Bulletin of the San Fernando Valley Dental Society

Dental Dimensions

www.sfvds.org

Summer 2013

SFVDS Meets With Assemblyman Bocanegra

- Guided Placement of Dental Implants
- Social Media Policies for the Dentist
- Implants for the Atrophied Posterior Mandible

You've built a practice as exceptional as you are. Now choose the optimum insurance to protect it.

TDIC Optimum

Anything but ordinary, Optimum is a professional bundle of products that combines TDIC's singular focus in dentistry, thirty years of experience and competitive multipolicy discounts. Creating the ultimate coverage to protect your practice, perfectly. And you wouldn't have it any other way.

TDIC Optimum Bundle

Professional Liability
Office Property
Workers' Compensation

Endorsed by
San Fernando Valley Dental Society

Protecting dentists. It's all we do.®

800.733.0633
tdicsolutions.com
CA Insurance Lic. #0652783

tdic®

DENTAL DIMENSIONS

Published by the San Fernando Valley Dental Society
9205 Alabama Ave., Suite B
Chatsworth, CA 91311
Office: (818) 576-0116
Fax: (818) 576-0122
E-mail: exec.sfvds@sbcglobal.net
Web Site: www.sfvds.org

Published quarterly by the San Fernando Valley Dental Society. The Society solicits essays, letters, opinions, abstracts and publishes reports of the various committees; however, all expressions of opinion and all statements of supposed fact are published on the authority of the writer over whose signature they appear, and are not regarded as expressing the view of the San Fernando Valley Dental Society unless such statement of opinions have been adopted by its representatives. Acceptance of advertising in no way constitutes professional approval or endorsement.

Graphics by: C. Stieger Designs

In This Issue

Summer 2013

Volume XLVII Number 3

Call for Submissions

Do you have an unusual case study or an interesting article you would like to have published? Dental Dimensions is looking for articles from our members so we can share our collective knowledge. Articles should be 500-1000 words withreferences where applicable and photos if possible. Send yoursubmissions to:
editor.sfvds@sbcglobal.net
or contact the dental society office at 818-884-7395

On The Cover.....

L-R SFVDS President, Nita Dixit, DDS; SFVDS Legislative Chair, James Mertzel, DDS; CA Assemblyman Raul Bocanegra; SFVDS Media Relations Chair, Jorge Alvarez, DDS (see story on page 7)

From the Desk of the Editor

Antitrust Laws-Do They Help Us or Hurt Us?

Antitrust laws were first enacted in the United States in 1890, although the history of competition law dates back to the Roman Empire. The purpose of antitrust laws is to promote competition in the marketplace. Competition lowers costs and this is beneficial to the public. Antitrust laws are enforced by the Federal Trade Commission (FTC) and the Department of Justice (DOJ). According to the Federal Trade Commission (FTC) website, "Competition in health care markets benefits consumers because it helps contain costs, improve quality, and encourage innovation".

There is a perception that antitrust laws have historically been used against us in dentistry, rather than for us. This is because federal regulators have aggressively pursued antitrust enforcement actions against health care providers. As a matter of fact, a landmark federal criminal case prosecuted against health care workers involved dentists in Arizona. In 1990, three dentists and their companies were found guilty of conspiring to raise the co-payment fees paid by members of four Tucson-area dental plans. Third party payors, on the other hand, have received relatively little scrutiny. Their actions to contain costs are viewed as beneficial because it results in lower costs to consumers. Penalties for antitrust violations are severe and can include up to 10 years in jail with fines of $1 million per violation for individuals and up to $100 million per violation for organizations. Aside from this, the cost of defense is usually exorbitant and not likely covered by malpractice or other types of insurance. Needless to say, treading on issues even remotely related to antitrust must be dealt with very carefully and judiciously in order to steer clear of any potential violations. The Sherman Antitrust Act , enacted in 1890 prohibits any concerted action that unreasonably restrains competition. The three main categories are "price fixing", "conspiracy to boycott" and "restraint of trade". According to the ADA's guide to antitrust laws in dentistry, the first rule of thumb in understanding the antitrust laws is that any action that results in increased prices also increases the risk of antitrust. "If the point of collective conduct is to stabilize or raise prices, the antitrust yellow flag is waiving". Remember, lowering prices and increasing competition is the purpose of antitrust laws. If two or more dentists compare fees and decide to charge the same fee for a procedure, it is called price fixing. If several dentists get together and decide they don't like the fee schedule an insurance company is offering and refuse to participate in that plan, it is considered conspiracy to boycott. There is no antitrust violation, however, if the dentists look at the same fee schedule and independently decide as individuals that they do not wish to participate. Nor is there a violation if the dentists are partners or part of a corporation. In these circumstances, the corporation or partnership is considered a single entity.

Restraint of trade violations are particularly problematic as evidenced by the FTC' investigation of the North Carolina Board of Dental Examiners. The FTC found that the North Carolina State Board of Dental Examiners illegally thwarted competition by taking actions to stop non-dentists from providing teeth whitening goods and services to consumers. The Commission claimed that The Dental Board's illegal actions led to higher prices and reduced choices for consumers. This decision was upheld by the 4th U.S. Circuit Court of Appeals on May 31, 2013. The initial complaint was filed in June 2010 and the case had been in litigation for three years.

Needless to say, antitrust violations are serious as well as expensive and time consuming to defend. Not only as organizations, but as individuals, we must be cognizant of any actions on our part that may violate antitrust laws. It may seem that our hands are tied and there is little that we can do. However, an important exception to the antitrust laws is the right for individuals and groups to collectively lobby government action, even if that action would harm competition, provided that the lobbying is in good faith. An important way we can exercise this right is by supporting Congressman Paul Gosar, a dentist from Arizona. Among other things, he has sponsored a bill, H.R. 911 which seeks to repeal the antitrust exemption afforded to health insurance companies by the McCarran-Ferguson Act.

The ADA has an excellent resource, "Antitrust Laws in Dentistry: A Primer of "Do's Don'ts and How To's", for dentists and dental societies". It can be found at www.dcdsny.com/pdfs/ members/antitrust_booklet_full.pdf.

Anita Rathee, D.D.S., M.P.H.
Editor, SFVDS

From the Desk of the President

Dear Friends,

I have a couple of things I would like to discuss in this issue of Dental Dimensions. One of them is the question of the upcoming cuts in the Premium Plan by Delta Dental. It hangs over our heads like the 'Sword of Damocles'. Delta has sent a letter to providers in Minnesota cutting their fees for the Premium Plan by an average of 7%.

Delta has cited the need to remain competitive in the marketplace as the reason for the cuts. SFVDS is taking steps to answer the question on the minds of all its members- why does CDA not start its own dental benefits plan? The CDA Dental Benefits Taskforce is also looking into this question. I will keep you updated as the situation develops. Meanwhile I would urge you to take a hard look at the profitability of the various plans in your office and make decisions based on your situation. Whatever you do, do not get together with your dentist friend next door and make joint decisions. As we all know, the anti-trust laws apply to dentists but not to the insurance companies. The charges could include conspiracy to boycott, restraint of trade and price fixing to name a few.

I attended an event sponsored by the Children's Health Partnership to highlight the pilot project of the Virtual Dental Home or Teledentistry completed by the University of Pacific. It is being touted as the solution to the access to care problem.

I see benefits in using the latest technology for information gathering by allied personnel in remote locations but draw the line when I hear about new codes being created to charge out examinations and placement of interim therapeutic restorations by trained RDAs and RDHs. It is supposed to reduce cost but have we not tried this before? There needs to be a study of how creating Registered Dental Hygienists in Alternative Practice (RDHAPs) has alleviated the access to care problem before we go barking up the same tree. A tightly controlled study in hardly remote areas such as at MEND in Pacoima and at Venice Dental Clinic does not mean that these trained auxiliaries will work in remote areas.

My personal feeling has always been that the emphasis should be on oral health education to help alleviate this problem. Some of you may have seen the Public Service Announcements (PSAs) created by the SFVDS Foundation on infant dental health in English and Spanish, and being aired on Time Warner Cable. You can watch them on You Tube - http://www.youtube.com/watch?v=TBFUAflgwVY or on the Foundation website- http://www.sfvdsfoundation.org. And for the latest news, become a friend at https://www.facebook.com/pages/San-Fernando-Valley-Dental-Society/57205805193.

The Foundation will be holding its first fundraiser on Oct. 26th at the Knollwood Country Club and I invite you to save the date to come and attend an evening of fun and camaraderie with your fellow members.

I hope all of you have a wonderful summer with your families and as always, please feel free to share any thoughts or ideas about the dental society with me.

Best wishes,
Nita Dixit, DDS

From the Desk of the Executive Director

Now that summer is half-way over, the first thing that pops into my mind is – How did we get here so fast? Somehow, it seems as though the cool weather was just last week, yet here we are, already averaging 90+ degrees, the kids are about to start school again and many vacations have already been taken.

