to explore possible options for ethics testing by the Board of Dentistry.

7. Approved: A resolution to sustain the president's authority to make the appointment to the alternate delegate spot on the ADA delegation before this year's ADA election.

8. Approved: A resolution to appoint Maynard Phelps to the ADA alternate delegate position vacated by Ed Weisberg.

9. Approved: A resolution that the VDA send an informational letter to the Tobacco Commission outlining trends in the dental profession and the impact on future dental graduates.

Welcome New Members

By: Karen Clendenen, VDA Membership and Meeting Coordinator

Tidewater Dental Association

Leigh Blakiston – Chesapeake – VCU 2014

Houman Chegini – Virginia Beach – VCU 2014

James Ryland Gwaltney – Suffolk – VCU 2014

David J. Herce – Virginia Beach – VCU School of Dentistry 2011/NY-University of Rochester Eastman Dept. of Dentistry 2013/Pediatric Dentistry

Heather Jennings – Virginia Beach – Case Western Reserve University 2013/ GPR Summa Health System 2014

Christine Lynn Ogden – Virginia Beach – University of Pittsburgh 2001/United States Army, Endodontics Residency 2008

Collin N. Rice – Kilmarnock – VCU 2013/Georgia Regents University GPR 2014

Marcus Sur – Norfolk – Columbia University 2013/NY St Barnabas Hospital 2014

Andrea Wissink – Chesapeake – VCU 2013/University of Connecticut 2014

Scott Wolpin – New Church – Tufts University School of Dental Medicine 1989

Peninsula Dental Association

Charlie D. Boxx – Newport News – VCU 2014

Zachary T. Duman – Poquoson – VCU 2014

Christina D. Franklin – Williamsburg – VCU 2014

Mary Catherine McGinn – Williamsburg – VCU 2014/ Naval Medical Center Portsmouth 2015

Jill Elizabeth Nowadly – Williamsburg – VCU 2014/UVA GPR 2016

Sonia W. Tao-Yi – Newport News – University of Detroit Mercy, School of Dentistry 1999/Langley Air Force Base, VA (Doctor of Dental Surgery) 2000

Southside Dental Society

Vaishali P. Patel – Colonial Heights – NYU College of Dentistry 2013/NYU Advance Placement program for International Student

Michelle E. Stelmach – VCU 2014

Richmond Dental Society

Tyler Evan Ames – Richmond - University of Nevada 2012/ General Practice Residency 2014

Ala'a Al Arabi – Richmond – VCU 2014

Lindsay Kinyon Ashton – North Chesterfield – VCU 2014/Langley AFB Dental Clinic 2015

Jessica R. Aylward – Midlothian – VCU 2014/VCU AEGD 2015

Isabel Barbato – Richmond – VCU 2008

Sarita Bhushan – Henrico – VCU 2014

Kevin R. Bibona – Richmond - Virginia Commonwealth University 2012/Orthodontics 2014

Mallika R. Chary – Glen Allen – VCU 2014

Mi-Yon Choi – Richmond – VCU 2014

Hee-Chul Chung – Glen Allen – University of Iowa 2011

Andrew Charles Coalter – Henrico – VCU 2014

Kristin Alyss Davidson – North Chesterfield – VCU 2014

Patel Devanshi – Richmond – VCU 2014

Pallavio Vijay Dhingra – Midlothian – VCU 2013/ UTMCK GPR 2014

Benjamin D. Dunham – Midlothian – VCU 2014

Carl M. Embury – Glen Allen – SUNY at Buffalo 2013

Derek J. Galatro – Fredericksburg – VCU 1997

Andrew Clayton Gibson – Mechanicsville – VCU 2014/2016
Hanna Gruzynska – Richmond – VCU 2013

Hanna O. Gruzynska – Richmond – Virginia Commonwealth University 2013

Darrell P. Guttery – Midlothian – University of Oklahoma 2012/Wake Forest University 2014

Malinda Husson – Richmond – West Virginia University 2002/DC VA Medical Center 2003/NY Mt. Sinai Medical Center 2006

Ajinder Kaur – Henrico – Baba Faird University (India) 2003/Truman Medical Center

Geetu Lagoo – Henrico – VCU 2014

Ruslan Maidans – Richmond – VCU 2014

David Malan – Richmond – VCU 2014

Antonio Ernesto Mauri – Richmond – VCU 2014/VA Hospital 2016

Danielle McCormack – Richmond – VCU 2014/2017

Kate Pereira McDonald – Richmond – VCU 2014

John Andrew Mustian – Richmond – VCU 2014

Viet D. Nguyen – Richmond – Virginia Commonwealth University 2013/Maimonides Medical Center GPR 2014

