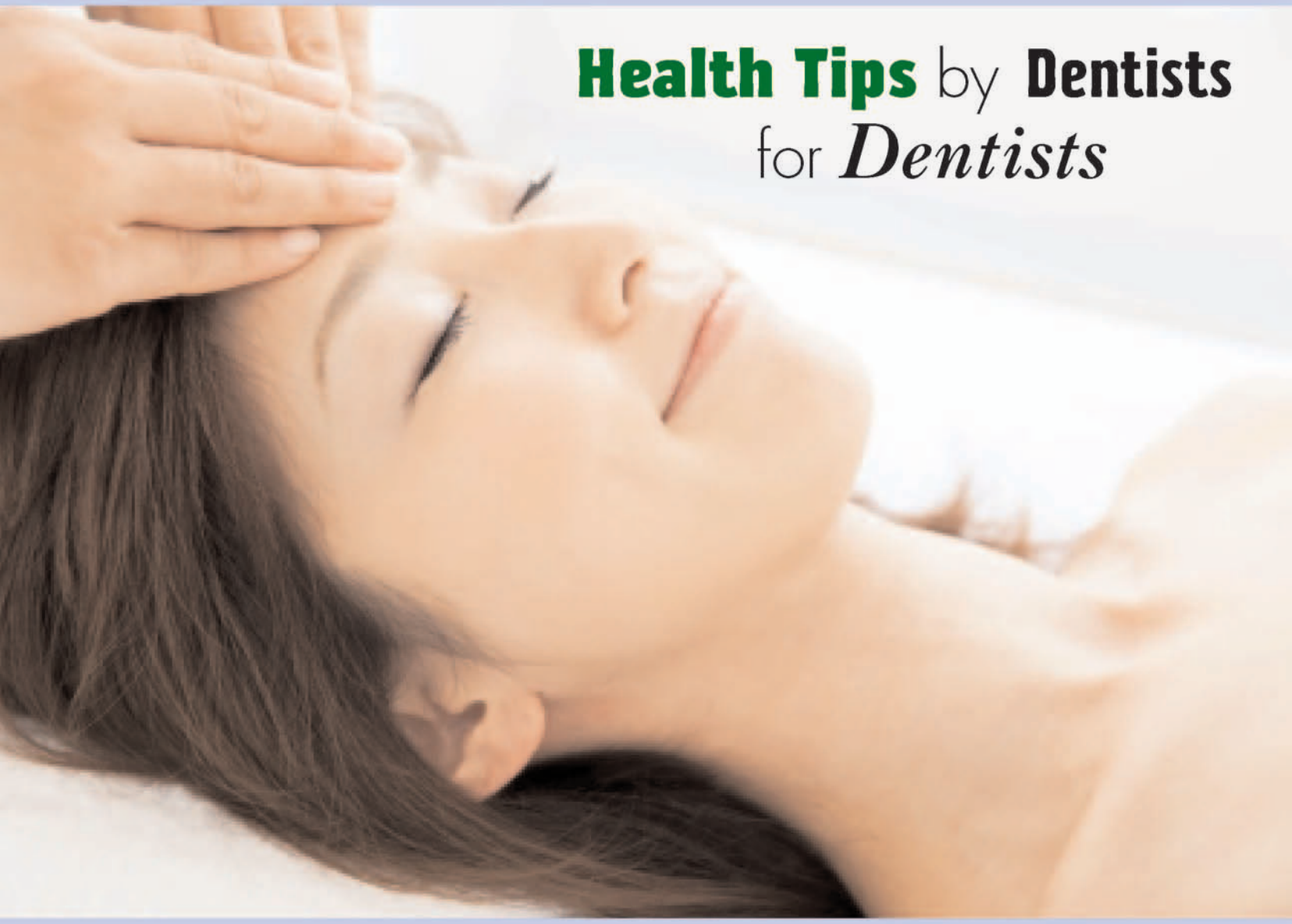
BULLETIN OF THE SAN FERNANDO VALLEY DENTAL SOCIETY

Dental DimensionS

Summer 2018
WWW.SFVDS.ORG



Health Tips by Dentists for *Dentists*

- Decoding Endodontic Pain
- Endodontic Retreatment
- SFVDS Endondontists
- About Peer Review

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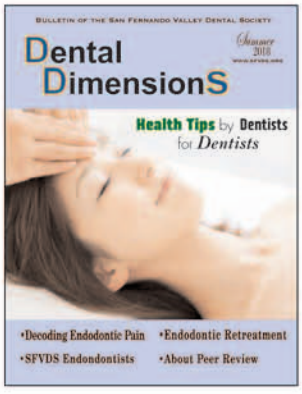
Call for Submissions

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 with references where applicable and photos if possible. Send your submissions to:
exec@sfvds.org
or contact the dental society office at 818-576-0116



On The Cover.....

Dental Demensions asked our members to help their colleagues combat dentist-related aches & pains by sharing their own tips on staying healthy and limber.
See story on page 19.

From the Desk of the Editor

Shukan Kanuga DDS, MSD.

It has been a 5-year long journey with Dental Dimensions. It feels just like yesterday when I started getting involved with our phenomenal board and our quarterly editorial. Time goes by very fast especially when you are having fun!

As professionals, we are all adept at multi-tasking. Managing a business, providing care to patients, cultivating employees, raising children and being there for their events big or small, caring for our parents and extended family, mingling with friends, being active in organized dentistry, and other leadership roles outside of dentistry are just a few things most of us do simultaneously on a day to day basis. We are adept at maintaining this fine balance called life and we do it so gracefully that people around us barely notice! However, when the layers of complexity get piled up to these tasks, this balance can shift ever so slightly and that's when priorities need to be shuffled around a bit to continue this juggling without losing balance!

That's the stage in my life and career that I find myself in right now. With a brand new start-up practice, the past few months have been analogous to being a mommy to a newborn with the amount of time and effort it takes to raise it to a functional level. And as if that's not enough, the energy that goes into raising my teenage daughter, who is about to enter high school, needs no further explanation!

The only thing that is constant is change. And it is time to allocate more time to personal and professional areas that are more demanding. While I will miss serving as the editor, I intend to continue to stay involved with our editorial efforts as much as I can. It gives me the utmost relief to know that Dental Dimensions is in very able hands under our executive director, Andy Ozols, and I am truly grateful for that. I could not have done it without his help and support over the last few years. He is truly instrumental in the success of the magazine and makes every effort to ensure that our 1400+ members are kept up-to-date with the activities in our component dental society.

Thank you for the opportunity to let me serve you as your editor for the last few years. Saying "good-bye" is not what I am very good at, so I prefer to say "See you soon!" After all, the beauty of our profession in general and organized dentistry in particular is that our paths always cross down the road!

'Till then,
Shukan

Corrections:
In the last issue of Dental Dimensions, our current treasurer's photo and brief bio (below) was inadvertently left out of the listing of SFVDS board members. Our apologies to Dr. Leung.

Chi Leung, DDS – Treasurer
Dr. Leung graduated from the USC dental school in 1995 and has been a dentist in general practice in Glendale, CA since graduation. She is the dental society's current treasurer, having been secretary in 2017. She is on track to be our next president-elect, followed by president in 2020. She has also served on numerous SFVDS committees including Peer Review, Membership, Legislation, Leadership and Ethics. In addition, she has served in numerous positions with both ADA and CDA, including membership, Well Being, and as a convention host for both organizations.

From the Desk of the President

Gib Snow, DDS

Where Do We Go From Here?

The future of our personal lives and the future of our profession directly depends on the decisions we are making now! Who you are in 10 years, totally depends upon the books you read and the people with whom you associate.

Last night (June 26, 2018) I was in meetings until 10:30pm, with people that are influencing both my personal and professional future. It would be hard to find a more worthy group holding meetings that are important to me and my profession. That is the board of directors of the San Fernando Valley Dental Society.

The agenda contained items that affect you on your personal and professional values. There was much discussion and debate behind all points of view and the information presented was, "How can we benefit the lives of the members of the SFVDS." So what you may ask? Well, conditions are changing and changing fast. As a profession, we have to combine our personal and professional values to influence the tides of change, in order to make this world a better place. This is what our agenda is all about. One of our grandest tools of influence is this organization. To make our organization work, we have to be strong in numbers. We need more people like those dedicated warriors I met with last night. We need more folks like you and your friends, to make those values stand loud and clear in the San Fernando, Santa Clarita and Antelope valleys.