But, as the saying goes, 'there is no rest for the weary', as the central office continues to work on the business of serving our members in a wide variety of ways. Staff are busy setting up and preparing for summer and fall membership events, while at the same time, making sure that the society's basic services and administrative functions continue unabated.

Zone meetings are planned for Glendale in August and 'CDA Presents' in San Francisco takes place early this year from August 15th through the 17th.

In September, a dental society outing to the Hollywood Bowl takes place to see and experience the Blue Man Group. We will also hold our second annual 'Afternoon Tea' to discuss and network about the unique challenges of being a female dentist. In addition, for the first time, we are hosting a 'Diversity Forum' to celebrate diversity not only within our component, but within organized dentistry as a whole. The leadership of all of the major ethnic dental societies have been invited to participate in a forum featuring top ADA, CDA and SFVDS leaders, who will discuss the rich diversity of the dental community and how we can all respect and work well with each other. Lastly, in September, Saj Jivraj D.D.S., MS.Ed, and Mamaly Reshad D.D.S, MSc, will present on 'Esthetic Implant Dentistry – From the Simple to the Most Complex'.

Come October, we have a number of events coming up that you won't want to miss. Early in the month, we'll have another 'Speed Pairing' event, where those looking to sell a practice will be brought together with those looking to buy a practice. We'll also host a zone meeting in Palmdale. Mid-to-Late month are the ADA annual conference in New Orleans, the third 'Schlep and Shred' of the year at the Chatsworth office and a CE meeting featuring Dr. Charles Wakefield speaking on whether all restorative materials are the same… or not! Then, on October 26, the SFVDS Foundation holds its first annual 'Masquerade and Costume' fundraiser at the Knollwood Country Club.

November brings the annual CDA House of Delegates meeting and December will showcase the society's Chatsworth office in our first ever, 'Holiday Social'.

Don't miss the opportunity to learn and network at these excellent events, so keep an eye on your emails for details as to the times and locations.

And, before you know it, I'll be sending my holiday greetings to everyone!

Andy

Legislation Report

AS DENTISTS, SHOULD WE CONSIDER BECOMING EMPLOYEES OF THE STATE?

By: Jim Mertzel, DDS

The Legislature of the State of California is concerned about the dental health of our indigent population. However the state fails to provide adequate compensation to health care providers to provide the necessary treatment. It appears that beginning in May, 2014, most adult dental services will be authorized under the Denti-Cal program. Presently there is no bill before the assembly or senate to reinstate the 10% reduction of the Denti-Cal fee schedule, or can we be so bold, to request a total restructuring of the fee schedule to come any-where close to help cover just the overhead expenditures of most dental offices.

In addition SB 809, the Controlled Substances Utilization Review and Evaluation System (CURES), is a bill which is designed to develop a sophisticated monitoring program to track individuals who use multiple sources to fill restricted drugs and to track prescribers who are overprescribing these drugs. The proposal by the legislators is to fund this program, not with the funds from the general fund, but by requiring a 1.16 percent licensure fee increase of the state board license fee for health care providers.

Consider this: If we were employees of the state we would be eligible to join the state public employees union. This would enable us to negotiate for increased fees, not subject to anti-trust laws and we could strike, if our demands were not met. State employees, legislators, university professors all received cost of living increases this year. -- just a thought!!!

Regarding other legislation:
AB 836 (Volunteer Retired Dentist) would reduce the number of CE units required to (60% of present requirements) 30 units for retired dentists who are providing free services to underserved patients.

SB 562 Proposed amendments to the Business and Professional Code to help define the responsibility of operators of mobile dental units and portable dental units.

AB 1174 (Virtual Dental Home) This is a two year bill sponsored by our local Assemblyman, Raul Bocanegra. This is to establish state funding to train Registered Dental

Continued on page 21

Trustees' Report

By: George Maranon, DDS

We are all receiving more and more of the information important to us online. CDA is making great strides to expand the number of ways members can receive information concerning the issues affecting their practice and actions of their association. All CDA publications are now available online in a new interactive format. Online offerings are also available for smart phones and tablets. This technology is unique to CDA and is a clear member benefit.

Dental benefits remain a major focus of CDA. A major concern is Delta Dental (Delta) of California's proposed decision to cut fees an expected average of 8 to 12 percent for its Premier product. CDA has made numerous attempts to intervene on behalf of dentists and challenge those reductions. Delta has not responded to those efforts. CDA leadership continues to evaluate all options to address the proposed fee reduction and lack of communication between Delta and their network of dental providers.

The California Dental Association Foundation has been hosting CDA Cares, free dental clinics to provide oral health services and education for underserved people at each event. The slogan for CDA Cares is "It's the best thing we do". The Foundation held the third CDA Cares free clinic and the first of this year on May 17- 19 in San Jose. Fundraising for the event reached the goal of $180,000. Nearly 2200 people received more than 11,324 procedures for an estimated 1.6 million dollars of pro-bono care. Care and services were provided by 1,658 volunteers over those two days. The next CDA Cares event is scheduled for December 7-8 in San Diego. I encourage all of our members to participate in the San Diego event. Sites are being identified for a possible 2014 Los Angeles/San Fernando Valley CDA Cares clinic. In addition, I hope that all members give their financial support to the CDA Foundation and choose to become a "Friend of the Foundation".

A ballot initiative is in the works by outside groups, including trial lawyers, to repeal the Medical Injury Compensation Reform Act (MICRA) and its cap of $250,000 on pain and suffering damages in cases involving medical malpractice. This cap has been in effect since 1975. CDA, along with Californians Allied for Patient Protection members, will be watching for the introduction of any legislation attempting to repeal MICRA and are developing strategies to resist changes to MICRA.

Continued on page 21

General Meetings - Preview

Esthetic Implant Dentistry – From the Simple to the Most Complex

Saj Jivraj D.D.S., MS.Ed, and Mamaly Reshad D.D.S, MSc

SEPTEMBER 18, 2013

2PM – 9PM Airtel Plaza Hotel, 7277 Valjean Ave., Van Nuys, CA 91406 818.997.7676

This course will systematically present the treatment concepts for the handling of single tooth gaps or extended edentulous spaces in the anterior maxilla. Emphasis will be placed on diagnosis and treatment planning. Important aspects of treatment planning, surgical procedures and prosthetic rehabilitation with provisional and definitive restorations will be presented, and the rationale discussed. *Sponsored by Nobel BioCare*

OCTOBER 19, 2013

Restorative Materials:
Is There any Difference,
or are They all the Same?

Charles W. Wakefield, DDS

2PM – 9PM Airtel Plaza Hotel, 7277 Valjean Ave., Van Nuys, CA 91406 818.997.7676

This lecture will review the confusing array of current restorative materials and the rationale for selection and clinical use of the most appropriate material in varying clinical situations. The confusion between marketing and evidence-based dentistry will be made clear. The application of color in dentistry, principles of smile design, and clinical restoration of cosmetic cases for the general dentist will be described and illustrated. ***Co-sponsored by Sybron Dental and Garrison Dental***

General Meeting Review

June 19, 2013
Dental Materials – An Update for the General Dentist
Ed Hewlett, DDS
Sponsored by GC America

Dr. Hewlett came back to update our membership on the newest dental materials and methods for using them most effectively. Attendees had a chance to ask questions about their own experiences and learned not only about new dental materials, but also a look at what is in the pipeline for the future.

SAVE THE DATE...

SEPT. 21	AFTERNOON TEA SOCIAL
SEPT. 21	DIVERSITY FORUM
OCT. 3	SPEED PAIRING-MISSION HILLS
OCT. 12	SCHLEP & SHRED-CHATSWORTH
OCT. 26	SFVDS FOUNDATION COSTUME PARTY FUNDRAISER
DEC. 13	SFVDS OPEN HOUSE/HOLIDAY SOCIAL

For more information on any of the events call the central office at (818) 576-0116

Recruit a new member, get $200

Dentists who refer a new member to the tripartite now can receive a $100 check from CDA and a $100 American Express gift card from the ADA.

The $200 total reward is part of the Member Get a Member campaign, which provides incentives for every member dentist who refers a new member to the tripartite membership (for a total of $1,000 maximum per referring member).

The combined campaign lasts through Sept. 30, after which time members will still receive $100 from CDA.
A growing tripartite means greater recognition for the dental profession, more resources and support for members and a stronger voice in the policy arenas of Washington D.C., Sacramento and locally.

To receive credit for a referral, an applicant must add the name of the member who referred them to membership on the standard membership application. The referring member may also enter the name of the dentist they referred on the recruiter's form at ada.org/MGAM. Once the referred member pays their dues, the referral incentives are mailed to the referring dentist.

There are many advantages to being a part of organized dentistry, but here are a few key benefits:

- Legislative advocacy;
- CDA Presents continuing education — free admission for the San Francisco and Anaheim meetings;
- TDIC insurance — member-only access and risk management hotline; Practice support services including ADA; and CDA publications.

