Bulletin of the San Fernando Valley Dental Society

Dental Dimensions

Winter 2010

www.sfvds.org

Bill Emmerson, DDS (L), Runs for State Senate

Practice Management Issue

- Recession Proof Your Practice
- Why Invest in Your Practice - NOW!
- The Economy May be Down but You Don't Have to be!

Perio for the General Dentist

AB 2637 - What the New DA Law Means to Your Practice

DENTAL DIMENSIONS

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In This Issue

Winter 2010
Volume XXXXIV Number 1

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 editor.sfvds@sbcglobal.net or contact the dental society office at 818-884-7395

On The Cover.....

Drs. Bill Emmerson (L) and Sam Aanasted, two dentists in the state legislature. Dr. Emmerson is now running for the state senate and deserves our support. See page 12.

From the Desk of the Editor

Proud to be a member!

The American Dental Association's House of Delegates (HOD) is the supreme governing body of the largest organization in the world representing dentists. The ADA Annual Meeting and HOD was held in Honolulu, Hawaii October 1st through 6th, celebrating ADA's 150th Anniversary. There were close to 25,000 attendees, over 8,000 of who were dentists. 467 delegates from across the country, including 67 from California and 7 from our own SFVDS component, congregated on this island paradise to spend most of their time indoors discussing, debating and voting on the resolutions of the House.

I had the privilege of attending this HOD session as a guest and, seeing our governance in action. It is hard to imagine the dedication of the delegates, staff and officers if I had not seen it myself. Although only delegates can speak on the House floor, any member can express their views at the three public Reference Committee hearings held to debate the resolutions in order for everyone to have a voice and expedite the business of the House. It is here that I spoke as a general member, and expressed my concerns about mid-level providers and what this means to our future as a profession. My concerns were heard, as well as those expressed by delegates and alternate delegates on this and many other issues facing dentistry and the ADA. After the hearing, the Reference Committee goes into a closed session to deliberate and make a recommendation to the House on each of the resolutions assigned to that reference committee. Each resolution is then presented to the House by the Reference Committee Chair with a recommendation to accept, reject or modify the original resolution. The house then further debates the resolutions and modifications and further changes can be made. Although most resolutions are passed or defeated, the House can refer the final version of the resolution to the appropriate ADA body for further investigation.

Continued on page 13

Jorge A. Alvarez, D.D.S.

A Note of Thanks

By the time you receive this issue of Dental Dimensions, the holidays and the year 2009 will be history. In 2009, I was honored to represent our component as your president. Upon reflecting on what was a challenging year, not only for me but, for all of us, I can only be grateful to belong to the noble profession of dentistry.

Despite a sluggish economy, dentistry has risen to keep the oral health of the public in good standing. Last year our dental society participated in various volunteer programs to help our communities maintain their oral health. In 2010 the participation continues, expanding our involvement in the communities we serve.

I do invite you to support your component and get involved in our society's committees. There are many issues in the professional and political arenas that will have a direct impact on our profession, and the way we deliver our services, which in turn, directly affects the public we serve. Your help is always welcome.

I want to take the opportunity to thank our central office staff: Our Executive Director, Andy Ozols, Membership and Sales Coordinator, Wendy Abrams and our Receptionist, Bella Penate - who have done a great job in supporting the needs of the public and of our members.

My final note of thanks goes to all of you, our membership.

Jorge A. Alvarez, DDS
San Fernando Valley Dental Society
Immediate Past-President

From the Desk of the Executive Director

By: Andy Ozols

While I am sure you have heard this many times in the first month or so of this year, I want to take this opportunity to wish all of our members a happy and prosperous New Year! I trust that 2010 will be a good recovery year for those of you who have seen a decline in your practices.

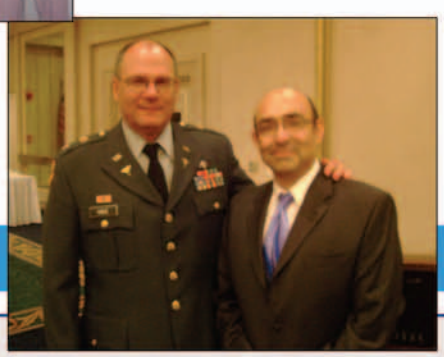
In addition, as we all see reports about the added stresses and financial pains of ordinary people caught in California's 12+% unemployment rate, the SFVDS will be working ever harder on helping provide some basic dental care to those most in need. Throughout the year, you will hear me call for volunteers to lend their expertise and I hope you will be able to help as much as your schedules allow.