What do we do? Each of us has to commit to bring at least one new member into the fold. Right now, through CDA, we are close to being the strongest lobby in Sacramento, but the members of SFVDS only represent about 64% of the practicing dentists in our area. Your associates may often ask, "What do I get out of membership?" The answer has to be clear!

You need to be able to respond readily with the benefits of membership. See the list at the end of this article. However, the list at the end of this exhortation doesn't cover all of what the CDA has done, and more importantly, what can be done when we have greater numbers. Just a few of the CDA's accomplishments include; winning more than $64 million from Delta Dental spread amongst its individual members, reversing a bill before the state legislature to create mid-level providers in the State of California and the CDA was largely influential in the passing of the tobacco tax, which has substantially expanded covered DentiCal services and increased reimbursements. This means that as an organization, we could influence the direction of our profession even further, as well as set the tone for the country as a whole. Remember that even within our own organization and within some dental schools, as well as some public health dentists, we find individuals not holding the same values that most of us hold dear.

So therefore, I urge you all to go out and find another just like you, to grow the greater power that will propel us into the society of our dreams! In the meantime, enjoy the benefits of your profession, and participate in helping the organization by volunteering your time and talents for the benefit of serving others and growing the SFVDS.

At Your Service,
Gib Snow, DDS

ADA/CDA/SFVDS MEMBERSHIPBENEFITS

MEMBERSHIP BENEFIT	MEMBER PRICE	NON-MEMBER PRICE	MEMBER BENEFIT
157,000 Dentists working together for common goals	FREE	NOT AVAILABLE	Untold
Government Representation Legislative advocacy	CDA members create a united voice for dentistry	Our voice would be stronger with yours	M
Presentations and telephone assistance on third-party payer and regulatory compliance issues	FREE	$150	$150
Spring & Fall CDA Presents	FREE	$890 each	$1780
50 CE Units at Spring and Fall CDA Presents	FREE	Cost per CE Unit varies	$1,000's
Convenient and local CE courses	$175	$300	$125
SFVDS's Dental Dimensions Magazine	FREE	$50	$50
Local CPR recertification training	$35	$65+	$34
Local zone meetings	FREE	NOT AVAILABLE	$35

ADA/CDA/SFVDS MEMBERSHIPBENEFITS (continued)

MEMBERSHIP BENEFIT	MEMBER PRICE	NON-MEMBER PRICE	MEMBER BENEFIT
Social events by, for and with other dentists including picnics, sporting events, amusement parks, holiday party, document shredding, etc.	Varies	NOT AVAILABLE	$100's
CDA Journal	$18	$75	$57
CDA Update	FREE	$24	$24
Access to CDA-endorsed programs,	FREE	NOT AVAILABLE	M
Access to the TDSC buying program	FREE	NOT AVAILABLE	$1000s
TDIC Risk Management Seminars	$75**	$250	$175
Peer Review System	FREE	NOT AVAILABLE	M
Regulatory Compliance Manual* & Radiation Safety Guide*	FREE	$330	$330
Compliance Poster Set (Required Federal, State and Dental Posters)	FREE	$75	$75
SFVDS Employment Referral Service	FREE	NOT AVAILABLE	M
CDA Classified Ads Online	FREE	NOT AVAILABLE	M
On the job dental ass't training manual	$70	$160	$90
Online dental referral	FREE	NOT AVAILABLE	M
CDA SMILE Dentist assistance helpline & web site access	FREE	LIMITED SERVICES	M
ADA BENEFITS/SERVICES Contract Analysis	FREE	NOT AVAILABLE	M
ADA Journal	FREE	$120	$120
ADA News	FREE	$65	$65
ADA Web site member access	FREE	NOT AVAILABLE	M
ADA Annual Scientific Session	$50	$750	$700
ADA Dental Library	FREE	LIMITED SERVICES	M
Access to ADA Retirement Program	FREE	NOT AVAILABLE	M
CDA Practice Support Center	FREE	NOT AVAILABLE	$1,000's
TDIC and TDIC Insurance Solutions Products and Services	ACCESS	NOT AVAILABLE	$1,000's
Pride in Participating in Community Service Opportunities and Organized Dentistry	FREE	NOT AVAILABLE	PRICELESS
ANNUAL BENEFIT			**$5,000+**

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*Available to members online at no charge

**Members who are TDIC policyholders pay $60.

M Benefits and services for members only!

Trustees' Report

By: Martin Countney, DDS

HELP for your office!!!!!

The SFVDS has pushed for CDA to help with the seemingly ever increasing burdens that Dental Insurance Companies impose on providers submitting routine claims. A task force has been created to examine the problems and find solutions. I have been selected to be one of the two CDA Trustees on the task force. Help the Task Force gather information by sending all rejected claims to the CDA Practice Support Center (cindy.hartwell@cda.org) with a brief summary of the rejection. Be sure to redact any patient identifiable information. CDA Practice Support Center can also be reached by phone 1-800-232-7645.

Why buy from TDSC?
The Dentists Supply Company (TDSC) is owned by CDA and is available exclusively to CDA members. It has the potential to be one of the largest buying clubs in the nation. Members using it have already saved $1.5 million. As more members use TDSC the discounts available will get larger. Since TDSC has come on the scene other dental suppliers have offered price matching; if TDSC disappears so will the price matching. Recently CDA won a significant battle with Delta Dental of California resulting in $65 million going back to CDA premier providers. That type of litigation is costly and can be covered by profits from TDSC. No TDSC and CDA is hindered in fighting those battles for you. TDSC recently hired Jim Wiggett, the former CEO of Sephora.com so you can expect the shopping experience to become world class (just ask anyone that buys makeup how they like the Sephora experience!) So the real question is why not buy supplies from the supply company you own?

Official Summary of the Board of Trustees Meeting
June 1-2, 2018

Prior to the CDA Board of Trustees (board) meeting, trustees and officers participated in a board development session in which they identified values that will help guide behavior, foster connectivity and contribute to the common good of the board. Trustees and officers will continue to participate in these sessions throughout the year.
Innovations in Membership Models Task Force Recommendations: In 2016, the board approved the establishment of the innovations in membership models task force to consider options to address the needs of future members and membership models that will attract dentists who practice in non-traditional settings. Dr. Richard Nagy, chair of the task force, provided the board with an overview of the task force recommendations, which the board adopted. The recommendations included:
ADA Bylaws Alignment that would allow members to provide either their home, practice or employment address as their primary address for component assignment, aligning with the ADA bylaws, which states, "…member in good standing of the constituent or component where the member either resides, or is employed or practices…". This resolution would also allow members with a primary address in a shared zip code to choose amongst the components within that zip code. Being that this resolution requires a bylaws change, it will be forward to the House of Delegates for further consideration.
Enhancing the Value of Membership by approving a $50,000 expenditure to further explore potential resources and services, and develop recommendations for board consideration in an effort to enhance and expand member benefits for targeted groups (students, graduate students, residents, associates and new dentists), ensuring that emerging dentists find value in organized dentistry and have access to peer support as they choose their practice mode. This would include practice support resources for associates and new dentists, development of a statewide job board and virtual community, and providing CDA Presents courses and endorsed programs for associates and new dentists.
The Value of Community establishing a task force to review the current tripartite membership structure and rules; and ultimately, identify opportunities to improve or add value to the structures in support of positive, transparent and inclusive member experiences.

Board and Nominating Committee Meeting Participation: The board discussed expectations for board participation, and adopted a new policy that allows members of the board and nominating committee to participate remotely with the understanding that such members abstain from voting, and be recused from breakout activities and closed sessions. This policy does not apply to meetings held via teleconference. The general operating principles will be amended to reflect this policy.

2017 Audit Results: The board received an overview of the consolidated 2017 audit results for CDA and its subsidiaries, which was conducted by Crowe Horwath LLP.

TDSC Update: The board held a thorough discussion on the TDSC Marketplace and growth strategy. TDSC, for marketing and clarity reasons, will be changing its name to The Dentists' Supply Company (still TDSC). Significant work is underway to improve the search and e-shopping experience with expanded warehouse capability (for fulfillment), search functionality, and selection variety. Trustees are encouraged to engage in discussions with members promoting purchasing in the Marketplace and the value and potential savings that it offers to their practices.

Delta Dental Litigation: The board received an update regarding the Delta Dental litigation. This update was held in closed session to protect attorney/client privilege; however, trustees may report that the amended settlement has been approved, and notifications are being sent to individuals who will be receiving payment as part of the settlement. Additionally, answers to frequently asked questions may be found at http://deltadentalofcaliforniasettlement.com/.