Here are some tips on recruiting a new member:

- Seek any colleague who is not currently a tripartite member.
- Share the benefits and services of the ADA, CDA and local dental societies.
- Ask a colleague to include your name on the membership application or, better yet, give them an application with your name on it. Applications are available online at cda.org/mgm.
- To find out if a dentist is a current tripartite member, visit cda.org under "Find a CDA Dentist." In addition, updated nonmember lists are available through local component offices.

For more information on Member Get a Member, visit cda.org/mgm.

Dental Implants for the Atrophied Posterior Mandible – Important Considerations

In general dentistry, we encounter patients with missing mandibular molars and premolars on a daily basis. In fact, the mandibular first molar is the most common tooth to be replaced with a dental implant. Too often patients and dentists alike have settled for removable partial dentures due to a myriad of reasons. If the teeth are not replaced, many of these sites undergo substantial bone loss. Many of those patients continue without any type of replacement because of the increased discomfort of a lower removable partial with atrophy in the posterior segments.

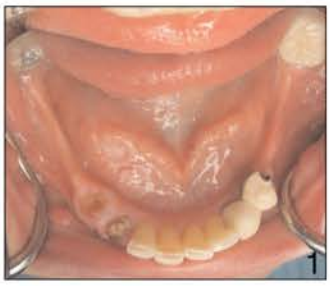
It is important for patients to understand that there are numerous options available to meet their specific needs. The benefits, risks, anatomic limitations, and financial commitments required for each option vary greatly.

Sufficient time should be devoted to asking patients about their expectations, rather than telling them what they need. What they are willing to endure to have fixed teeth is important since the atrophic posterior mandible can be fraught with risks, complications and unmet expectations.

Successfully treating the atrophied posterior mandible requires consideration of four areas: anatomy, surgical techniques, prosthetic restoration and digital workflow.

ANATOMIC CONSIDERATIONS:

As teeth are lost, bone is atrophied in multiple dimensions. It is very common to see knife-edge posterior ridges from the distal of the canine extending to the third molar area. In addition to horizontally deficient knife-edge ridges, bone is also lost in a vertical dimension in the posterior mandible. This causes excessive inter-occlusal space if the maxillary teeth do not supra-erupt. As bone is lost, the edentulous mandibular posterior ridge crest assumes a more lingual position.



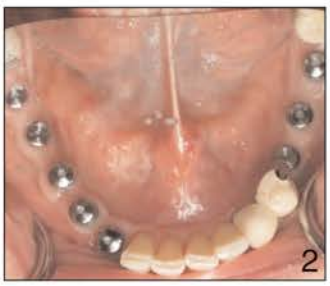


Figure 1 Knife-edge Ridges
Figure 2 Eight Implants in Knife-Edge Ridges

A substantial, steep undercut in the lingual posterior mandible is often seen due to the placement of the submandibular gland. It is crucially important in evaluating available vertical bone to understand this anatomic area. If this fossa is underestimated, dental implants can perforate the lingual plate. Surgical drills can easily enter vital structures such as the lingual artery and cause a rapid, life threatening hemorrhage. In addition, the large facial artery becomes more relevant in the presence of bone loss. It traverses the mandible in the area of the lower first molar. The lingual nerve also travels in this fossa.

The submandibular fossa undercut may be very steep. This will limit the length of the implant. This often changes the trajectory of the mandible. If the bone is leaning in one direction and the implants need to go in a different direction, surgical misadventures are more likely to occur.

The inferior alveolar nerve (IAN) is a main concern for patients and dentists. As the bone ridges become more atrophied, the nerve appears to be artificially more superficial in its position. The IAN is often bifurcated, sometimes trifurcated, splitting off into more than one nerve. This has become more apparent as 3-D cone beam scans have been used on a more regular basis. The additional branch nerve is usually more superficial than the main branch.

If dental implants are placed into, or near the nerve it often results in a paresthesia, dysesthesia, or complete total anesthesia. This may be temporary or permanent. This alone has paved the way for substantial litigation despite informed consent.

A safe zone of 2 mm is recommended when placing implants near the inferior alveolar nerve. Most dental implant manufacturers provide drills which are 1 mm longer than stated. This often ignored fact is often a contributing reason why the IAN becomes damaged during placement into areas of bone loss.

Fortunately the posterior atrophic mandible is usually only severely deficient in width or height. It does not typically present with both severe vertical and horizontal ridge deficiencies. If there is severe horizontal bone loss, the vertical bone loss is usually milder in nature. Of course, there are many cases where the bone is atrophic in all dimensions.

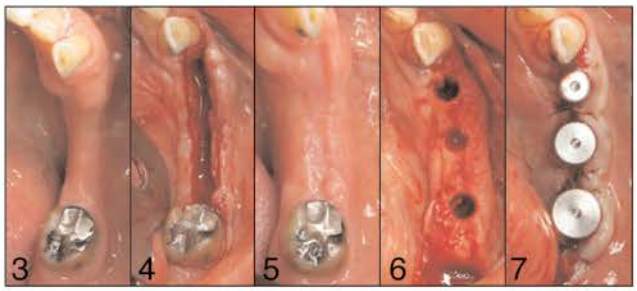
SURGICAL TECHNIQUES FOR DENTAL IMPLANTS IN THE ATROPHIC POSTERIOR MANDIBLE:

- Short dental implants for vertical bone loss
- Narrow diameter implants
- Horizontal/ Vertical bone grafting
- Alveoloplasty to reduce a thin ridge until it widens anatomically
- Inferior alveolar nerve repositioning

Continued on page 11

- Titanium mesh reconstruction
- Block bone grafting
- Vascularized pedicled bone grafts (ridge splitting)
- Guided bone regeneration (GBR)
- Segmental osteotomies
- Distraction osteogenesis
- Prosthetic design avoiding area of bone loss (i.e. cantilever)

Horizontal bone grafting is not just limited to block bone grafting with rigid fixation bone screws. Ridge splitting (vascularized pedicled bone flap) is an effective technique for widening knife edge ridges. In this technique, the tissue is not reflected. The buccal wall of bone is out-fractured leaving the lingual plate intact. The trough created is filled with particulated allograft and covered with a collagen membrane. The author uses this technique routinely to gain 6-12mm of width.



(Figure 3-7) Vascularized pedicled bone flap–ridge splitting of thin ridge

Bone grafting of the posterior mandible can be done before or during placement of implants. It is recommended to always keep a minimum of 1 to 2 mm of bone facial to the implant platform. If grafting is done during implant placement, a slow resorbing graft material should be placed on the facial if GBR is being done simultaneously.

The purpose of a thicker buccal plate is to provide long-term stability to the crestal bone and free gingival margin. If the facial crestal bone is thin, it commonly resorbs within 1 to 3 years after dental implant placement. This alone contributes to most peri-implant disease because the tissue recedes and facial crestal bone is lost. This occurs in all implant types whether they are one piece, two piece, internal hex or Morse taper. All implants should have an abundance of facial bone for long term crestal bone health.

Bone grafting in the posterior mandible is complex due to muscle pull from the facial and lingual tissues. This is compounded with a thin band of keratinized tissue which (typically) is left behind after teeth are extracted. Dehiscence of the surgical site with major grafting such as titanium mesh reconstruction or onlay block bone grafts is common because of this muscle pull. Good surgical technique and patient compliance are key factors in bone graft success in the posterior mandible. Removable stayplate temporaries are contraindicated and may not be worn during the process as they often cause wound dehiscence.

Inferior alveolar nerve repositioning is an option when few other options exist. With the advent of piezo-electric bone instrumentation, this once daring and risky procedure has become safer for patients who desire teeth at all cost and risk. In this procedure, the IAN nerve bundle is removed from the alveolus and moved out to the buccal tissue. This creates more vertical height as the nerve is no longer in the way. The author uses this technique and has found patients have no permanent paresthesia.