Kevin Michael O'Brien – Richmond – VCU 2014

James E. Puryear – Richmond – VCU 2014/2016
Erik Blake Roberts – Henrico – VCU 2014

Lisa Ann Turner – Midlothian – VCU 2014/2017

Chinh Long Van – Richmond – VCU 2014

Tiffany L. Williams – Richmond – University of NC Chapel Hill 2010/NC Medical Center 2011/VCU 2014

Piedmont Dental Society

Orlando J. Abreu-Fuerte – Blacksburg – Universidad Santa Maria (Venezuela) 2004/University of Puerto Rico 2012

David R. Brajdic – Roanoke – University of Pittsburgh 1984
Christina M. Dunkin – Danville – VCU 2014

Erin M. Farabaugh – Lexington – University of Maryland 2012

Lee B. Kreger – Roanoke – VCU 2013

Brandon Watkins Newcomb – Charlotte Court House – VCU 2014

Dustin S. Reynolds – Appomattox – WV University 2011/2013

Matthew K. Stephens – Salem – VCU 2014

Adam Clark Williams – Roanoke – VCU 2014

Myrna Odeth Gamez – Danville – Universidad Autonoma De Nuevo Leon (Mexico) 1998/AEGD 2013

Southwest VA Dental Society

Kevin M. Albert – Charlottesville – Ohio State 2014

Matthew Todd Ankrum – Blacksburg – WVU 1998/ MCV VCU 2003

Kathryn A. Biery – Harrisonburg – MCV VCU School of Dentistry 1985/ MCV VCU Dept. of Oral Surg/Anesthesia

Megan Elizabeth Lutz – Tazewell – VCU 2014

Richard M. Newton – Christiansburg – VCU/MCV 1984

Shenandoah Valley Dental Association

Kevin M. Albert – Charlottesville – Ohio State 2014

Matthew Paul Harrison – Charlottesville – VCU 2014/ UVA 2016

Young H. Lim – Luray – WV University School of Dentistry 1998

Jessica E. Burse Todd – Charlottesville – University of Tennessee 2014

John D. Roller – Crozet – VCU 2010

Welcome New Members

Continued

Mina M. Saif – Winchester – UMDNJ 2013

Richard W. Sedwick – Fishersville– VCU 2011

Northern VA Dental Society

Bushra Bhatti – Ashburn – Boston University 2011 (Certificate in Pediatric Dentistry, Masters of Science in Dentistry)

Kenneth Blais – Arlington – Tufts University 2007/Louisiana State University 2014

Kevin Andrew Brewer – Alexandria - Baylor College of Dentistry 2008/Oral and Maxillofacial Surgery 2013

Melody Butler – Centreville – Ohio State University 2014

Tarah Jocelyn Coleman – Bethesda, MD – VCU 2014

Truong Dong – Alexandria – VCU 2013/UCLA 2014

Robert P. Dziejma – Stafford – University of Connecticut School of Dental Medicine 1975

Keith Wallace Eldridge – Purcellville – VCU 2014

Parastoo Farhoodi – Fairfax – University of Southern California 1992

Lauren Gibberman – Alexandria – VCU 2014

Iris Hernandez – Lorton – NYU College of Dentistry 1993/Interfaith Medical Center 1995

Julia L. Jackson – Annandale – Temple University School of Dentistry 2005/Howard University Hospital 2011

Rajiv N. Kalra – Springfield – University of Florida 2014

Ji Won Kim – Falls Church – Buffalo University 2013/Faxton-St. Lukes Healthcare GPR 2014

SungHee Kim – Arlington – VCU 2012/DC-Children's National Medical Center 2014

Dima Lakkis – Arlington – Beirut University (Lebanon) 2006/Periodontics 2011

Jason Lam – Alexandria – VCU 2014

Rachel Lin – Fairfax – Ohio State University 2014

Frederick Liu – Fairfax – Columbia University 2004/2008

Adenike Ogunbekun – Chantilly – Nigeria/University of Lagos – Scotland/University of Glasgow 1983/AEGD 2007

Connie Oh – Annandale – Univerity of the Pacific Arthur A. Dugoni School of Dentistry 2011