2019 CDA Cares Locations and Dates: The board ratified the 2019 CDA Cares locations and dates as follows:
CDA Cares Solano, Solano County Fairgrounds, March 8-9, 2019
CDA Cares San Bernardino, National Orange Show Events Center, September 27-28, 2019

Emerging Issues: The board received an update on the dental plan loss ratio and transparency legislation, as well as presentations on dental workforce projects including community dental health coordination, community based dental education and expansion of the virtual dental home in California. Supporting resources are available online at cda.org/board under 'presentations and supporting documents'.

2019 and 2020 Board of Trustees Dates: The board was provided with the board dates for 2019 and 2020.

The board took additional actions of an operational nature, which are reflected on the meeting agenda and will be recorded in the official minutes of the meeting.

PEER REVIEW....
USED BY FEW, PAID FOR BY ALL....my opinion

By: Alan Lewis, D.D.S. Chairman, SFVDS Peer Review Committee

Is it possible to assign value to the many benefits afforded each and every one of us through our tripartite membership? We've got local meetings, yearly conventions, seminars, journals, continuing education opportunities in Hawaii, community service opportunities, mentoring opportunities, holiday parties.....I could go on and on.

And don't forget our political action committee; always representing our profession's best interests within the legislative landscape of California. All of these are tangible benefits. The majority of our members will participate or have some level of interest in many of the aforementioned items.

Surely, we all have a favorite. But what about the intangible benefits which very few of us will ever use? What about Peer Review? Is there value in the Peer Review system?

Recently, I heard about a poll that asked fellow dentists to rate the value of 39 of these membership benefits. Peer Review finished a distant 36th. Can that be possible? Do our peers place virtually no value on Peer Review? One argument is that the Peer Review system is paid for by 100% of our members and is only used by approximately .6%. Where is the fairness there?

Why would any one of us be happy paying for something we hope we never have to use? In fact, we do it all the time. There's health insurance, car insurance,

malpractice insurance and earthquake insurance just to start. We pay for extended service contracts on our cars, our office equipment and we pay to insure our jewelry. We pay for all of these with the hope that we will never have to use them.

36th.....really?

There was a recent push at the state level to eliminate the peer review system. What would it mean to our membership if in fact peer review was no longer accessible? Currently, any quality-of-care issues that arise between doctor and patient can be referred to the Peer Review Committee. The work in question will be examined, impartially by your peers, using criteria set forth by the California Dental Association. Our member dentist is afforded a personal interview, and his/her patient chart and x-rays are reviewed regarding the work in question. A decision is rendered and whether positive or negative, there is no reporting of that decision to any agencies. The member dentist is also cautioned that the committee's decision, while binding for the doctor, is non-binding for the patient. So Advice is given to the member to leave a negative decision out of the patient's record, but to include a positive decision, because peer review decisions are not discoverable in a court of law, unless they are in the patient's record.

The entire process can be settled in approximately eight weeks. Peer review is totally impartial, with decisions running right around an even split between doctor and patient. I know we're impartial because the committee receives an equal number of complaints from doctors and patients regarding our decisions. Without the peer review process, which has been standard practice for more than 40 years, and continues to be a very successful one, our doctors will could more easily be thrown into the legal blender. Some will end up defending their reputations through their insurance carriers and others will find themselves in the small claims arena. Neither will end up well. Our doctors can could expect see increases in their malpractice costs, along with both a psychologically tarnished professional reputation and personal misgivings about their competence. And count on at least one to two years of stress. In the small claims world, our doctors wouldn't stand a chance. Forced non-binding mediation after the judge hears the case and likely postponement until another day if the case can't be mediated, invariably forces us to settle, rather than losing more income by being pulled out of our offices another day. Do you want a judge with no dental understanding passing judgement on you? This would very likely be our fate without peer review.

About Peer Review

- Peer review is a process by which the dental profession reviews and resolves problems or misunderstandings regarding dental treatment. Peer review exists for the benefit of the patient, the dentist and third party financial intermediaries.
- Every dental society has established a system of peer review to resolve any disagreements about dental treatment that a patient and a dentist have not been able to resolve themselves.

Virtually every doctor appearing before the committee is appreciative for the work of the committee and thankful that they have a group of peers they can fall back on to keep them out of the legal fray. Peer review is a silent but powerful benefit of membership. I hope peer review remains "paid for by all and used by few." Truth be told, I think that if peer review was the only benefit provided, our dues would be well worth it.

By the way, peer review chairs throughout the state banded together to make our opposition known toward the proposed elimination of the peer review system. We were successful. Peer review is intact and here to stay.

Dr. Lewis has served on the Peer Review Committee for twenty-six years; the last seven as chair. The Peer Review Committee is actively recruiting new members. If interested, contact Wendy, Peer Review Coordinator at 818-576-0116

General Meeting Review

Gordon Fraser, DMD

June 20- Soft Tissue Concepts for the General Dentist: Understanding What's Possible and What's Not.

Attendees learned the importance of mucogingival therapy for correction of defects in morphology, position and underlying bone support at teeth and implants. Dr. Fraser illuminated facts vs. theory through case studies and examples. Mastering these concepts was said to be the overall success of the dental practice, patient satisfaction and bottom line.

General Meetings -2018

Joyce Bassett, DDS

September 26, 2018 - Cutting Edge Technology With Digital Design and Real World Cosmetic Dentistry: Faults, Failures and Fixes.

This course will focus on aesthetics that are built to last. Clear, concise and systemized techniques will be presented to treat every aspect from simple to complex cases involving veneers, crowns and implant restorations. These protocols will increase profitability by preventing failures that occur day-to-day in the dental office.
Cutting edge preparation techniques that will simplify difficult space management cases will be presented, along with how to handle shade challenges and when preparation modifications may be necessary. Attendees will understand state of the art digital smile design linking 3D prosthetic planning with fundamental principles and real-time communication that decreases dentist chair time and ceramist re-work.

Rob Lowe, DDS

September 29, 2018 - The Art & Science of Prosthodontics — From Basic to Complex.

"Hands-on"

The purpose of this course is to demonstrate in a detailed step-by-step fashion, procedures that if practiced can impact on your ability to deliver an improved level of artistic and functional dentistry in your practice tomorrow!
Didactic Objectives:

- To discuss and differentiate all ceramic restorative options for different clinical situations.
- To review preparation requirements for all ceramic systems
- To learn the importance of biologic provisionalization in overall case management
- To learn a proven reliable technique for "flawless" master impression making.
- To learn a cementation protocol for reliable placement and occlusal adjustment during delivery of definitive restorations.
- To learn some "creative" ways to plan and treat complex aesthetic and functional problems.

Hands-On Objectives:
1. Anatomic tooth preparation for full coverage e.max and zirconia restorations.
2. How to handle tooth preparation for the "crowded arch" to predictably create aligned restorations that have the proper restoration contour and position, yet control excessive tooth reduction.

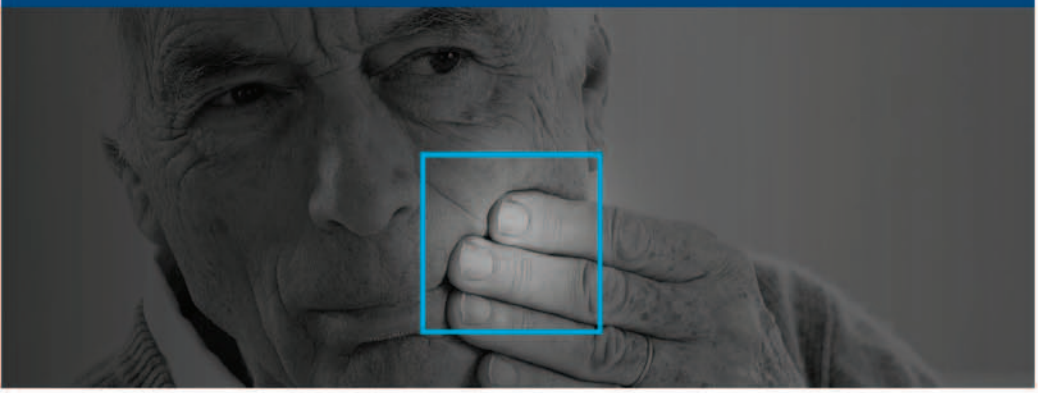
Susan McMahon, DDS

October 24, 2018 - Conservative Cosmetic Dentistry for Teenagers and Young Adults.