Nerve repositioning (photos)

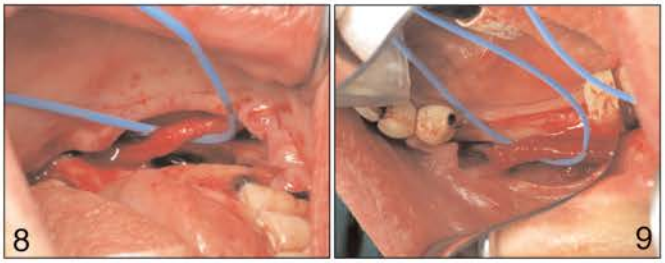


Figure 8 Left IAN removed from bone
Figure 9 Right IAN shown branching to mental nerve

Figure 10 Implants placed into IAN repositioned atrophic mandible

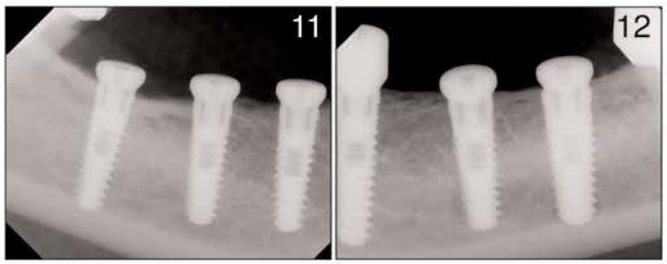


Figure 11 Implants placed after IAN repositioned
Figure 12 Implants placed after IAN repositioned

Continued on page 12

Dental Implants for the Atrophied Posterior Mandible – Important Considerations

Continued from page 11

PROSTHETIC CONSIDERATIONS FOR THE POSTERIOR ATROPHIC MANDIBLE

Limited inter occlusal space considerations:

- Screw retained restorations to increase retention
- Splinting of prosthetics for increased retention
- Use of monolithic materials such as gold or full contour zirconia. (Monolithic materials recommended because fracture of the restoration is common.)
- Difficulty in seating-single units are difficult to seat due to small interproximal contacts (splinting recommended)

Excessive inter occlusal space considerations:

- Excessive crown to root ratio
- Splinting short implants
- Food impaction into vestibule
- Gingival contour (long crowns)
- Large embrasures
- Long and flat proximal contacts
- Gingival colored ceramics in place of long crowns
- Lack of interdental papillae

Occlusal concepts for the atrophic posterior mandible should also consider the force of function. If small, short implants are used and the opposing dentition is natural teeth or implants, light centric contact is suggested. Avoid steep inclines and lateral interferences. If the implants are overloaded, crestal bone loss usually results. Fracture of prosthetic veneering porcelain is common. Monolithic materials should be considered in this area of high function and low esthetics. Lingualized prosthetic positioning due to bone atrophy is a common outcome if horizontal overlap is not considered. This often creates teeth with facial cantilevers.

Placement of implants at least 8mm in length in the mandible is recommended. When implants are 8mm or less, an increased number of implants should be used to bear the loads of this large space. For example, if tooth 29 -31 were missing and there was only space for placement of 3.7mm diameter x 8mm implants, it would be best to place three short, narrow implants splinted as opposed to two implants with a bridge, or three individual crowns. The bite force transferred to the crestal bone will be more evenly distributed in this manner.

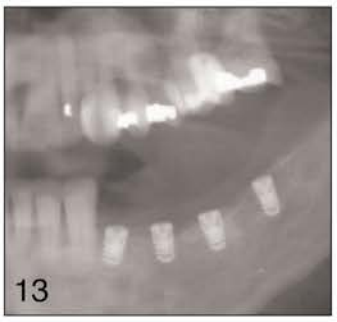


Figure 13 Short implants, splinting recommended

USE OF DIGITAL TECHNOLOGY WHEN TREATING THE ATROPHIC POSTERIOR MANDIBLE

Surgical guides with three-dimensional analysis (cone–beam computerized tomography or CBCT) have opened up options that may have not existed in the past. Digital workflows truly allow a "crown down" diagnostic approach. 3D evaluation may allow for implants to be placed non-ideally into limited available bone and corrected by the use of CAD/CAM custom abutments. A common problem exists in that virtual implant/bone graft surgery and true surgery do not always coincide. Corporate manufacturers have placed great emphasis on this technique. However, those experienced with using stereolithographic guides have found there may be more risk in using the guide for depth control in the atrophic posterior mandible. Many drill guides are difficult to stabilize in the mouth. Because surgical irrigation is inhibited while drilling through a guide, bone may be easily overheated causing a zone of necrosis and subsequent implant failure.

The evolution of lab designed CAD/CAM abutments is helpful in the bone deficient posterior mandible. If the implants are well placed and there is normal occlusal relationship, stock prefabricated abutments will be acceptable in most scenarios. However, excessive inter-occlusal space creates retention issues when the crowns are long and stock abutments are too short. Alternatives include using longer custom abutments for cement retention or choosing a screw-retained prosthesis.

CAD/CAM custom abutments are stronger for the posterior mandible and have better prosthetic fit than their gold cylinder casted counterparts. Miscasting within the prosthetic connections is eliminated. Tissue contours can also be idealized. Tiny screws used for multiunit abutments can often be avoided with CAD/CAM abutments the posterior mandible thereby lessening the chance of screw fracture/loosening.

Titanium abutments are the material of choice for the posterior mandible because aesthetics is typically not a concern. If zirconia abutments are to be used in the posterior mandible the author strongly suggests a metal interface between the platform and the abutment. Friction from zir-

Continued on page 13

By: Ramsey Amin D.D.S.

conia versus titanium at the interface has been shown to wear down the internal aspect of the titanium implant due to micro-motion. A zirconia interface should be avoided in the posterior region.

CONCLUSIONS: Moderate to severe posterior mandibular atrophy can be successfully treated with dental implants and fixed prosthetics. The atrophied posterior mandible poses unique anatomical challenges. These challenges must be treated with unique surgical techniques that often stray from the norm. When planning fixed restorations for the atrophied mandible, limited and excessive inter-occlusal space pose restorative concerns. These concerns are best addressed in the pre-surgical phase. Lastly, the use of digital technology increases safety and expands surgical and restorative options that may not have existed in the last decade.

*all photos and x-rays are dentistry performed by Ramsey Amin, DDS, DABOI, FAAID

Citations

Basa, Selcuk, Altan Varol, and Neslihan Turker. "Alternative bone expansion technique for immediate placement of implants in the edentulous posterior mandibular ridge: a clinical report." The International Journal of Oral & Maxillofacial Implants 19.4 (2004): 554

Mizbah, K., et al. "The clinical relevance of bifid and trifid mandibular canals." Oral and Maxillofacial Surgery 16.1 (2012): 147-151

Parnia, Fereidoun, et al. "Tomographic volume evaluation of submandibular fossa in patients requiring dental implants." Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology 109.1 (2010): e32-e36

Worthington, Philip. "Injury to the inferior alveolar nerve during implant placement: a formula for protection of the patient and clinician." The International Journal of Oral & Maxillofacial Implants 19.5 (2004): 731

Winkler, Sheldon. "Implant site development and alveolar bone resorption patterns." Journal of Oral Implantology 28.5 (2002): 226-229

Misch, Carl E. Contemporary implant dentistry. Mosby, 2007

Chrcanovic, Bruno Ramos, and Antônio Luís Neto Custódio. "Inferior alveolar nerve lateral transposition." Oral and Maxillofacial Surgery 13.4 (2009): 213-219

Taylor, Thomas D., Urs Belser, and Regina Mericske-Stern. "Prosthodontic considerations note." Clinical Oral Implants Research 11.s1 (2000): 101-107

Stimmelmayr, Michael, et al. "Wear at the titanium–titanium and the titanium–zirconia implant–abutment interface: A comparative in vitro study." Dental Materials (2012).

Dr. Amin maintains a surgical and restorative implant dentistry practice in Burbank. He performs all related procedures, such as bone grafting and complex dental reconstructions. He is a Diplomate of the American Board of Oral Implantology/Implant Dentistry (ABOI/ID) as well as a Fellow of the American Academy of Implant Dentistry. He has placed and restored thousands of dental implants over the course of 14 years.

THANK YOU!

The San Fernando Valley Dental Society Foundation wishes to thank the following 2013 financial contributors.

FRIEND OF THE FOUNDATION

Dr. Mehran Abbasian • Dr. Nita Dixit • Dr. Afshin Mazdey • Dr. Gib Snow
Furness & Associates Accountancy Corporation • San Fernando Valley Dental Society

CONTRIBUTOR

Pair Orthodontics

DONOR

Dr. Tomothy Buckley • Dr. Miriam Buenaventura • Dr. Allan Forrest • Dr. Gerald Gelfand
Dr. Alan Lewis • Dr. Franklin Niver • Dr. Karen Zak Kent

OTHER

Dr. Edward Baker • Dr. Vladislav Viksman • Dr. Kevin Ju • Dr. Thomas Lee • Dr. Carolina Mendoza • Dr. Jorge Montes
Dr. Kay Murakami • Dr. Melissa Nabors • Dr. Mark Shimizu • Dr. James A. Pasternak • Dr. Carrie Riley • Dr. Fred Weiner

Please join your colleagues in supporting the SFVDS Foundation as it begins its programs of oral health literacy and free restorative services to low/no income adults and seniors who have no insurance, and do not qualify for any other forms of assistance. Please use the form below to send in your tax-deductible donation and to volunteer to help deliver much needed services to the adult and senior populations. Please also mark you calendars and attend the foundation's first annual costume fundraiser at the Knollwood Country Club on Saturday, October 26, 2013.