By the time you read this issue, we will be well on our way with the ADA sponsored, "Give Kids a Smile" program, sending volunteer SFVDS dentists to more than 25 locations to help low income, disadvantaged kids. In April, Remote Area Medical is coming back to Los Angeles, so we'll be joining the other four L.A. area dental societies, and the hygienists' and dental assistants' associations in recruiting the hundreds of volunteers that will be needed.

That being said, now let me tell you a little about the photos you see on this page and the next. They are pictures of some of the SFVDS' activities in the last quarter of 2009.

1. At the September General Meeting, Dr. Carol Summerhays, 2009 CDA President, came to help us recognize our members who have been members for 50 or more years, and presented them with certificates of our appreciation.

2. At that same General Meeting in September, 2009 Past-President of the SFVDS, Colonel Bob Hale, DDS, returned to present an "Oral and Maxillofacial Review" lecture to the membership. Pictured with Dr. Hale is the 2009 President, Dr. Jorge Alvarez, who many of you may remember, was Dr. Hale's Program Chair in 2005.



3. L-R, Drs. Dell Goodrick and Karin Irani, MEND Dental Clinic Manager, Denise Benitez and SFVDS Administrative Assistant Bella Penate educated and provided oral health screening for children at the Delta Sigma Theta Community Health Fair in Pacoima in October.

4. L-R, SFVDS Administrative assistant, Bella Penate, Dr. Punita Oswal, Dr. Craig Ford, Senator Alex Padilla, Dr. Karin Irani and SFVDS Andy Ozols, Executive Director, at the Latino Diabetes and Health Fair in Pacoima, where we educated and provided oral health screening for children.

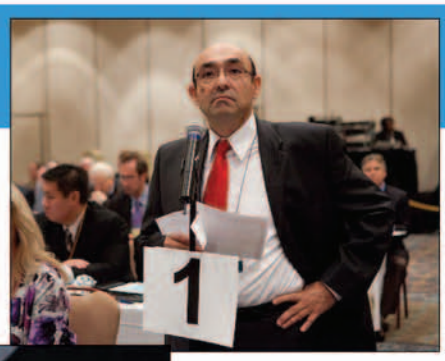
5. L-R, Drs Gilbert Snow, Rosemary Navarro and Jacob Moreno, three of a dozen or so members in the Antelope Valley who participated in our October zone meeting at Applebee's in Lancaster.

Continued on page 6

Continued from page 5

6. A few shots of our First Annual SFVDS Holiday Party, held December 10 at the Knowllwood Country Club in Granada Hills. 238 Member doctors and their office staff attended, ate a buffet-style dinner, danced and played casino games as a fundraiser for our Give Kids a Smile program. For a first year effort, everyone agreed it was a smashing success.

7. A few shots from the annual CDA House of Delegates meeting in Sacramento in November.



7-b) SFVDS President, Dr. Jorge Alvarez addressing the CDA House of Delegates.

7-c) Outgoing CDA president, Dr. Carol Summerhays, with incoming CDA President, Dr. Tom Stewart.

7-d) ADA President Dr. Ron Tankersly.

7-e) SFVDS delegate, Dr. Virginia Hughson-Otte addresses the CDA House.

7-f) SFVDS delegate, Dr. Gerald Gelfand uses a special, 'point of order' microphone to address the Speaker of the House, Dr. Alan Felsenfeld.

7-a) The SFVDS House delegation of 12.

7-g) The SFVDS delegation, their spouses and friends assembled for a group photo at the CDA President's, Carnavale Party at the CDA House of Delegates.

Legislation Report

By: Jim Mertzel, D.D.S.
Chair, SFVDS Legislation Committee

At the present time there are three ways that dental students in California Dental Schools can obtain a license to practice in California.

A clinical and written examination developed by the California State Board.

A clinical and written examination administered by the Western Regional Examining Board.

A minimum of 12 months of a general practice residency or advanced education in a general dentistry program approved by the American Dental Association's Commission on Dental Accreditation.