Our practices are full of younger patients with minor cosmetic dental needs and desires. Recognizing these desires and offering these elective conservative treatment options can boost their confidence and boost our bottom lines.
How do we initiate discussions about cosmetic procedures with this age group? This course will look at cosmetic dental issues that are of particular concern to our teenage and young adult patients: tooth color and staining issues, post orthodontic refinement of smiles, spacing and crowding, dental trauma, tooth size discrepancies, misshapen teeth, peg laterals, congenitally missing teeth, and soft tissue considerations. Treatment options and step by step treatment procedures will be discussed. We will look at whitening and microabrasion, direct composite bonding, finessing of post-orthodontic smiles & laser soft tissue sculpting.

Clinical Tips for Decoding Endodontic Pain

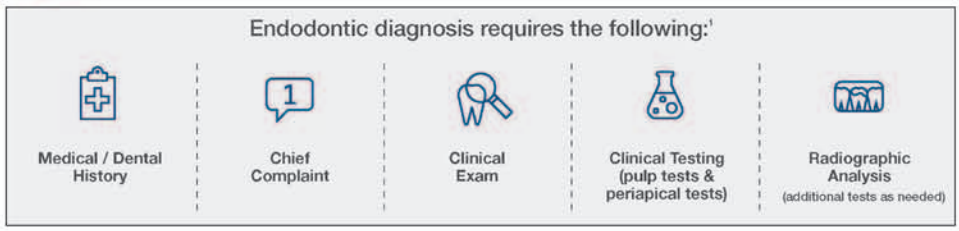
Dr. Bernice Ko, Board Certified Endodontist



By: Bernice Ko, DDS

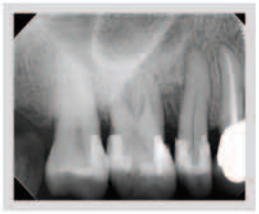
Endodontic diagnosis may be complicated. A step-by-step diagnostic approach is presented to illustrate a variety of endodontic scenarios.

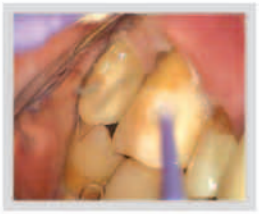
CASE 1



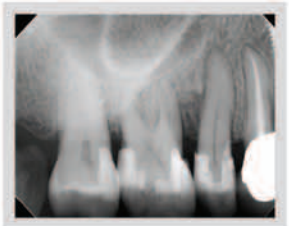
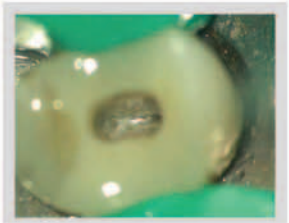
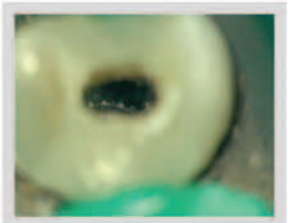
The goal is to reproduce the patient's chief complaint and specifically to recreate, individually or each tooth, the stimulus that elicits the pain.[2] A correct endodontic diagnosis will enable the dentist practitioner to render the correct treatment plan to ultimately resolve the patient's symptoms.

WHEN PATIENT REPORTS: Quick non-lingering sensitivity to thermal stimulus and biting pain





Clinical Exam:	Teeth #3-4	Gingival Recession / Periodontal disease
Clinical Tests:	Tooth #3	Hypersensitive @ cervical root dentin with cold Biting and Percussion tests are WNL
	Tooth #4	No Response with cold and electric pulp test Biting and Percussion tests created PAIN
Radiographic Analysis:	Teeth #3-4	Periodontal Breakdown
	Tooth #4	Widened PDL/early periapical radiolucency (PARL)
Endodontic Diagnosis:	Tooth #3	Reversible Pulpitis/Dentinal Hypersensitivity due to periodontally exposed root dentin
	Tooth #4	Pulp Necrosis/Symptomatic Apical Periodontitis

Treatment:	Tooth #3	Dentinal Hypersensitivity with brush and bond
	Tooth #4	Nonsurgical Endodontic Treatment
Armamentarium:	Cold Pulp test:[4]	Endo ice by Hygenic (-26.2 degrees C) or Carbon Dioxide stick (-56 to -98 degrees C)

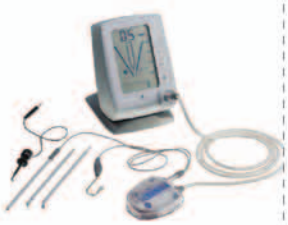
Hygenic® Endo-Ice® Refrigerant Spray by Coltene/Whaledent[4]

Cotton pellet used to apply the Refrigerant Spray to the tooth surface[4]

Carbon Dioxide Tank with apparatus attached to form solid Carbon Dioxide stick[4]

Carbon Dioxide stick extruded from the end of the plastic carrier[4]

Electric pulp test:[4] Vitality Scanner by Kerr Endodontics



Elements Diagnostic Unit by Kerr Endodontics

Dental Resin and Adhesives: Brush & Bond by Parkell, Inc.

Biting test:[4] Tooth Slooth by Professional Results, Inc.

This patient presented to the practice as an emergency case as she was leaving for a vacation the following day. An accurate diagnosis of the involvement of two teeth that contributed to her overall chief complaint enabled me to provide emergency treatment to both teeth #3 and #4. Dentinal Hypersensitivity Treatment [3] resolved my patient's quick non-lingering sensitivity to thermal stimulus for tooth #3. Nonsurgical Endodontic Treatment resolved my patient's biting pain for tooth #4. This case portrays an endodontic-periodontal presentation, thus, the pulp necrosis status confirmation of tooth #4 with an additional electric pulp test was decisive. In addition, the periodontal status of these teeth will need to be addressed for necessary treatment to optimize the long term prognosis of these teeth. The patient made a long-distance phone call and sent a lovely thank you card to express her gratitude for the emergency treatment rendered thereby allowing her to enjoy her vacation with pain-free teeth.

Diagnostic Terminology Approved by the American Association of Endodontists and the American Board of Endodontics: [5]

Reversible Pulpitis

Based upon subjective and objective findings indicating that the inflammation should resolve and the pulp return to normal following appropriate management of the etiology. Discomfort is experienced when a stimulus such as cold or sweet is applied and goes away within a couple of seconds following the removal of the stimulus. Typical etiologies may include exposed dentin (dentinal sensitivity), caries or deep restorations. There are no significant radiographic changes in the periapical region of the suspect tooth and the pain experienced is not spontaneous. Following the management of the etiology (e.g. caries removal plus restoration, covering the exposed dentin), the tooth requires further evaluation to determine whether the 'reversible pulpitis" has returned to a normal status. Although dentinal sensitivity per se is not an inflammatory process, all of the symptoms of this entity mimic those of a reversible pulpitis.[5]

Pulp Necrosis

A clinical diagnostic category indicating death of the dental pulp, necessitating root canal treatment. The pulp is non-responsive to pulp testing and is asymptomatic. Pulp necrosis by itself does not cause apical periodontitis (pain to percussion or radiographic evidence of osseous breakdown) unless the canal is infected. Some teeth may be non-responsive to pulp testing because of calcification, recent history of trauma, or simply the tooth is just not responding. This is why all testing must be of a comparative nature (e.g. patient may not respond to thermal testing on any teeth).[5]

Symptomatic Apical Periodontitis

Represents inflammation, usually of the apical periodontium,producing clinical symptoms involving a painful response to biting and/or percussion or palpation. This may or may not be accompanied by radiographic changes (i.e. depending upon the stage of the disease, there may be normal width of the periodontal ligament or there may be a periapical radiolucency). Severe pain to percussion and/or palpation is highly indicative of a degenerating pulp and root canal treatment is needed. [5]

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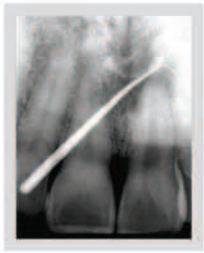
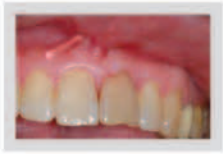
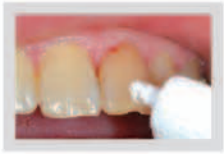
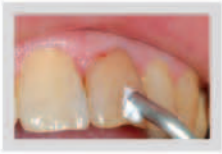
CASE 2 - Clinical Tips for Decoding Endodontic Pain

WHEN PATIENT REPORTS: Intermittent discharge of pus through an associated sinus tract
(Gradual onset with little or no discomfort)

Definition of sinus tract: A pathway from an enclosed area of infection to an epithelial surface; opening or stoma may be intraoral or extra oral and represents an orifice through which pressure is discharged; usually disappears spontaneously with elimination of the causative factor by endodontic treatment. The term fistula is often inappropriately used.