Contribution Form

(All contributions to the SFVDS Foundation are tax deductible, charitable contributions.
You will receive a confirmation letter for your tax records)

Name:_____

Contact phone and/ or email:_____

❒ $5,000 Founding Member* ❒ $2,500 Sponsor* ❒ $1,200 Friend*
❒ $500 Supporter ❒ $250 Contributor ❒ $100 Donor

❒ Enclosed is my check (Payable to: San Fernando Valley Dental Society Foundation)

❒ Charge my credit card #_____
(Visa, M/C, Discover only)

Exp Date:_____ Sec Code:_____ Street number of billing address: _____ Billing address Zip Code_____

_ * Initial here _____ if you would prefer to have your 'Founding member', 'Sponsor' or 'Friend' level donation charged to your credit card in 12 equal monthly installments.

I would also like to volunteer to:

❒ Provide Triage Screening for Adults and the Elderly ❒ Provide emergency care in my office
❒ Provide screening for GKAS ❒ Follow-up care for GKAS
❒ Help with Fundraising ❒ Join a Foundation Committee

Once completed, please fax/email/mail this form to the foundation office at (818) 576-0122. exec.sfvds@sbcglobal.net or SFVDSF, 9205 Alabama Ave., Ste B, Chatsworth, CA 91311

Guided Placement of Dental Implants: an Introduction for the General Dentist

By: Ryan J. Monti, Ph.D., D.D.S.

Approximately two-thirds of U.S. adults are missing one or more permanent teeth. Dental implants have proven to be a predictable and successful long-term treatment strategy to address partial or complete edentulism. Recent meta-analyses have confirmed that survival rates for implants supporting single crowns are about 97% at 5 years and 95% at 10 years [1], and for implants supporting fixed partial dentures are about 95% at 5 years and 93% at 10 years [2]. These survival rates have remained consistent over the last decade with no measurable variation between implant manufacturers. General features of the macro- and micro-morphology of implants that vary between implant manufacturers and product lines may, however, play a role in the primary stability of an implant, and therefore the timeline for restoration[3]. These data suggest that dental implant design and manufacturing have reached a point of technological maturity.

As a result of the maturity of this technology, the success or failure of an implant for a particular patient is largely attributable to patient or provider variables. Similar to endodontic treatment, extractions, or removable prosthetics, the evolution of implant treatment has progressed to a point where adequately prepared general dentists can treat selected patients. One major hurdle to broader integration of implant surgery into General Dentistry practices is the perception that proper visualization of the boundaries of the alveolus always requires flapped surgery. The use of an appropriately designed and fabricated surgical guide can eliminate the need for flap elevation in many patients.

A major paradigm shift in the treatment planning of dental implants has resulted from the advent of affordable cone-beam computed tomography (CBCT) imaging machines. CBCT studies allow accurate [4] pre-operative visualization of the dimensions of the alveolus and precise three-dimensional measurement of the positions of any structures contained within (e.g. nerves or sinuses). This ability to non-invasively screen patients for possible anatomical considerations is the first step in the selection of patients that may be appropriate for treatment by general dentists.

Some authors have gone as far as suggesting that CBCT studies are the standard of care in implant treatment planning [5]. However, having a CBCT study does not guarantee a simple surgery or desirable outcome. The full utility of CBCT studies for implant surgery can only be realized when they are used to digitally plan implant surgeries and produce a surgical guide that restricts the placement of those implants. Consider the difference between pre-operative CBCT studies with vs. without a guide as being analogous to making a long trip after reading a map vs. having turn-by-turn directions. The use of a guide makes predictable flapless implant surgery possible.

This review will provide an overview of the principles of surgical guide design and fabrication, a summary of major guide manufacturers and their key features, the benefits and limitations of using surgical guides, and a brief introduction to a guide-based surgical protocol. Tischler and Ganz [6-8] have published a more comprehensive guide to the clinical details of the placement of dental implants that is a good introduction for general dentists.

TYPES OF GUIDES

D'Souza and Aras [9] have performed a recent review of the wide variety of fabrication protocols and designs for surgical guides. They present a conceptual delineation between guide types that allows the categorization and assessment of current and future surgical guides. An understanding of these categories will aid dentists in choosing a surgical guide system appropriate to their goals and level of training.

Non-limiting guides provide information to the surgeon about the position of the planned prosthesis, and thereby the point at which the implant must emerge from the gingiva. However, they do not inform or control the angle or depth of the osteotomy and do not convey any information about the acceptable positioning of the implant within the alveolus. These guides are the simplest to fabricate, typically consisting of a vacuum-formed shell from a diagnostic wax-up or duplication of an existing prosthesis. Surgical exposure and visualization of the alveolus is necessary for the appropriate application of this type of guide.

Partially limiting guides attempt to provide control of the angle of the osteotomy, and frequently include depth control as well. The fabrication of these guides is again based on the planned prosthesis, but incorporates some radiographic data into the planning of the drilling angle. The accuracy of these guides is heavily dependent on the accuracy with which the radiographic data can be transferred. Because many are based on periapical or panoramic radiographs, the buccolingual angula-

Continued on page 16

tion of the osteotomy cannot be based on radiographic anatomy. Surgical exposure and visualization of the alveolus may be necessary for the appropriate application of this type of guide.

Fully limiting guides provide control of the depth and angle of the osteotomy throughout the surgery, and frequently can provide control of the placement of the implant in the osteotomy. These guides are always based on three-dimensional imaging studies, typically CBCT. They are fabricated using CAD/CAM processes, allowing precise positioning of the guide tubes based on the planned final position of the implant within the alveolus. For providers interested in performing flapless implant placement, fully limiting guides are the only appropriate choice. When used correctly, these guides can accurately transfer the planned implant position to the patient[10-12]. The remainder of this review will focus on these guides.

TABLE 1

Manufacturer	Compatible with:	Limiting	Supports Manufacturers Drills	Full drilling sequence through guide
BioHorizons (formerly Implant Logic)	Proprietary	Partial	N/A	No
Cybermed In2Guide	Universal	Fully	No	Straight-walled implants only
Dentsply Facilitate (Astra) ExpertEase (Ankylos andXiVE)	Proprietary[1]	Fully	N/A	Yes
iDent iGuide	Universal	Partial	No	No built-in depth control
Keystone Dental Easy Guide	Universal (pilot only)	Partial	No	No
Materialise Dental	Universal	Fully	Yes	Yes
MIS MGuide	Proprietary	Fully	N/A	Yes
Nobel Biocare Nobel Guide	Proprietary	Fully	N/A	Yes
Zimmer Dental Zimmer Guide	Proprietary[1]	Fully	N/A	Yes

Table 1: A summary of major surgical guide manufacturers listing implant compatibility, guidance category, support for implant manufacturers drills (for third-party manufacturers), and whether the full drilling sequence can be performed through the guide. This table is based on publicly available information from the guide manufacturers.

[1] guides are produced by Materialise Dental

Table 1 summarizes the key features of the guides produced by the major manufacturers of CBCT-based surgical guides. All of these guides are fabricated based on the virtual placement of an implant within a CBCT data set, and therefore have the potential to fully restrict the drill when performing an osteotomy. Three popular systems that are not fully limiting are included for comparison. Two of these systems (Biohorizons and Keystone) are "pilot" systems. The guide fully restricts a 2.0 mm drill, but the guide is removed for the completion of the osteotomy. The third (iDent) fully restricts the angle of all drills in the sequence, but does not include default depth control.

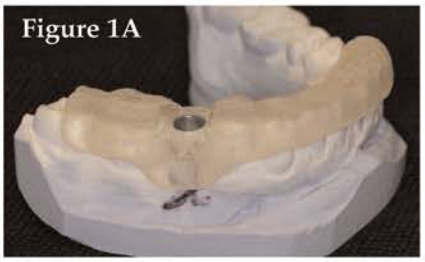
General principles of design and fabrication

The design of all fully-limiting guides follows a similar sequence. For patients with sufficient remaining teeth to stabilize the guide intra-operatively, a single CBCT study is performed. Some guide manufacturers require a scan prosthesis to be in place during the CBCT to facilitate registration of digital and physical models. For edentulous patients, or those whose remaining dentition will not provide at least tripod support, a dual-scan protocol is followed. The patient is scanned wearing a well-adapted removable prosthesis with radiopaque markers attached, or a radiopaque duplicate of the prosthesis. The prosthesis is then scanned alone. The two CBCT data sets are registered and merged and the prosthesis is used as the template for the surgical guide.

The CBCT data are imported into a guide planning software program specific to the manufacturer. Digital implants are superimposed on the CBCT data, and can be adjusted to orient them in an ideal position. Most software packages include

Continued on page 17

implant libraries that allow realistic outlines of the planned implant to be displayed, allowing correct positioning of the implant to include a consideration of the implant design.



From these data sets the guide is manufactured, most commonly by sterolithographic printing or computer-aided machining of a lab-fabricated guide. A metal guide cylinder is placed into the guide opening. Figure 1A shows a basic tooth-supported surgical guide designed for the placement of an implant in the tooth #29 position. This guide was generated by a sterolithographic printing protocol by Materialise Dental.