Assembly bill 1524, Licensure by Portfolio, introduced in February, 2009, would eliminate the clinical and written examination currently offered by the Board. Provisions of the bill would allow the Board to offer the portfolio examination as an alternative to initial licensure for general dentists in addition to other two pathways available to students graduating from dental schools in California.

The Board would determine the curriculum and requirements for the student to perform while in school who would certify that student had performed the procedures at the standard required by the Board.

Although I have been practicing for many years, I still remember the fear in my heart thinking about my clinical examination. I had confidence in my ability to perform the procedures, but there was that 'what if'. What if my gold foil doesn't hold? (Yes, I go back to the gold foil days), or, what if my patient doesn't show up? And then it happened to me. At 5:00 AM on the morning of the exam I received a call from the patient on whom I was supposed to perform my procedures. My patient was a medical student who had been working in the pediatric ward of a hospital for the past week and had been inflicted with the stomach flu. He told me that he had been up all night and was constantly vomiting. He said he would come to the clinic but did not think that he would be able to keep a rubber dam on.

The panic set in. All my training for four years preparing for this day was going up in smoke. Bottom line, the patient showed up and after the third attempt to place the rubber dam, the patient's stomach calmed down and I was able to perform the procedures required.
Question. Should all our training and preparation to be licensed to be a dentist be dependant on that one day?

Then there is the opposing view. Should a dental school be the entity to determine whether the student is qualified? There certainly is motivation by the school to certify every student. It would not be to the benefit of the school to disqualify too many students. What if the school determined that the student needed more remedial training? That would require more space in the school, thus limiting the access to space for students entering the clinic. Should there be an outside third party monitoring the competence of the dental school to train the students?

I present both sides of the issue. I do not profess to have the answer.

The following bills were passed by the Legislature and signed by the Governor in this last legislative session.

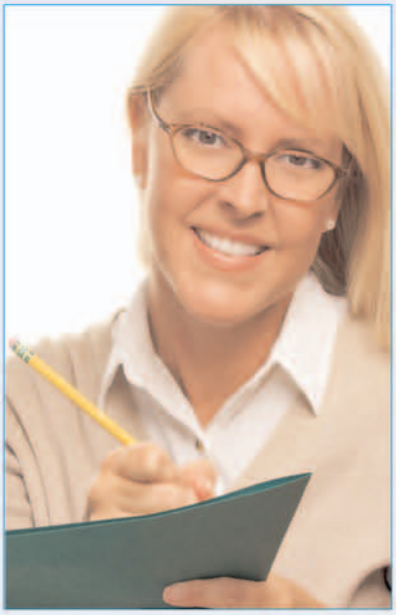
AB 667 Topical Fluoride Application - Permits non-healthcare providers to apply topical fluoride and fluoride varnish in public health and school facilities once a prescription and protocol have been established by the dentist responsible for that program.

AB 171 Dental Services – Commercial Credit Products - Prohibits a dentist or his employee from arranging for or establishing credit extended by a third party for a patient without first providing a written notice and written treatment plan. Prohibits the arrangement or establishment of credit with regard to a patient who has been administered or is under the influence of general anesthesia, conscious sedation or nitrous oxide.

SB 630 Reconstructive Surgery - Provides that the requirements imposed on health care service plans and health insurers define reconstructive surgery as including medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate.

AB 762 Healing Arts - Makes it unlawful for a city or a county to prohibit a healing arts licensee from engaging in any act or performing any procedure that falls in the professionally recognized scope of practice of that licensee.

AB 2637——What it Means to You and Your



On September 28th, 2008, Governor Schwarzenegger signed into law a comprehensive bill defining scope, oversight, education and licensure for all dental assisting categories. This landmark legislation repeals all previous bills, and became effective January 1, 2009.

The introduction of AB2637 was in response to the frustration, confusion and inaction by establishing categories of dental assisting that made sense to those most impacted – dental assistants and dentists. With a blank piece of paper, a clear view of recent history, and a conceptual vision enhancing the future, the new bill satisfies many of the wants and needs of the dental profession and the direct-care needs of our patients. With the California Dental Association and the Dental Assisting Alliance working closely together, the new scheme includes the most progressive duties both could think of incorporating, without compromising patient safety.