Clinical Exam:	Tooth #9	Draining sinus tract at buccal mid-root level of #8 Coronal brown discoloration of #9
Clinical Tests:	Tooth #9	Gutta-percha cone tracing of sinus tract leads to #9 apex No response with cold and electric pulp test
Radiographic Analysis:	Tooth #9	Periapical radiolucency
Endodontic Diagnosis:	Tooth #9	Pulp Necrosis / Chronic Apical Abscess Coronal Discoloration
Treatment:	Tooth #9	Nonsurgical Endodontic Treatment Intracoronal Bleaching Treatment

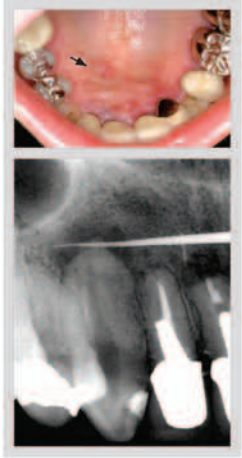
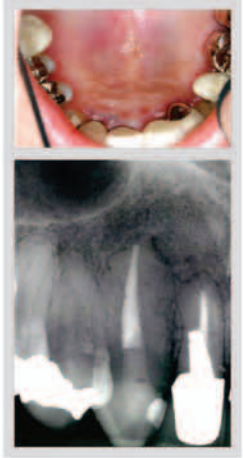
Learning Objective:
A sinus tract may manifest itself distant from the tooth involved. A careful clinical and radiographic exam and testing of the involved tooth and adjacent teeth is essential for correct diagnosis and treatment.

Another example:

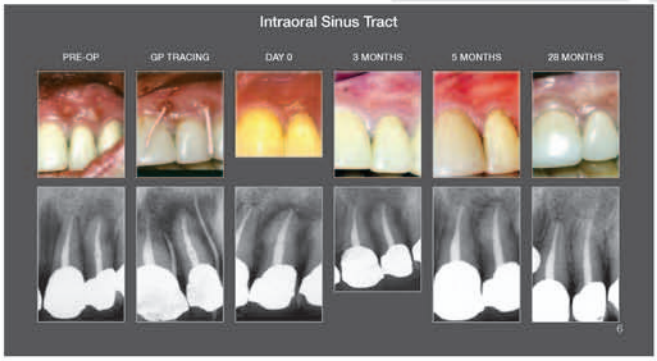
Endodontic Diagnosis: Tooth #6 – Pulp Necrosis / Chronic Apical Abscess (confirmed with no response with cold and electric pulp test)

Resolution of palatal sinus tract and periapical radiolucency with nonsurgical endodontic treatment of #6.

Gutta-percha cone tracing of a palatal sinus tract hidden at palatal rugae (see arrow) leading to #6 periapical radiolucency.

On limited occasions, there could be a double sinus tract presentation. This necessitates a double gutta-percha cone tracing and usually the tooth in the center of the tracings which in this case is #10 is the origin of the endodontic problem.

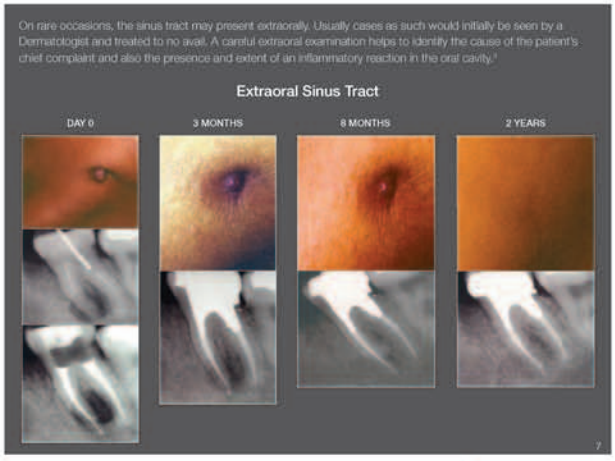


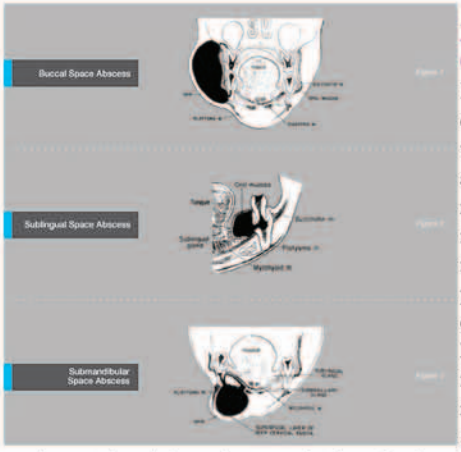
Endodontic Diagnosis: Tooth #10 – Previously Treated / Chronic Apical Abscess

Treatment Protocol: Upon nonsurgical endodontic retreatment of tooth #10, it was ascertained that apical patency was not accomplished during initial treatment. Careful determination of working length with an apex locator enabled a thorough biomechanical

preparation of the canal. Intracanal calcium hydroxide medication was placed. Obturation was accomplished once the sinus tracts have resolved (Day 0). The 3 month, 5 month and 28 month recall showed gradual and complete resolution of the periradicular radiolucency.

Learning Objective: Tooth #10 also exhibited a wide 12mm PPD in the entire buccal area. Otherwise a 3mm normal PPD was found circumferentially. This illustrates a "sinus tract-type probing pattern" of pulpal origin. The probing depths along root surfaces with these defects are usually within normal limits until the defect is encountered. The probing depth at this point will precipitously become very deep as the probe enters the tract. Continuing circumferentially, the probing depth will just as precipitously return to normal.[2] The increased PPD of tooth #10 simultaneously returned to normal with the resolution of the sinus tracts as the endodontic treatment goal was attained.





Learning Objective: In particular this extraoral sinus tract case involves a mandibular 2nd molar. A mandibular 2nd molar has 50% possibility of either buccal or lingual perforation from a periapical infection and has 50% chance for root apices to be either above or below the buccinator or mylohyoid muscle.[4] On the buccal aspect, the abscess will form either in the vestibule or in the buccal space, depending on the relationship of the buccinators muscle (Figure 1). On the lingual surface, exit of the infection above the mylohyoid muscle will result in a sublingual abscess (Figure 2). Perforation below the mylohyoid muscle produces an infection of the submandibular space (Figure 3).[4]

Endodontic Diagnosis: Tooth #18 – Previously Treated / Chronic Apical Abscess

Treatment Protocol: Upon nonsurgical endodontic retreatment of tooth #18, it was discovered that the ML canal was left untreated due to its calcifications. An apex locator confirmed the thorough biomechanical preparation of all the canals to working lengths. Intracanal calcium hydroxide medication was placed. Obturation was accomplished 2 weeks later (Day 0). Endodontic therapy with an effective inter-appointment antibacterial agent over a relatively short period (1 to 2 weeks) is sufficient to ensure effective disinfection of the canal.[5] The 3 month, 8 month and 2 year recall showed gradual and complete resolution of the periradicular radiolucency and extraoral sinus tract without further dermatologic intervention.