Sachi D. Patel – Woodbridge – Howard University 2012/King's County Hospital Center 2013

Norachai Phisuthikul – Falls Church – NYU 2005/Rutgers 2009

Anna Sidor – Vienna – Rutgers 2009/Jersey Shore University 2014

Christine M. Stang – Reston – VCU 2010

Richard Yuang-Pay Sun – Reston – University of Illinois 1999

Huy C. Trinh – Annandale – NY University 2006/Washington Hospital 2011

Vinh Chi Trinh – Annandale – VCU 2014

Nicole Melissa Rivera Vargas – Herndon - University of Puerto Rico – School of Dental Medicine 2012/General Practice Residency 2013

Ansam A. Zaiber – Woodbridge – Howard University 2014

In Memory of:

Name	City	Date of Death
Dr. John Ames	Newport News	March 10, 2014
Dr. Mike Etessami	Vienna	June 19, 2014
Dr. Joel Gardner	Roanoke	February 15, 2013
Dr. Richard Gardner	Abingdon	May 27, 2014
Dr. Robert Hulbert	Sterling	June 12, 2014
Dr. Jack Hurley	Bluefield	July 31, 2011
Dr. Robert Lawrence	Lexington	January 22, 2014
Dr. Stephen Myers	Christiansburg	July 6, 2014
Dr. Michael Schulte	Stafford	November 12, 2013
Dr. Marion White	Richmond	October 11, 2011

Member Awards & Recognition

L-R: Dr. Lanny Levenson, Dr. Carl Atkins, Dr. A.J. Booker, Dr. Richard Bates, Dr. Scott Gerard, Dr. Tegwyn Brickhouse, Dr. Lawrence Kyle

2014 VDA Fellows

Virginia Dental Association

Send your "Awards & Recognition" submissions for publication in the *Virginia Dental Journal* to Shannon Jacobs, VDA Director of Communications Email: jacobs@vadental.org

UNITED STATES POSTAL SERVICE® Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

1. Publication Title	2. Publication Number	3. Filing Date
Virginia Dental Journal	0066-0300	September 29, 2014
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Quarterly	4	$12.00

7. Complete Mailing Address of Known Office of Publication (Not printed) (Street, city, county, state, and ZIP+4®): 3460 Mayland Court, Ste 110, Henrico, VA 23233 — Contact Person: Terry Dickinson; Telephone (Include area code): 804-288-5750

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printed): 3460 Mayland Court, Ste 110, Henrico, VA 23233

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)

Publisher (Name and complete mailing address): Virginia Dental Association - 3460 Mayland Ct., Ste 110, Henrico, VA 23233

Editor (Name and complete mailing address): Dr. Richard Roadcap - 3460 Mayland Ct., Ste 110, Henrico, VA 23233

Managing Editor (Name and complete mailing address): Shannon Jacobs - 3460 Mayland Ct., Ste 110, Henrico, VA 23233

10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)

Full Name	Complete Mailing Address
Virginia Dental Association	3460 Mayland Ct., Ste 110, Henrico, VA 23233

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☒ None

Full Name	Complete Mailing Address

12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☒ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)

PS Form 3526, July 2014 (Page 1 of 4 (see instructions page 4)) PSN: 7530-01-000-9931 PRIVACY NOTICE: See our privacy policy on www.usps.com

13. Publication Title: Virginia Dental Journal
14. Issue Date for Circulation Data Below: July 15, 2014

15. Extent and Nature of Circulation — Dental Periodical

			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)			4319	4420
b. Paid Circulation (By Mail and Outside the Mail)	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	3197	2983
	(2)	Mailed In-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	239	229
	(3)	Paid Distribution Outside the Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid Distribution Outside USPS®	0	0
	(4)	Paid Distribution by Other Classes of Mail Through the USPS (e.g., First-Class Mail®)	23	38
c. Total Paid Distribution (Sum of 15b (1), (2), (3), and (4))			3459	3250
d. Free or Nominal Rate Distribution (By Mail and Outside the Mail)	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541	271	273
	(2)	Free or Nominal Rate In-County Copies included on PS Form 3541	16	16
	(3)	Free or Nominal Rate Copies Mailed at Other Classes Through the USPS (e.g., First-Class Mail)	6	23
	(4)	Free or Nominal Rate Distribution Outside the Mail (Carriers or other means)	489	811
e. Total Free or Nominal Rate Distribution (Sum of 15d (1), (2), (3) and (4))			782	1123
f. Total Distribution (Sum of 15c and 15e)			4241	4373
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))			64	62
h. Total (Sum of 15f and g)			4305	4435
i. Percent Paid (15c divided by 15f times 100)			82	74

* If you are claiming electronic copies, go to line 16 on page 3. If you are not claiming electronic copies, skip to line 17 on page 3.