The first step eliminates the three specialty categories of registered assisting – the Registered Orthodontic Assistant, the Registered Surgery Assistant and the Registered Restorative Assistant – and the work experience pathway to these licensure categories that caused so many problems for all involved. The result is two specialty permits that unlicensed assistants can obtain without having to complete an 800-hour program!

Unlicensed DAs wishing to perform orthodontic procedures that have been previously designated to the RDA, may obtain a special permit, called the Orthodontic Assistant Permit (OAP). The bill creates a permit process that either a licensed or an unlicensed assistant may obtain via an educational pathway that may be obtained through a Board-approved provider.

This move allows for specialty permits in an unlicensed dental assisting category previously devoid of regulation or laws. The educational requirement for the OAP is 84 hours via a Board-approved program or provider which are currently undergoing review by the Board and should become available early this year.

The bill also established the same permit for surgical assistants or those working in a general practice whose doctor is permitted to perform general anesthesia or sedation procedures. A specialty category that oral surgery has fought long and hard to see has finally made its debut in the Dental Sedation Assistant Permit (DSAP). As with the OAP, the DSAP placed into statute the duties and functions that many unlicensed assistants have been performing illegally for many years. AB2637 creates a permit process that either a licensed or an unlicensed assistant may obtain via an educational pathway through a 110 hour, Board-approved provider. The DSAP allows for the performance of sedation-related functions by an unlicensed assistant without the need to maintain or obtain a RDA license. Most all other surgical assisting procedures have been placed into the unlicensed DA category as well.

Both specialty permits (DSAP and OAP) will require successful completion of mandatory education in infection control (8 hours), basic life support (4 hours) and the dental practice act (2 hours), successful completion of a state-administered written examination, biennial permit renewal fees, and continuing education (25 units).

Unlicensed DAs who are in a dentist's continuous employment 120 days or more must also com-

Dental Assistants.

By: LaDonna Drury-Klein, RDA, CDA, BS, President
California Association of Dental Assisting Teachers

plete, within a year of the date of employment, these mandatory educational requirements. Lastly, the new Business and Professions Code of the Dental Practice Act (B&P Section 1750) also mandates that the employer of a dental assistant shall be responsible for ensuring that the dental assistant maintains certification in basic life support.

The three main categories of assisting remain consistent – unlicensed DAs, licensed RDAs, and licensed RDAEFs. The work experience eligibility pathway to obtaining an RDA license has been increased from 12 to 15 months effective 1/1/2010. Unlicensed DAs wishing to begin a Board-approved program in the duties of the DSAP or the OAP may not do so until he/she has completed a minimum of six (6) months work experience and will not be eligible to sit for the DSAP or OAP examinations until they have completed the program and 15 months work experience.

Although reworked, the RDA written and practical examination will remain, along with the addition of a written examination in Law and Ethics. The educational programs approved by ADA-CODA and the Dental Board will be required to expand their hours to meet the new educational statutes and the added duties/content areas of their licensure categories. RDA programs will be expanded from 720 hours to 800 hours and RDAEF programs an additional 80 hours.
The duties and functions of the DA, RDA and RDAEF have been expanded while specifically allowing for more restorative procedures in the RDA and RDAEF categories. Much of the specialty-related duties of ortho and surgery have been placed in the DA category with a few exceptions - a much-needed vehicle to legal performance of these advanced functions without the necessity of completing an RDA program.

There is so much more to the new legislation impacting our profession. Therefore, we encourage all dental healthcare professionals to review the full version of the bill by going to www.leginfo.ca.gov, Bill Information, 2007-2008 session, and entering Assembly Bill 2637 into the search grid. If after reviewing the bill you have any questions, please contact your component Executive Director, Andy Ozols, (exec.sfvds@sbcglobal.net) and your questions will be forwarded to me.

In the meantime, dental assisting educators will be working hard over the next year to establish meaningful and approved educational tools for your staff in order to meet all the new requirements.