Additional Diagnostic Terminology Approved by the American Association of Endodontists and the American Board of Endodontics: [6,7]

Pulp Necrosis: A clinical diagnostic category indicating death of the dental pulp, necessitating root canal treatment. The pulp is non-responsive to pulp testing and is asymptomatic. Pulp necrosis by itself does not cause apical periodontitis (pain to percussion or radiographic evidence of osseous breakdown) unless the canal is infected. Some teeth may be non-responsive to pulp testing because of calcification, recent history of trauma, or simply the tooth is just not responding. This is why all testing must be of a comparative nature (e.g. patient may not respond to thermal testing on any teeth).[6,7]

Previously Treated: A clinical diagnostic category indicating that the tooth has been endodontically treated and the canals are obturated with various filling materials other than intracanal medicaments. The tooth typically does not respond to thermal or electric pulp testing. [6,7]

Previously Initiated Therapy: A clinical diagnostic category indicating that the tooth has been previously treated by partial endodontic therapy such as pulpotomy or pulpectomy. Depending on the level of therapy, the tooth may or may not respond to pulp testing modalities. [6,7]

Chronic Apical Abscess: An inflammatory reaction to pulpal infection and necrosischaracterized by gradual onset, little or no discomfort and an intermittent discharge of pus through an associated sinus tract. Radiographically, there are typically signs of osseous destruction such as a radiolucency. To identify the source of a draining sinus tract when present, a gutta-percha cone is carefully placed through the stoma or opening until it stops and a radiograph is taken. [6,7]

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Bandary	Narbeh	DDS	4910 Van Nuys Blvd Ste 100	Sherman Oaks	CA	91403-1718	
Bassali	Emad	DDS	4940 Van Nuys Blvd Ste 101	Sherman Oaks	CA	91403-1773	(818) 789-2200 (818) 789-4455
Bell	Ron	DDS	17620 Sherman Way Ste 104	Van Nuys	CA	91406-352	(818) 996-6629
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Massoth	Irvin	DDS	5567 Reseda Blvd Ste 100	Tarzana	CA	91356-2648	(818) 705-1274 (818) 705-6782
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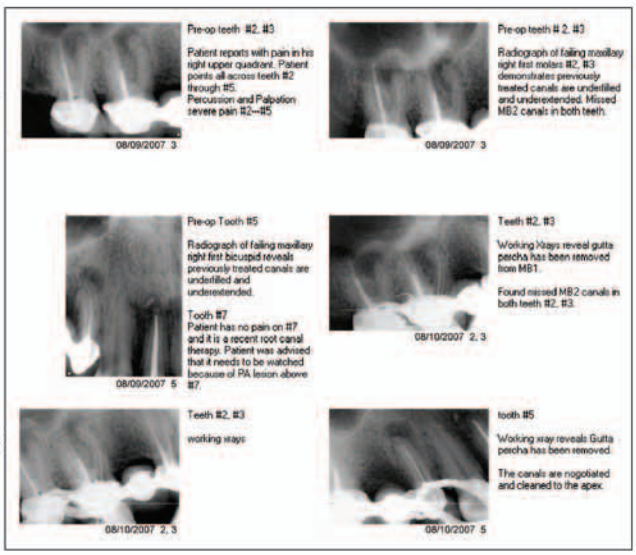
Retreatment or Implant: Let's go back to BASICS!

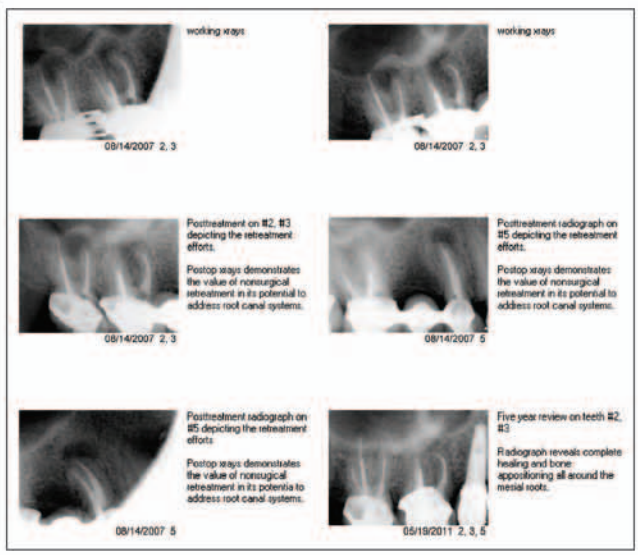
What would you do if it was your tooth? This is a common question I hear in my daily practice. When evaluating for endodontic retreatment or implant cases, one has to address predictable successful outcomes. Today, 50% of my practice, even with the evolvement of implant dentistry, is retreatments. There is an alternative after all.

Endodontic success and failure is directly related to the 'Root Canal System'. One must first Look at the initial X-ray and evaluate the branches that communicate with periodontal attachment apparatus furcally, laterally, and most often apically. Pulpal breakdown and formation of lesions occur adjacent to the portal of exit. Inadequacies in shaping, cleaning and obturation, iatrogenic events, or reinfection of root canal system when the coronal seal is lost after completion of the root canal system, are all attributed to Endodontic failures[1,2,3]. Leakage is the aggregate of all causes attributing to endodontic failures regardless of the commencing cause [4,5,6].

Factors influencing retreatment and or implant decision making may be that it is poor quality endodontics, but has good quality restoration, patient is asymptomatic and exhibits no pathology. As such, it may be best to just leave it alone and watch your patient. In a symptomatic case with poor quality endodontic, you want to intervene. Other influencing factors we have to ask ourselves are: Is it a strategic tooth? A long-span bridge? Do you need to get periodontist and orthodontist colleagues involved? Would the tooth benefit if it were to be uprighted? Is an occlusal evaluation warranted? What does the patient want? Restorability? Ferrule effect? In addition, is crown lengthening needed or not? Periodontal pocket, mobility, crown root ratios need to be evaluated. Do we need a cone beam scan? Options, costs, prognosis and alternative treatment plans all should be discussed.

Let's review patient M (X-rays from left to right). M was new to our referring dentist. He was referred to our office for a second opinion. Teeth involved were #2, #3 and #5. Root canals were all four-years old with the exception of a recent endodontic treatment on #7 - all done by his previous general dentist. The patient had been referred to an oral surgeon by his previous dentist, after which the patient sought a different general dentist.





prognoses were all reviewed. You can follow the retreatment of the involved teeth with complete healing and bone appositioning in a five-year review. You can see the nine-year review in the last X-ray of the complete healing and bone apositioning on #5.

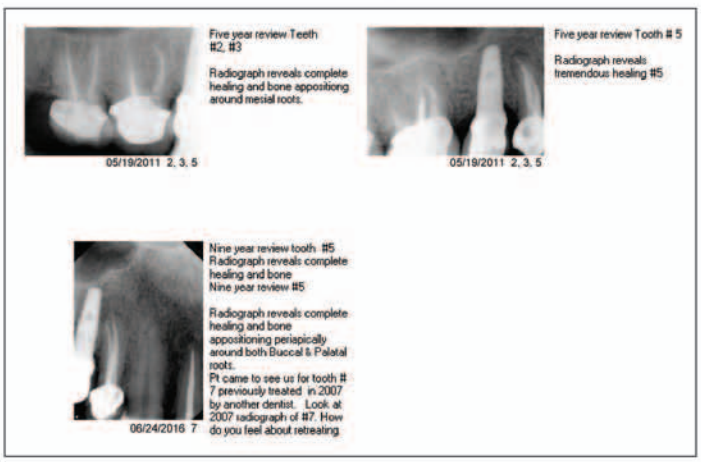
Conclusion

There is an alternative after all. One must not rush to committing the patient to undergo an implant when the issue at hand may be resolved by retreatment. The retreatment option offers less morbidity and less cost. For M, Inadequacies in shaping, cleaning and obturation in the canal system contributed to endodontic failures on all three of his teeth (#2, #3 and #5). In M's situation I treated just the affected mesial canals in molars #2 and #3 and both Buccal, Palatal roots in the bicuspid. Let's clarify the reasoning behind that. Pulpal breakdown and formation of lesions occurred adjacent to the portal of exit on the mesial roots of both molars as you observe the pre-op X-rays. The etiology of the infection in the molars were just the canals in the mesial roots. Just treating the mesial roots reduced the chance of compromising the rest of the structure.

Pulpal breakdown and formation of lesions occurred adjacent to the portal of exit on both B and P canals in the bicuspid #5. The etiology was around both B and P roots of the bicuspid. In the bicuspid, the canals have more proximity and it makes sense to treat them both.

In M's case, I decided to use routine Gutta Percha and AH plus as the final seal. Since 2007 when I treated M, endodontics has evolved. As endodontists we now have had many different rotaries, ultrasonic options, chemicals and other superior filling materials added to our armamentarium. Solutions like EDTA, Sodium Hypochlorite, Chlorohexidine, combination EDTA and Chlorohexidine and liquid antibiotics. Using all the different solution cocktails we have at our finger tips and enough time spent in the canals, you even have superior outcomes. Not to mention the help of a cone beam scan and microscopes, of course.

Although I could not have asked for better results, I may choose to use Mineral Trioxide Aggregate (MTA) seal as my final seal in my retreatment cases. MTA was introduced by Torabinejad in 1990. The material is very hard to work with, is not retreatable and one can easily block themselves while



By: Mahrouz Cohen, D.D.S

sealing the canal. Knowing the material and having the hang of it over the 25 years I have used MTA, the material is great for dealing with aggressive Bacteroides Faecalis (the bacteria we commonly find in retreatment cases).