Figure 1B shows a schematic cross-section of the guide in place. In a flapless protocol, the base of the guide does not rest on the crest of the bone. As a result, the length of the drills used in a guided surgery must account for the distance from the top of the guide cylinder to the crest of the bone. Not shown is the drilling collar required to close the diameter between the cylinder and the drill.

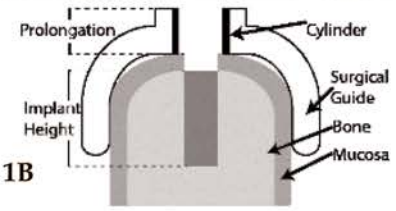


Figure 1B

Clinical procedures

Briefly, the patient, operatory, and surgical team are prepared as appropriate for an aseptic surgery. The guide is tried in place and a correct and stable fit is confirmed. Some systems include a tissue punch designed for use with the guide. Alternatively, the gingiva may be marked through the guide and then the guide removed to allow use of a standard tissue punch of an appropriate diameter. The tissue plug is removed with a curette. The guide is returned to the patient's mouth, and the first drill in the manufacturer's recommended sequence is used. All guides require a drilling collar that has inner and outer diameters matched to the drill and guide cylinder. The design of these collars varies between manufacturers. All depth-controlling systems have a stop that is built into the drill. The drill is simply carried to length with the collar properly seated in the guide, and the osteotomy will be at the planned position.

After the first drill is used, a periapical radiograph may be taken to confirm the angle of the osteotomy. However, because the data set used to plan the guide is more comprehensive than a periapical film, this step is not mandatory in a fully-guided protocol. The drilling sequence is completed according to the implant manufacturer's protocol. The implant may be placed with a carrier designed for use through the guide or the guide may be removed and the implant placed in the osteotomy site. A final periapical film is used to confirm the crestal position of the implant and any adjustments are made.

Limitations

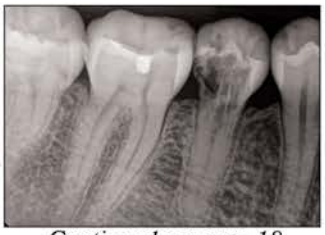
There are a number of circumstances under which treatment with a flapless approach is not appropriate. Inadequate vertical or horizontal bone dimensions requiring grafting, immediate implant placement into areas with significant interproximal or periapical bone loss, or cases requiring transposition or grafting of keratinized mucosa are all contraindications to flapless surgery. However, even in these circumstances, the use of a guide by an appropriately trained surgeon can simplify the implant placement portion of the treatment by restricting the osteotomy to a position that may be otherwise difficult to achieve by freehand drilling.

The primary limitation to the use of surgical guides is the maximum distance to the opposing arch over the surgical site. Because of the prolongation of the drills to account for the height of the guide cylinder, patients with limited opening can be more difficult to treat. One option is to use a guide that allows the drill to be placed laterally into the guide. This reduces the necessary clearance by the 5-7 mm height of the guide cylinder. Another option is to reduce the length of the implant being placed. Recent data indicate that there is little or no benefit to implant lengths greater than 11 mm, and that implants as short as 8-9 mm can have high rates of success in some locations[13].

Clinical Example

Figures 1-3 outline the replacement of tooth #29. An otherwise healthy 38 year-old female presented with a severe internal resorptive defect of this tooth (Figure 3A), rendering it non-restorable. The tooth was extracted without complication and an allograft was placed into the extraction site and covered with a resorbable membrane. After 10 weeks of healing, a periapical radiographic showed good bone density and maturation at the graft site.

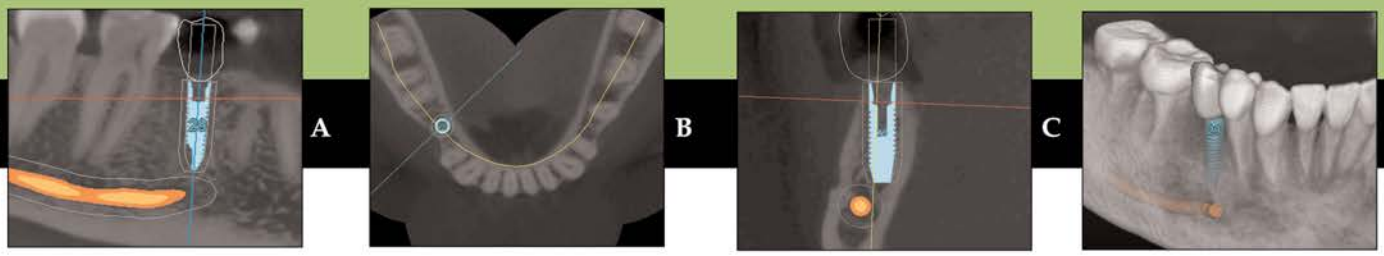
Figure 3A



Continued on page 18

 Continued from page 17

Figure 2



The patient had a natural narrowing of the mandible in the premolar area (see the are of #20-21 in Figure 2B). This narrowing of the mandible and the desire to use a screw-retained restoration required precise position and angulation in the buccolingual direction. The proximity of the inferior alveolar nerve and mental foramen were additional considerations. The CBCT data shown in Figure 2 were used to fabricate the surgical guide shown in Figure 1A. The implant surgery was completed without complication and with an operative time under ten minutes. Figure 3B shows the post-operative film confirming the crestal height of the implant prior to placement of the healing abutment.

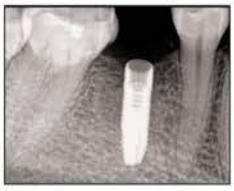


Figure 3B

Conclusion

The advent of affordable CBCT machines has made the use of these studies an indispensible part of implant treatment planning. Furthermore, the combination of CBCT studies with physical representations of the dental arch allow the fabrication of fully-limiting surgical guides. The use of these guides makes implant placement a fast and predictable procedure for many patients. The reduction of surgical trauma and avoidance of vital structures made possible by these guides reduces the incidence of significant post-operative complications. General dentists choosing to perform flapless implant placement surgeries using a surgical guide based on CBCT data can be confortable that they are providing treatment that exceeds the standard of care.

References

1. Jung RE, Zembic A, Pjetursson BE, Zwahlen M, Thoma DS. Systematic review of the survival rate and the incidence of biological, technical, and aesthetic complications of single crowns on implants reported in longitudinal studies with a mean follow-up of 5 years. Clinical Oral Implants Research. 2012 Oct;23 Suppl 6:2–21.
2. Pjetursson BE, Thoma D, Jung R, Zwahlen M, Zembic A. A systematic review of the survival and complication rates of implant-supported fixed dental prostheses (FDPs) after a mean observation period of at least 5 years. Clinical Oral Implants Research. 2012 Oct;23 Suppl 6:22–38.
3. Elias CN, Rocha FA, Nascimento AL, Coelho PG. Influence of implant shape, surface morphology, surgical technique and bone quality on the primary stability of dental implants. J Mech Behav Biomed Mater. 2012 Dec;16:169–80.
4. Maloney K, Bastidas J, Freeman K, Olson TR, Kraut RA. Cone Beam Computed Tomography and SimPlant Materialize Dental Software Versus Direct Measurement of the Width and Height of the Posterior Mandible: An Anatomic Study. YJOMS. Elsevier Inc; 2011 Jul 1;69(7):1923–9.
5. Curley A, Hatcher DC. Cone beam CT--anatomic assessment and legal issues: the new standards of care. J Calif Dent Assoc. 2009 Sep;37(9):653–62.
6. Tischler M, Ganz SD. The "first implant": protocol for the GP part 2, utilizing CT guides. Dent Today. 2011 Oct;30(10):132–134–7.
7. Tischler M, Ganz SD. The "first implant": protocol for the GP, Part 3. Dent Today. 2011 Dec;30(12):64–66–68–9.
8. Tischler M, Ganz SD. The "first implant": protocol for the GP part I, treatment planning. Dent Today. 2011 Aug;30(8):64–66–68–9.
9. D'Souza K, Aras M. Types of Implant Surgical Guide in Dentistry: A Review. Journal of Oral Implantology. 2012 Oct 2;38(5):643–52.
10. Platzer S, Bertha G, Heschl A, Wegscheider WA, Lorenzoni M. Three-Dimensional Accuracy of Guided Implant Placement: Indirect Assessment of Clinical Outcomes. Clin Implant Dent Relat Res. 2011 Dec 15.
11. Van Assche N, Quirynen M. Tolerance within a surgical guide. Clinical Oral Implants Research. 2010 Apr 1;21(4):455–8.
12. Van Assche N, Vercruyssen M, Coucke W, Teughels W, Jacobs R, Quirynen M. Accuracy of computer-aided implant placement. Clinical Oral Implants Research. 2012 Oct;23 Suppl 6:112–23.
13. Annibali S, Cristalli MP, Dell'Aquila D, Bignozzi I, La Monaca G, Pilloni A. Short dental implants: a systematic review. J. Dent. Res. 2012 Jan;91(1):25–32.