General Meetings - Preview

FEBRUARY 19, 2010

Speaker: Parish Sedghizadeh, DDS, MS

9AM – 4PM Airtel Plaza Hotel, 7277 Valjean Ave., Van Nuys, CA 91406 818.997.7676

Bisphosphonates and Oral Lesions

About the Speakers: *Dr. Parish P. Sedghizadeh,* is an Assistant Clinical Professor and Director of the University of Southern California (USC) Center for Biofilms at the School of Dentistry. He received his Bachelor of Science degree in biology from the University of California, Los Angeles (UCLA), and went on to receive his Doctorate of Dental Surgery from USC. After his doctorate, he pursued specialty training in Oral and Maxillofacial Pathology at Ohio State University, where he also attained a Master of Science degree in oral biology and fellowship status in the American Academy of Oral and Maxillofacial Pathology. His current research interests focus on the study, characterization and treatment of microbial biofilm infections of the jaws.

About the Program: Upon completion of the course, participants will understand the following concepts related to Jaw Osteonecrosis:
Definition of Jaw Osteonecrosis. Risk factors and risk assessment. The role of bisphosphonates and anti-resorptives in disease pathogenesis. Identification of clinical and radiographic lesions of Jaw Osteonecrosis. Staging of patients with Jaw Osteonecrosis. Prevalence of the disease nationally. The importance of imaging studies for disease evaluation and follow-up. The role of microbial biofilms in disease pathogenesis. Current research trends in the field. Management and treatment strategies for all stages of the disease. Prevention protocols and the importance of dental care. Medico-legal considerations and case histories.

MARCH 10, 2010

Speaker: Ms. Marcela Oster, RDA

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

California Dental Practice Act and Infection Control

About the Speaker: *Marcella Oster* has 26 years experience in the dental industry including working as a dental assistant and RDA for 13 years. In 1993, Marcella co-founded and was President of EcoSolutions, the first company to provide comprehensive hazardous chemical waste management services to dental offices (including processing of the chemicals). In 1999, EcoSulutions merged with the industry's largest medical waste management company.

About the Program: California Dental Practice Act

Topics covered will include:

- Highlights and updates of the Dental Practice Act • Scope of practice for dentists and allied dental health professional
- License renewal requirements, continuing education, laws governing citations and fines • Laws pertaining to prescriptions
- Dental record keeping • Acts in violation of the Dental Practice Act including unprofessional conduct

Infection Control Training

The Dental Board of California requires 2 hours of Infection Control for license renewal for all dental employees.
This creative, interactive presentation summarizes the Dental Board of California's minimum standards for all dental professionals.

General Meetings Review

By: Andy Ozols

The last quarter of 2009 offered four excellent CE courses for our membership. Attendance of both member doctors and supporting vendors was very good, averaging approximately 140 attendees and 20 vendor supporters at each meeting. For the first time, we held a joint CE course with the Santa Barbara/Ventura County Dental Society at the Renaissance Hotel in Agoura Hills. The other three courses were held at the Airtel Plaza Hotel, which everyone seems to agree is a very comfortable venue with good food as well. Below is a brief summary of each of those four courses.

September 16, 2009 – Colonel Bob Hale, DDS presented an "Oral and Maxillofacial Review". In addition to an excellent and enlightening presentation, many members were happy to have the opportunity to visit with Dr. Hale, our 2005 SFVDS president who now serves in the U.S. Army full time as the Program Director of their Oral and Maxillofacial Surgery Residency at the Brooke Army Medical Center in San Antonio.

September 18, 2009 – L. Stephen Buchanan, DDS, FICD, FACD presented on the "The Art of Endodontics". Members of both the SFVDS and the Santa Barbara/Ventura County Dental Societies, in a special joint session, were treated to an outstanding presentation on the state of the art in Endodontics, in a Friday daytime session.

October 21, 2009 – Glen Clark, DDS and Michael Simmons, DMD presented on the Medical Consequences and Dental Treatments of Snoring and Sleep Apnea, a growing area of concern in dentistry as well as medicine itself. From these two leading authorities, attendees were able to gain a better understanding of these conditions and diagnosis issues, and cooperation with and referral to medical doctors in a manner that delivers the best care to afflicted patients.

November 18, 2009 – John Yagiela, DDS presented on "Pharmacologic Misadventures and the Dentist". Dr. Yagiela, faculty at the UCLA School of Dentistry, reviewed the basics about local anesthetics, antibiotics, analgesics and other therapeutic agents most commonly used by dentists. He provided updates on the latest research and follow up studies on which drugs to use, when, and what side-effects dentists should watch out for to avoid harm to the patient.