PS Form 3526, July 2014 (Page 2 of 4)

How do you want your future to look back at you?

How do you want your patients to look back at you in the future?
Do you know what your restorations are made of? And where?
Trusted quality name brand products, or just a generic knockoff?

“15 Year Limited Warranty on Lava Plus Full Contour Crowns”

“10 Year Limited Warranty on Lava Ultimate Crowns”

We are a Premier Lava Milling Center
Call for details on how we may help serve your restorative needs.

Custom designed
Custom Manufactured
Finished by hand
in Our Laboratory
Here in America

Baran Dental Laboratory

The Choice for Crowns, Bridges & Implants
4433-E Brookfield Corporate Drive, Chantilly, Virginia 20151
703.961.0116/800.941.4291

& Milling Center

Virginia Dental Journal

Virginia Dental Association
3460 Mayland Ct, Unit 110
Henrico, VA 23233

VISIT US ONLINE AT www.VADENTAL.org/PRO

Member Spotlight - Dr. Brenda Young

Giving Everyone Something to Smile About

By: Dr. Chris Spagna; Associate Editor, Component 8

Growing up, Brenda Young always knew that she wanted to practice somewhere in the field of medicine. The blend of interacting with others, helping them to feel better, working with her hands … it all seemed to make sense. But it wasn't until her college days that she decided to follow the path of dentistry rather than becoming a veterinarian. And looking back, she couldn't be happier with her choice.

Dr. Brenda Young graduated from James Madison University in 1982 and VCU Dental School in 1986. She maintains a private family practice in Fairfax, Virginia, and truly treasures every day - going in to see the patients she has for so many years. It's probably the combination of her big heart and the value she finds in these interpersonal relationships which has lead her to care for people far beyond her practice, volunteering to give back to a community she feels has been so supportive of her.

Dr. Young has been a member of both the ADA and VDA since her early days in dental school. She has been active on the local level serving as president of the Northern Virginia Dental Society (NVDS) as well as several positions on the executive board. Additionally, she has been part of the VDA Delegation for the past 15 years at the state level. She is a firm believer in organized dentistry and has worked to shape her profession for a brighter future. In addition to her dental volunteer efforts, she has served on the Lanier Middle School PTA, participated in the Susan G. Komen Race for the Cure and is involved with "Our Daily Bread", a volunteer-based organization focused on easing the plight of low-income residents in Fairfax County, by helping them maintain self-sufficiency. But of particular interest to Dr. Young, is the issue of access to dental care, which helped to inspire her to organize the Give Kids a Smile!® program for the NVDS many years ago.

On the first Friday in February, dental professionals from across the country provide free oral health care services to thousands of underserved children through Give Kids a Smile! (GKAS). A program of the American Dental Association, Give Kids a Smile! focuses on offering oral health education to all children while providing free preventive and restorative care to the kids that need it most. The very first year it took place in Northern Virginia, Dr. Young remembers a small group of volunteers who braved a fierce winter storm to see a van-load of about 20 children. To expand on the smaller confines of the Northern Virginia Dental Clinic, they set up additional portable chairs outside of the operatories where the volunteers could provide oral exams and education to these young children in need. Though the conditions might not have been ideal that snowy day, the smiles of those children were all anyone needed to ensure the longevity and success of this program.

And it has come a long way since. Over the past ten years, GKAS has grown substantially in our area and moved to the Medical Education Campus of Northern Virginia Community College. At this location they now see over 250 preschool children each year. The kids are referred by the Northern Virginia Dental Society, and are seen by local volunteer dentists, hygienists, and dental assistants for evaluations, cleanings, and sealants. Those children with advanced tooth decay receive on-the-spot treatment to fill or extract problematic teeth. Additionally, the Give Kids a Smile! program helps to highlight for policymakers the ongoing challenges that underserved children and children with disabilities face in accessing dental care.

"It's all about giving back" she says, "Dentistry has been great for me, and given me so much." And dentistry is sincerely grateful for people like Dr. Young; grateful for all the smiles she has given to so many in her community over the years.