Ryan J. Monti, Ph.D., D.D.S. is a General Dentist in private practice in Valencia, CA. His practice covers all areas of dentistry for adults. He earned his Ph.D. in Physiological Science and his D.D.S. from UCLA, and has served as a Lecturer at UCLA and Harvard. Dr. Monti lives in Valencia with his wife, Amy, a Pediatric Dentist, and his two children. Dr. Monti can be reached at: drmonti@thedentist.com

Experts weigh in on dental practice social media policies

By: CDA Practice Support Center

Dental patients are online and use that forum to share their experience whether dentists choose to embrace social media or not – that is the reality in today's Internet age.

A dentist's online reputation and presence can be powerful marketing tools, both personally and professionally, and platforms such as Google Places, Facebook Places, Yelp and Foursquare have grown at exponential rates in recent years. With an online presence comes responsibility and the possibility of negative reviews, however. The best way to protect a dentist's online reputation is for them to have a proactive and engaged online presence.

That starts with a practice developing a social media policy for the office, says Patrick Barry, CEO of CDA Endorsed Program Demandforce.

"The dentist has to be the one to set up the practice's social media policy," Barry said. "If there is a partnership, the partners should have a discussion about it. Whomever the business owner is should be in charge of the policy."

Barry said a dental practice should treat a social media policy like any other internal policy and that it needs to be agreed upon by all partners and staff.

Here is what Barry says should go into a social media policy:

- who is going to manage the practice's social media presence;
- how much the dentist(s) wants to participate in the posting of content;
- what social media sites and services the practice will participate in; and
- what subject matter is appropriate.

Subject matter is key, says Sherry Mostofi of Mostofi Law Group.

"The online presence of a practice is critical to its reputation and could cause legal liability. The management of the online presence of a dental practice is not an aspect of the business that can be delegated to a third party, such as an employee or a marketing company, without putting in place strict policies on the type of content that can be posted," said Mostofi, who has lectured on social media and led a course at *CDA Presents* Anaheim last April.

As part of a practice's social media policy, Mostofi recommends dentists put together an outline of "example" social media posts for their staff. In order to properly guide the party who is handling the practice's online presence, such a policy should include detailed information and examples of permissible posts. The number of examples included in the outline will vary according to the extent of the practice's desire to be present on the Internet, but should include a minimum of about 25 to 50 examples, Mostofi said.

The next step to take after developing a policy is to designate someone to run the practice's social media presence. Barry says to choose wisely.

"You look for someone who is trustworthy and well-established in the practice because it's a little more difficult for a new employee to take on," Barry said. "Look for someone who uses social media and enjoys it; someone who has a good personality and an interesting way of saying things; someone who is a good writer and is funny and social."

The person who is selected should be knowledgeable of the ways of the practice and liability risks. Staff may respond to a negative review with the best intentions, but it is recommended that they are made aware of patient privacy risks and office liability for all content and communications on behalf of the practice.

"It's important to follow proper protocol because many legal aspects can come into play with online posts; the risk of HIPAA violations and a myriad of other potential legal liabilities may present themselves," Mostofi said.

Mostofi says the person in control of the accounts should be made aware of the following:

- posting information about patients including names, pictures and testimonials without the proper consents could constitute violations of HIPAA and California law;
- the definition of fee splitting; and
- copyright laws in terms of using statistics and photos from outside sources without providing the proper references to those sources.

According to the CDA Practice Support Center's *Guide for the New Dentist*, which has a chapter dedicated to social media, copyright laws protect photos, videos, graphics, music and text published on the Internet. Citing or crediting the original copyright owner does not grant freedom to use content without obtaining documented permission to do so. Even "shareware" or "royalty-free" media such as clip art requires users to read and accept the terms of use agreement. Dentists should review the provisions of any user agreement to ensure they do not use material in a way that violates the contract.

Continues on page 20

Experts weigh in on dental practice social media policies

Continued from page 19

By: CDA Practice Support Center

Barry says to also stay away from product pitches.

"Avoid pitches for products or services because your services should stand on their own. You expose yourself to saying things that are not true," Barry said.

Having information and content that is current and without typos also is important.

The Guide recommends dentists ensure any official account is created under their name, e-mail and security settings. Otherwise, the control of their online presence may not stay with their practice if an employee leaves.

In terms of setting up social media accounts, Mostofi recommends dentists create the accounts under the legal name they have established for their operations. For example, an individual who operates under a corporate entity should create any social media accounts under that corporate title.

"If you present yourself as a corporation, then that's how your account should be set up. If you practice under a fictitious business name that you filed at the county level and obtained a permit through the dental board for, then that should be the name on the account. A clear demarcation between personal and business operations needs to be in place," Mostofi said.

When asked how social media is done "right" in a dental practice, Barry said it needs to be "engaging and interesting."

"You need to make an actual effort to post interesting content to be engaging and funny," Barry said. "The dental office is an extension of family in many cases, so it makes perfect sense for there to be a social connection there because it creates long-term relationships and that's good for retention."

Mostofi reminds dentists and their staff to follow a policy that will keep the practice out of any legal predicaments.

"Social media has to be a highly controlled aspect of marketing. It can be effective in promoting your online presence but only to the extent that it doesn't create liabilities for your practice," Mostofi said.

For more information about using social media in the dental practice, visit cda.org/newdentist. Members also can also call the TDIC Risk Management Advice Line at 800.733.0634 for personal support from risk management experts.

ADA publishes cone-beam CT advisory statement

The ADA's Council on Scientific Affairs has released a new advisory statement addressing the use of cone-beam computed tomography in dentistry.

"Consistent with its mission to serve as a primary resource on the science of dentistry, the ADA Council on Scientific Affairs reviewed the current science, guidance and other resources available from professional organizations to prepare this advisory statement of principles for the safe use of CBCT in dentistry," the council's statement said.

Published in the August Journal of the American Dental Association, the statement, according to the ADA, offers "essential principles for consideration in the selection of CBCT imaging for individual patient care with an overall emphasis on the practitioner's primary ethical obligation to protect patients from harm including weighing the potential clinical benefits and risks of CBCT versus other options; the importance of keeping radiation exposure as low as reasonably achievable; and establishing a facility quality control program to maintain compliance with applicable local, state and federal requirements."

"CBCT technologies offer an advanced point-of-care imaging modality," the authors wrote; but they caution that CBCT imaging should not be performed for screening purposes, and additional considerations should be weighed before use with children and adolescents.

The final statement was created only after initial recommendations had been through a broad stakeholder review process that included input from other ADA councils and several dental and health organizations, the ADA reported.

The complete statement can be viewed online at jada.ada.org/content/143/8/899.full.

The U.S. Food and Drug Administration has a "Dental Cone-beam Computed Tomography" landing page available on its website that provides a description of cone-beam systems, the uses, benefits/risks, information for patients and parents, information for dental professionals and industry guidance.

To view all of this information and more, visit http://www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/ucm315011.htm.

Legislation Report

Continued from page 7

By: Jim Mertzel, DDS

Assistants and Registered Dental Hygienists to work in areas remote from an attending dentist, to determine what x-rays are necessary, to use hand held x-ray units and cameras connected to a computer, and give a visual report to a dentist in a remote area by tele-dentistry. The dentist would then make recommendations to the attending mid-level provider as to whether that patient should be referred or if the mid-level provider could place an interim restoration (glass ionomer). The hygienist could perform a prophy, fluoride treatment and place sealants. The theory for this program is that only the patients who need actual restorations, RCT or surgery would be seen by the dentist, thus utilizing the dentist's time for only the treatment he/she could provide. It would save the patient from traveling from a remote area if the patient could be treated at the place of the exam. There is some controversy regarding this legislation and CDA dentists will be having their input over the next year. As seen on the cover of this issue, your SFVDS leadership has already met with Assemblyman Raul Bocanegra to express our concerns and offer our help as the bill eventually works its way through the legislature.

One more thought:
Jim Wood, a dentist who has been very active in CDA affairs as Cal-D-Pac chair, has served on the Government Affairs Council, is running for the State Assembly. Although I am a registered Republican, I strongly endorse Jim to represent organized Dentistry in the Assembly. As a Democrat, Jim will carry more weight in the highly polarized Democratic Legislature. I have worked with Jim on the Cal-D-Pac Committee and on the GAC. He not only has served CDA well, but has served on his City Council. I am proud to endorse Jim and ask for your financial support in his campaign.