Thank you to all who attended 2009's general meetings and helped to make them a success.

Academy of General Dentistry Honors a SFVDS member

By Joshauna Walker, AGD staff

Dr. Paula Jones, AGD President and Dr. Joel Miller

SFVDS member, Joel S. Miller, D.M.D. of Valencia, CA was recently honored with the prestigious 2009 Lifelong Learning and Services Recognition (LLSR) award by the Academy of General Dentistry (AGD). The award recognizes Dr. Miller's commitment to lifelong learning, volunteer services to communities in need, mentorship to associates and new dentists, and participation in organized dentistry. Dr. Miller is only the fourth dentist in the State of California to receive this award.

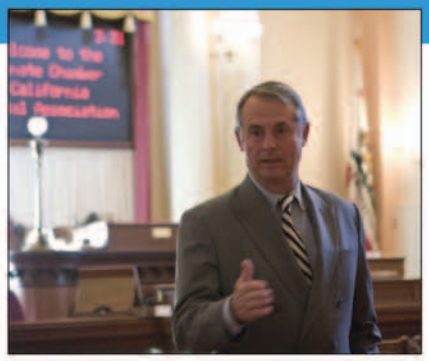
The LLSR award is a formal acknowledgment of the AGD Mastership awardees ongoing dedication to continuing education. AGD Masters who receive this additional recognition have completed more than 1,600 hours of continuing dental education in all disciplines of dentistry, including 550 hours dedicated to hands-on skills and techniques, and more than 100 hours of service to the community.

Of the 160,000+ dentists in the United States, 35,000 are members of the AGD and of those, only 123 AGD members have earned this award.

"Dr. Miller's commitment to the profession, willingness to give back to his community and recognition as a role model among his peers is why he is a great example of an AGD LLSR recipient," said AGD President, Paula Jones, D.D.S., F.A.G.D. "His dedication is an inspiration to other members of the dental profession to continue to strive for excellence."

Bill Emmerson, DDS

By: Jim Mertzel D.D.S.



A Dentist for State Senate

THE CALIFORNIA DENTAL ASSOCIATION ENDORSES AND SUPPORTS BILL EMMERSON'S CAMPAIGN FOR THE CALIFORNIA STATE SENATE. AS MEMBERS OF CDA, WE MUST DO EVERYTHING WE CAN TO HELP BILL EMMERSON, D.D.S. GET ELECTED.

The most important role of CDA is to monitor and look out for the benefit of our members, our patients and our profession. One important way they do that is by influencing the members of our state legislature who make the laws affecting dentistry

When we, as members of CDA, have the opportunity to elect one of our own dentist members to the State Senate, we MUST get involved.

BILL EMMERSON has served our profession well. As a practicing Orthodontist for more than 20 years, he was chairman of CALDPAC, and a member of the CDA Council on Legislation. As a member of the State Assembly he has already had a positive effect on dental legislation.

• He authored the 2006 law that required oral health screenings for incoming elementary school children

• He introduced legislation that allowed dental schools to have special permits for dental educators that are not licensed, to practice in California.

• He supported efforts to maintain Denti-Cal services for children.

• He voted against tax increases for small businesses like ours, including a proposed tax on "services".

Bill has earned the respect of members on both sides of the aisle in the Assembly, thus enabling him to be a very effective legislator.

> He voted against tax increases for small businesses like ours, including a proposed tax on 'services'.

BILL EMMERSON needs our help. There is a special election in April to fill a vacant seat in the State Senate. As he will be completing his term in the state assembly and not returning due to term limits, we want to keep him active in the Legislature.

Bill needs to get the message out to the public in the very short period of time, before the election in April. Please send your contributions immediately. We encourage you to send as much as possible, any amount you can afford will help and be greatly appreciated, but please do it today. Bill Emmerson is a friend to dentistry and he needs our help!

Dr. Bill Emmerson, his wife Nan, his two daughters, Kate & Caroline, and one of the family's two dachsunds.