MTA is anti-fungal, cementogenic, osteogenic, and hydrophilic. As good as this alternative sounds there is a dark side to using this material. In essence, using MTA is much like crossing a bridge and not being able to come back. One must exercise the ultimate restraint and consideration when using this material, because once MTA is installed, retreatment is deemed not possible.

M returned due to symptoms for Tooth #7 nine-years later. He remembered our advice that this tooth needed to be watched (the one treated by his previous dentist in 2007). Now with what you have seen in this case how would you go about treating #7?

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New Court Decision Makes Independent Contractor Criteria Stricter

By: CDA Staff

The Supreme Court of California recently ruled that employers must ask themselves three questions as part of an "ABC" test to determine whether someone working for the company should be classified as an employee or an independent contractor. Dentists in California should be aware of the new guidelines as they are more narrow than what dentists may have been used to in the past.

As of May 1, workers in California can now only be considered independent contractors if the employer can establish that all of the following factors are true:

A. The worker is free from control and direction over performance of the work, both under the contract and in fact.

B. The work provided is outside the usual course of the business for which the work is performed.

C. The worker is customarily engaged in an independently established trade, occupation or business (hence the ABC standard).

Factor B in the ABC test essentially means that any professional performing dentistry in a dental practice most likely should not be considered an independent contractor. This applies to specialists and hygienists as well. Therefore, the workers who may be classified as independent contractors under this new decision are, but are not limited to, janitors, electricians and billing and human resources professionals, as these are professionals who are not performing dentistry.

If a dentist owner has workers classified as independent contractors who are practicing dentistry and do not meet all three of the new criteria, they could be subject to penalties, potential administrative actions and lawsuits. Misclassification of an employee creates a potential liability for employment taxes and penalties and liability for failure to fulfill the many legal obligations owed to an employee, such as unpaid overtime or meal- and rest-break violations. If a worker has been classified as an independent contractor in the past and they do not meet all three criteria of the new ABC test, then they may need to be reclassified as an employee and receive the benefits of an employee, e.g., workers' compensation and sick leave.

The new case is a reminder that the classification of an individual as an independent contractor is largely dependent on federal and state tests, not an employer's desire to reduce administrative burdens or payroll costs. The standards for determining whether an individual is an independent contractor or an employee are different under federal and state laws depending on the purpose of the analysis. Dentist owners should assume that all workers are employees unless they clearly meet all legal requirements and pass all the various state and federal tests that are used by agencies to determine independent contractor status.

For employers who are still uncertain about how to classify an employee or how to change a classification from independent contractor to employee, CDA Practice Support recommends speaking with legal counsel.

For more information, contact CDA Practice Support at 800.232.7645 or TDIC Risk Management at 800.733.0633.

Health Tips for *Dentists*

Editor's Note: Dental Dimensions thought to publish an article about your health, particularly while on the job as a dentist, so we asked SFVDS members to send in their personal tips about staying healthy. We received seven tips from our members, which are shared in the coming pages.

Every Day Routines

By: Jorge Montes, DDS

Thank you for asking what we do in our routines to keep our health and to be able to do our dentistry.

After being in dentistry since 1974 as a dental technician and a UCSF graduate of 1985 with my wife Dr. Teresa Romero, there are bound to have been some aches and pains along the way in our careers.

My routine to maintain agility and stamina starts when I wake up. I stretch in bed by bringing one knee to my chest for a count of 30 seconds each leg while moving my ankles. When I get up, I don't only stretch forward and sideways but also backwards. When I take my morning shower I listen to great soothing music from the 40's to the 80's. While showering I bend my legs to keep tension on my quadriceps and tense my stomach muscles to keep my core muscles active.

Either before or after showering I do 30-50 push-ups at an incline against the sink counter. Then I tense all my upper body muscles for 60 seconds. After shaving I place coconut oil or suntan lotion on my face and hands to avoid wrinkles and spots. I make sure I eat breakfast, even if it is eating in the car. In the car I try to listen to motivational CD's or Books on CD, or lectures. At the office, while in the chair, I try to stretch my neck and crack my back every time the patient goes to rinse, and I stretch my wrists by placing my hands in the prayer position and try to bend my hands back.

To avoid Carpal Tunnel Syndrome pain, I sleep with a special orthopedic wrist brace and I see my chiropractor, Dr. Javier Suarez, who uses electrodes on my wrist every six months. In my rest room I have a pull-up bar and I just hang to stretch my back, and then I do at least three to five pull-ups. I also wear long compression socks because I had Deep Vein Thrombosis and a Pulmonary Embolism. That's why I hike and exercise at every opportunity. Plus, I use an elliptical exercise machine at home.

Since we bend our heads all day to do our dentistry, we are bound to have neck problems so every chance I get I turn my head as far as I can to the left and then to the right. Then I pull my head sideways, with my ear toward my shoulder. After work I stay late to finish my charts and I place a timer on my phone so that every 28 minutes I alternate with either 50 jumping jacks, or 50 sit-ups, 50 deep knee bends, or 50 incline push-ups.

Being athletic all my life, I have knee and back problems so I can't play my tennis or racquetball like I used to. Now I do a lot of hiking and cycling to stay in shape. So if there is a group of dentists and their staff who would like to start a weekly or monthly hike or bike trip, let me know and we can all stay in shape together, and at the same time share other ideas of health and dentistry. I hope these few suggestions turn in to habits and we get to retire without being hunched and walking like old people.

Dr. Jorge Montes can be reached at: 818-765-6671

Back to Dentistry

By: David Hand, DDS

If you ask someone who has back problems "How are you doing?", many times, they answer "There's good days and not so good days" ..... or....."I feel like (expletive deleted!)."

Unfortunately, many of us have or will experience back pain. Sometimes it is obvious that immediate care is necessary. Other times, there are signs and symptoms some people ignore and shouldn't. Such examples are extremity weakness, increasing frequency/intensity of pain, numbness, and muscle cramping that may be associated with nerve inflammation. If you have symptoms, get a good diagnosis before attempting to rehab yourself. It is possible that an incorrect physical therapy program can exacerbate a problem and not help it. Since our profession has always been on the forefront of prevention, what can we do in a prophylactic sense to help ourselves? The sooner a good exercise/physical therapy program can be initiated AND maintained, the better off we will be. Personally, I know this is true, especially the part of maintaining a program. I definitely feel better when I more strictly adhere to my exercise program.

My back specialist/surgeon's office has created an app that can be a benefit. It is called the Back Doctor and is available at your app store. It is a good start for a preventive program if you do not have access to any other. Remember, the root of back pain (sic) can be different than that of other muscles and joints. One needs to appreciate that fact and approach and treat it differently.

If you have any questions, feel free to contact me at 2dhanddds@gmail.com

Health Tips for *Dentists*

Reiki, Reiki, Reiki

By: Khanh Diem Le, D.D.S.
Diplomate, American Board of Pediatric Dentistry

We've all had one of those days. It's only the morning but you're already wishing for the end of the day when you can catch your breath and relax. It may be because your best assistant called in sick and you've got a packed schedule, or perhaps it's a procedure that seemed straightforward enough but now it's an hour later and you're still hard at work making it right for your patient. Reiki can help smooth out the tension in these situations. It can help ensure you have less and less of these stressful days and when they do occur, it can help soothe you and everyone involved, facilitating a better outcome.

Reiki, a Japanese healing technique, promotes stress reduction and relaxation. Reiki is also known to accelerate the body's innate healing ability and is recognized by The National Institutes of Health as adjunctive therapy.

Reiki was first introduced by a Japanese Buddhist named Micao Usui in 1922. It was brought to the U.S. in 1937 and in the 1980's spread to Europe then to the rest of the world. It is practiced all over the world today, in many settings such as hospitals, hospices and private practice. In the U.S., reiki is available in more than 80 hospitals and reiki education is offered at 800 hospitals. The International Center for Reiki Training estimates that there are more than 4,000,000 people worldwide who are reiki certified.

The word reiki means universal life energy; reiki is a precise method of connecting to that life force energy. This life force energy, present in all living things, gives us our vitality. Reiki's subtle effectiveness is based on the premise that we are more than our physical bodies. We have an energetic body that consists of an aura (what science calls the biofield), our chakras (energy centers) and the meridians (energy pathways). The more well-known practice of acupuncture uses points along these meridians. Just like our physical body needs food, so too do we need to fuel our energetic body.