Send your check to James Wood for Assembly • 102 South Main Street • Cloverdale, CA 95425
Email: jwooddds@comcast.net

Trustees' Report

Continued from page 7

By: George Maranon, DDS

With respect to the workforce expansion, both CDA President Dr. Lindsey Robinson and CDA Executive Director Mr. Peter Dubois had conversations with Shelley Gehshen from the Pew Foundation. PEW and the Children's Partnership led efforts with Senator Alex Padilla to initiate a study allowing auxiliaries to perform some restorative procedures and extractions on children. These efforts stalled because the cost of the study was determined to be too high. Ms. Gehshen asked about CDA support for a California Office of Statewide Health Planning and Development (OSHPD) study for the expansion of auxiliary duties. This type of study would not meet the criteria of being rigorous and scientific as set forth by CDA policy. Dr. Robinson and Mr. Dubois informed Ms. Gehshen that CDA would not support an OSHPD study. Senator Padilla has decided not to move forward with any further legislation on dental workforce expansion at this time. Earlier this year, Assembly Member Raul Bocanegra (D-Los Angeles) introduced AB 1174, which proposes to provide a permanent funding source for the Virtual Dental Home concept currently being tested under the direction of Paul D. Glassman, DDS. Dr. Glassman's study involves dentists directing auxiliaries in restorative care from remote locations using the internet to transmit images. Assembly Member Bocanegra has decided to make AB1174 a two year bill.

Last year, the San Fernando Valley Dental Society (SFVDS) Board expressed significant concern about the assumptions and findings made in a CDA sponsored study of the capacity of the California dental delivery system. That study suggested that there was inadequate capacity for dentists and the dental delivery system to see more patients. This study was used as a basis for the CDA policy on workforce. Lead by the SFVDS delegation, the November 2012 House of Delegates adopted a resolution to establishing the Dental Care Capacity Task force. The task force would direct the review of that capacity study. SFVDS President, Nita Dixit, was chosen as an at large member of that task force and her appointment was ratified by the Trustees.

Crowe Horwath LLP recently completed an audit of the Associations financial statements. The financial position of CDA is strong. Total liabilities and net assets as of December 31, 2012 for the Association are $401,625,215 compared to December 31, 2011 of $372,482,899. Because of the effective management of the Association assets, CDA has not had a member dues increase in 14 years. The balance sheet of CDA far eclipses that of ADA and most comparable state and national associations.

The application deadline for leadership positions at CDA closed on June 1. Stanislaus trustee Elizabeth Demichelis and CDA treasurer Cleland "Butch" Ehrlers submitted applications for the position of Secretary of CDA. Applications for the position of Treasurer were received from SFVDS member and former trustee Alan Stein and Sacramento trustee Kevin Keating. Finally, the trustees voted to donate $10,000 to the Oklahoma Dental Association's Dental Relief and Disaster Grant Program to assist with relief efforts following the 2013 tornado near Oklahoma City.

Antelope Valley Report

By: Char Brash

Hi Desert Childrens Dental Clinic benefits from the 19th Annual Thunder on the Lot Event.

Volunteers for the Hi Desert Childrens Dental Clinic participated in the 19th Annual Thunder on the Lot Event. The Clinic has been a participant at this event for the past seven years. Each year this event focuses o assisting hundreds of children in the Antelope Valley. As this event has grown, so have the donations to local charities. Since 1994 the Thunder on the Lot Event has raised more than three million dollars and all of the go to kids' charities. This event has become a tradition in the Antelope Valley and is fully organized and staffed by hundreds of volunteers.
Each charity is required to sell 25 $100 Raffle Tickets, and this year our clinic, due to the generosity of our local dental professionals, sold 61 tickets! We are happy to announce that two local dentists who purchased raffle tickets were winners: Kirk Brewster, DDS won the Man Cave Package; and Phil Lopiccolo, D.D.S. won the 2013 AV Fair Gold Concert Ticket Package.
For more information on this event go to: www.thunderonthelot.com

Glendale/Burbank/Foothills Report

By: Chi Leung, DDS

An exciting event for the Foothills/Glendale area took place with the recent election of SFVDS member, Dr. Armina Gharpetian, to the Glendale Unified School Board. This indicates that our professional service can also serve our community in other ways, including politics. Clearly our voices and opinions will not only be heard professionally, but also politically. It will be an exciting year for our school district with such a distinguished school board member from our dental community.

Complimentary (and legally required) 2013 Employment Law Posters remain available from the SFVDS office and my office (607 N. Central Ave., Ste 302, Glendale – 818.243.6172). These are required by law to be posted in every office and include federal, state and dental board required notices.

The next zone meeting will be August 1, 2013 at 6pm at Clancy's Crab Shack. The meeting is free to SFVDS members and includes a scrumptious seafood dinner. Former SFVDS Peer Review Chair, Richard Hoefke, DDS will present on the value of the Peer Review system to members and will share the secrets of successfully insulating and defending yourself against patient complaints, and will answer member questions about the process and system. Contact the society office for details. RSVP to wendy at 818.576.0116 or Wendy.sfvds@sbcglobal.net.

Keep an eye on your emails for announcements of upcoming activities and events through the end of the year, including how to sign on for our foundation's newest community service project to help adults and seniors who cannot afford needed oral health care, and our annual 'Give Kids a Smile' screening and follow-up program coming up in February, 2014. We'll also announce the final location of the society's free document shredding event in October. We will also be announcing additional zone meetings and social events for our members in the Foothill/Glendale area. Your suggestions regarding topics and speakers important to you would be greatly appreciated and should be sent to our executive director, Andy Ozols, at exec.sfvds@sbcglobal.net

Welcome New Members

William Trevor, DDS
9720 Reseda Blvd. Ste. 3
Northridge, CA 91324
General
818.993.1114
UCLA, 2010

Taline Kotchounian
8540 S. Sepulveda Blvd., Ste 918
Los Angeles, CA 90045
General
USC, 2008
818) 667-0624

Ali M. Khosrovani, DDS
13564 Van Nuys Blvd
Pacoima, CA 91331
General
818.897.5771
NYU, 2005

Arbi Keshishian, DDS
General
USC, 2012
(818) 640-4848

Nishan Odabashian, DMD
1138 N. Brand Blvd
Glendale, CA 91202
Endodontics
818.552.3636
Tufts University, 1991

Hyungrim Oh, DDS
29002 Mirada Circulo
Santa Clarita, CA 91354
General
Chosun University, Korea, 1996

Nathan Turley, DDS
26357 McBean Pkwy
Valencia, CA 91355
Oral Surgeon
661.255.1661
Univ. of Colorado, 2008

Monica Herdoiza, DDS
6915 Reseda Blvd. # 3
Reseda, CA 91335
General
818.881.6844
Univ Central del Ecuador, 1986

Pallavi Kavety, DDS
2455 Colorado Blvd
Los Angeles, CA 90041
Pediatrics
USC 2010
Lutheran Medical Center 2013

Saragon Lazarof, DDS
16101 Ventura Blvd. Ste. 350
Encino, CA 91436
General
310.659.1999
USC, 1986

CLASSIFIED ADS

Position Available: Associate Dentist
Almi V. Hernandez Dental, Inc. • 15323 Stagg St., • Van Nuys, CA 91406
smile4me0627@yahoo.com • 818-988-9481

Associate Dentist GP Wanted: : Seeking associate dentist to join our growing, private practice in Bakersfield,CA. Office is high tech, we use quality equipment, schedule is strong, staff and patients are trained and friendly, and we DO NOT accept Denti-Cal or capitation plans. Send resume to admin@customdental.com for more information

Space Available • Encino Location
Medical building with ample parking. Modern suite shared with general dentist. Available without dentist or share daily. Call Dr. Greg Don (818) 784-5414.

General Dentists Needed: Family Smiles desires motivated, quality oriented general dentists to work in our busy New Mexico practices. At Family Smiles, we focus on providing the entire family superior quality general dentistry in a modern technologically advanced setting with experienced support staff. Because we understand the tremendous value of our associate dentists, we make sure that their compensation package is amongst the best. Our competitive compensation package includes: minimum guaranteed salary starting at $120,000 with potential to earn up to $300,000, visa sponsorship, and health and malpractice insurance reimbursement. To apply, please email CV to jboyce@kosservices.com or call 312.274.4520.

Unique Clinical & Lab Services in Oral Pathology and Orofacial Pain
We provide the following services for your patients: 1. Microscopic diagnosis for the biopsies submitted by dentists; 2. Diagnosis and therapeutic management of oral mucosal lesions, such as chronic ulcers; vesiculobulous disorders; burning or dry mouth, etc.; 3. Diagnosis and management of orofacial pain disorders including TMD; 4. Diagnosis of ambiguous white/red lesions(oral cancer/precancer) and clinical follow-up programs; 5. Comprehensive care of prior/post radiotherapy for head/neck cancers
Lan Su, DMD, PhD, Diplomate, American Board of Oral & Maxillofacial Pathology
31332 Via Colinas, Suite 109 Westlake Village, CA 91362 Telephone: 818 865 1039 www.oralpathmed.com

San Fernando Valley Dental Society
9205 Alabama Ave., Suite B
Chatsworth, CA 91311

PRESORTED STANDARD
U.S. POSTAGE
PAID
CANOGA PARK, CA
PERMIT NO. 337

DATED MATERIAL