You can contribute on line at www.billemmerson.com or mail to:
Friends of Bill Emmerson
P.O. Box 1565
Oakdale, CA 95361

From the Desk of the Editor

continued from page 4

SFVDS representatives of the ADA House's 13th district, (L-R) Drs. Jennifer Holtzman, Gary Herman, Virginia Hughson-Otte, Anita Rathee (Dental Dimensions Editor), Joe Sciarra, Mike Bromberg, Gerry Gelfand and Alan Stein

The entire process is surprisingly interesting and exciting to follow, but what I found the most gratifying, was the seriousness with which the delegates took their charge of representing each of us, the grass roots member. This was exemplified by the exhaustive two hours taken at near the end of the House to debate an increase in membership dues. In these tough economic times when all organizations are struggling, it was a contentious issue. Strong arguments were made from the Treasurer, Budget and Finance committee members, and delegates to vote for a dues increase, and to not dip into reserves to balance the budget. Equally strong arguments were made to not put any additional financial burden on the members. Tough times call for tough decisions and the House ultimately voted NOT to increase dues, even by a dollar.

I am not sure if the delegates, staff, or officers even got an hour to lie in the sun on the beautiful Waikiki beach just outside their doors, or felt more than a few minutes of the warm balmy air as they walked from one meeting to another. I know I didn't, and I just went to observe! The dedication and hard work I saw on our behalf makes me proud to be a member!

Anita Rathee, D.D.S., MPH
Editor, SFVDS

A Full ADA House of Delegates session in Hawaii. Recongnize anyone in the second and third rows?

ADA Executive Director, Dr. Kathleen O'Laughlin addresses the ADA House

ADA delegates were entertained at the Waikiki Shell during the opening day of the House of Delegates.

Management of Periodontal Patients in the General Dental Office

By: Robert L. Merin, DDS, MS.

I am writing this article in response to a request by SFVDS President, Dr. Mark Amundsen. He recognized a problem with referring patients for comprehensive periodontal treatment during these tough economic times. Since a lot of patients have lost their dental insurance and large portions of their cash reserves, he felt that many were unwilling to complete periodontal treatment at specialty offices. His questions to me were:
"How should a general dentist handle this problem?"
"What non-surgical options should the general dentist consider?"

What follows are my thoughts on these questions.

PERFORM A COMPREHENSIVE PERIODONTAL EXAMINATION

The primary care dentist is responsible for performing a complete dental and periodontal examination. Guidelines for the periodontal portion of the exam can be found in the Parameters on Comprehensive Periodontal Examination on the American Academy of Periodontology's Web Site at www.perio.org.[1] The dentist should have appropriate radiographs, full-mouth periodontal charting, and a complete medical and dental history (See Table 1). The chronic nature of periodontal diseases requires that clinicians regularly reassess patients for lifelong disease management.[2] Periodontal diseases can affect soft and hard tissues, and practitioners should address both soft tissue and bone involvement.

DETERMINE A DIAGNOSIS AND RISK ASSESSMENT

The dentist needs to determine whether the disease is mild (gingivitis), acute, chronic, severe, or aggressive (rapidly progressive) and decide on the diagnosis. Tables 2 and 3 present the current AAP classifications.[3] In addition, the clinician needs to evaluate the risk for tooth loss and prosthetic replacement.[4] The evolving paradigm of periodontal disease affecting diabetes, pregnancy, cardiovascular disease, and other systemic health problems must be considered in the risk assessment.[4,5,6]

INFORM THE PATIENT OF YOUR FINDINGS AND RECOMMENDATIONS

Based on the results of the examination, a diagnosis, proposed treatment plan, and consequences of no treatment should be presented to the patient.[1] The education, experience, and interest of individual practitioners vary, and specialty referral may occur at different stages of disease and risk level. If you feel that referral to a periodontist is indicated, you should discuss this with the patient. An example of a case that would have benefited from earlier specialty referral is shown in Figures 1 and 2. If the patient does not feel they can afford the cost of private practice specialty care, you can discuss referral to a dental school residency program (such as UCLA or USC), and the non-surgical and maintenance options you can provide in your office. You must provide information about the risks of not having the periodontal specialty care so that the patient can make an informed decision if they refuse your recommendations.