Our aura takes in the energy, the chakras act as transformers breaking it down for use and it is distributed by the meridians. We are already mindful of surrounding ourselves with positive influences; this is why we gravitate towards a smiling face or go outdoors to rejuvenate by connecting to nature. With reiki, we can consciously take in the high frequency of universal life energy. Reiki is a natural and holistic technique that can keep our body, mind and spirit healthy and balanced.

There are three levels of reiki. Level one is the entry level and you need to lay hands on a person to transmit energy. Reiki flows out mostly from the palms. The second level bumps up the power of reiki; time and space are no longer variables. You can now send reiki from a distance so you no longer need to touch the person to give reiki. Level three is where you learn to attune and ignite a student's ability to flow reiki.

Like a house already wired for electricity, everyone has the ability to transmit reiki; it just lies dormant within us. With the attunement process, the reiki master teacher flips on the switch to ignite this ability. In this way, reiki is easy to learn. Once you are attuned to reiki, it is yours for the rest of your life and its strength never diminishes. As the practitioner, you are only a conduit for reiki to flow through. Unlike other healing energetic practices, reiki is easy to use because it does not need to be harnessed or guided. Being from source energy, reiki will do what's needed each time it's used. Its applications are wide and varied; it works on people, animals and plant life. It is not based on a religious system of belief.

Reiki is easy to incorporate into your life and your practice. It can be used daily, morning and night by laying hands on your self. Self-care is important because we need to put the oxygen mask on ourselves first so we have the resource to help others. In your practice, it's as simple as activating and flowing reiki during treatment and reiki will help soothe and relax your patients. Reiki will enhance everything you do. For invasive procedures, healing is quickened and patients have fewer symptoms, therefore needing to take less pain medication.

Four years ago, I was introduced to reiki at a function sponsored by the San Fernando Valley Dental Society. Seeing the many smiling faces of reiki practitioners who showed up that night made me realize I wanted to feel that good too. In a relatively short time, I became certified in all three levels of reiki and am living a reiki-infused life. I am convinced of reiki's place in dentistry and thus want to share this complementary technique with as many of my colleagues as possible. I have spoken of its benefits at last year's CSPD WOW session and at this year's AAPD breakfast rounds. I currently teach workshops and lead events at the Reiki Center of Los Angeles. Please feel free to contact me with any questions or comments. I am available for private reiki sessions, including sessions for your dental patients during their appointments, as well as in-office intro demos, where you'll learn more about reiki and experience reiki first hand.

With consistent use of reiki, calm, joy and peace can be yours, whether you're at home or in the office. You become the high vibrating individual others want to be around. This improves your daily life. Your high energy can be your greatest asset. Imagine living your most vibrant life, doing more from a perspective of openness and enjoying the benefits of well-being. Reiki offers the key to the truest version of you.

If you have any questions, feel free to contact me at: reikibright@gmail.com or (310)463-7960 cell phone.

A Few More Healthy Suggestions

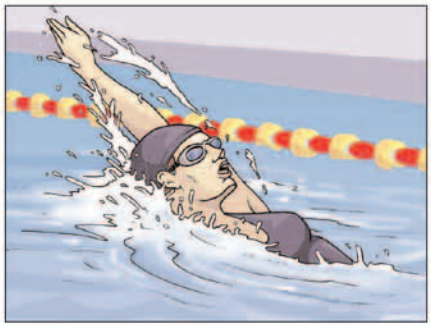
By Wednesday night, after working Monday, Tuesday and Wednesday, my back was killing me until until I got the Bruno dental stool with sliding arm rests by Scandex. The chair seat is contoured, the back has great lumbar support but it was the sliding arm supports that made all the difference in the world. Before I invested in this chair, they shipped it to me on a trial basis.

I feel like the chair has saved my back and my career in dentistry.

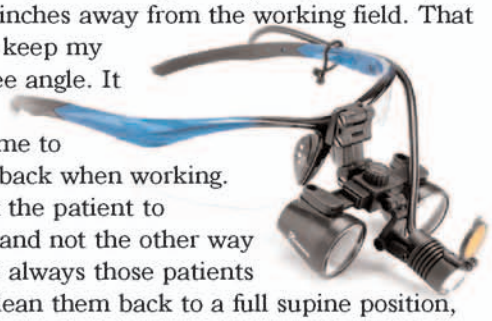
In my personal experience, with more than 30 years of practice, I've been working out lower back, upper back and my abdominal muscles. Just when I stopped my work out the pain comes. I've been doing this 1-2 times a week for more than 10 years. I hope this help my colleagues somehow.

Regards,
G Henao, DDS

Here are somethings that have helped me:
I used to swim and do slow laps (back stroke). It helped my shoulders and my back throughout the years. It was a great exercise and since during that time you can't check your phone, talk to anybody or watch anything on the monitor, it became my meditation time also. I started with 5 laps and was able to do about 60!



I also believe in the power of loupes!! my loupes are adjusted to keep me 12 inches away from the working field. That distance helps me keep my back at a 90 degree angle. It helps my posture and doesn't allow me to stoop or bend my back when working. I also try to adjust the patient to accommodate me and not the other way around. There are always those patients who don't let you lean them back to a full supine position, but I try to keep that to a minimum. Also, use indirect vision as much as possible and keep shoulders straight.



I learned from the beginning (from my Hygiene instructors) that all movements in my arm and hand have to come from the elbow, not from the wrist. so when doing any repetitive motions, I keep my wrist and hand straight and move my arm from the elbow.

I believe in prevention. I have been practicing for 15 years and never had back pain or needed adjustments.

So basically, I recommend applying all the good stuff we learned at school.

By: Karin Irani, D.D.S

Antelope Valley *Report*

By: Andy Ozols, Executive Director

On May 10, 2018, the SFVDS held a zone meeting at Gino's Restaurant in Lancaster concerning data breaches and HIPAA compliance. 15 members from the Antelope Valley took advantage of this opportunity to better understand the gravity of data breaches, how to set up HIPAA compliant office computer systems and secure back-up systems. There was even a review of the severe fines that are imposed by the Department of Health and Human Services on those who experience data breaches and/or fall out of HIPAA compliance.

The program was conducted by Mr. Eric Soto, CEO of one of our long-time supporting vendors, Infinite Computer Technologies (ICT) of Valencia. ICT is a dental/medical technology and services company that among their specializations is securing dental office data and patient records.

Glendale-Foothills Report

By: Chi Leung, DDS

When you think of summer, you probably think of swimming pools, cookouts and sunshine — but do you also think of your dental office and professional emergency training?

All dental professionals (including dentists, hygienists and assistants) are required to have a current BLS provider certification. This certification must be renewed every 2 years.

The SFVDS training program is specifically designed to provide dental professionals with the ability to recognize several life-threatening emergencies, provide CPR, use an Automated External Defibrillator (AED), and relieve choking in a safe, timely and effective manner.

We will offer a CPR recertification course again in September. Please join us and bring your entire office staff. The cost is only $35 with $5 of it donated to the SFVDS Foundation. This is an excellent member benefit since costs for CPR recertification are generally $60+ per person from private recertification providers.

Lastly, I would love to hear from you as we plan another zone meeting in the Glendale/Burbank/Foothills area in the fall. Please let the central office staff know if there is a particular topic you would like to see covered. Maybe it's social media, employment law, insurance coding or something else. We want to be the organization that provides its members with the information they want and need to know to make their practices thrive – so please let us know!

Welcome New Members

Dae Kim, DDS
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Periodontist
USC, 2018

Vahe Karimian, DDS
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General
USC, 2018

Juliet Ebrahimian, DDS
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General
USC, 2018

Ariga Abrahamian, DDS
818-640-4278
General
USC, 2018

Valentina Babuchyan, DDS
323-889-9058
General
UCLA, 2018

Chantelle Ghiam, DDS
818-730-1209
Orthodontist
UCLA, 2018

Charlotte Etesse, DDS
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General
UCLA, 2018

Daniel Lee, DDS
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General
UCLA, 2018

Scott Carr, DDS
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General
USC, 2018

Mitra Minovi, DDS
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General
USC, 2018

Julieta Sanchez Martinez, DDS
818-461-4882
General
Loma Linda, 2018

Mina Habashi, DDS
626-253-3971
General
UCLA, 2018

Fnu Abhishek, DDS
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General
USC, 2018

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Marufa Lala, DDS
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Argina Kudaverdian, DDS
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General
UCSF, 2017

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General

CLASSIFIED ADS

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

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