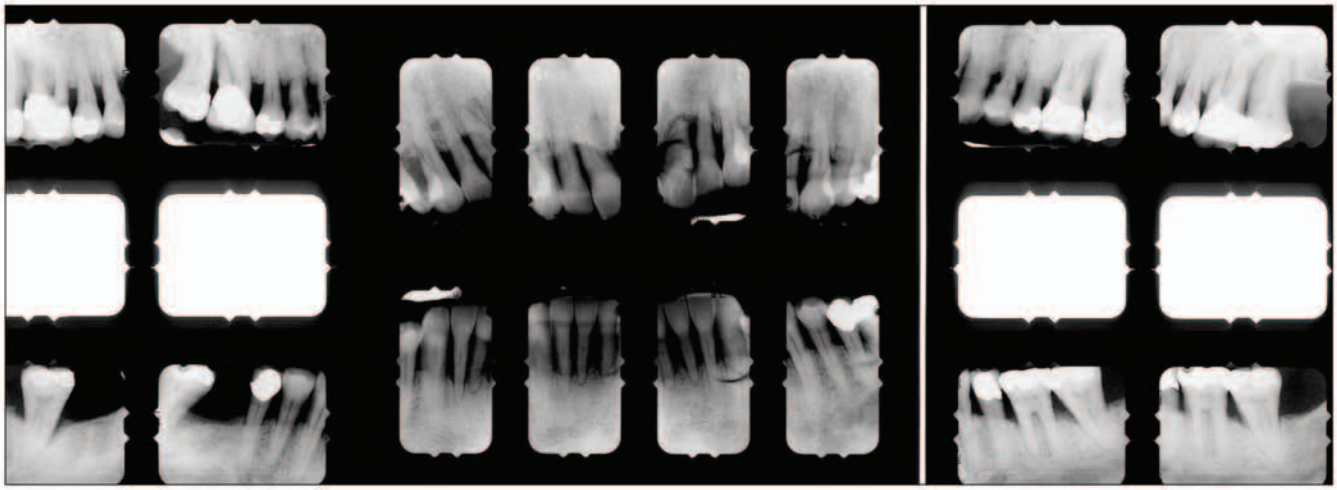


Figure 1

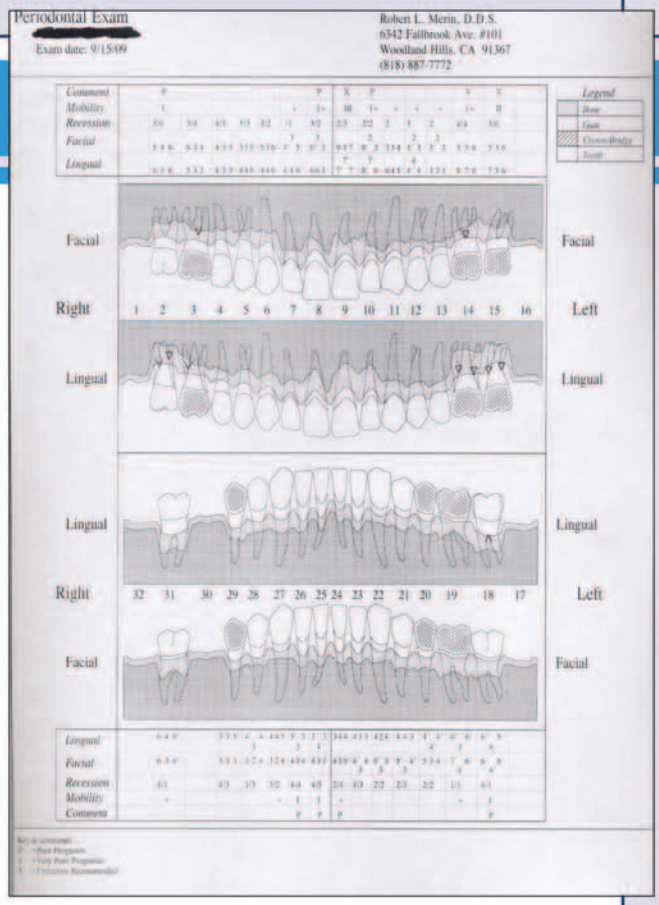


Figure 2

WHAT ARE YOUR OPTIONS WHEN THE PATIENT REFUSES REFERRAL TO THE PERIODONTIST?

UNDERSTAND THE BASIC CONCEPTS

Periodontitis begins with a microbial infection followed by a host-mediated destruction of the soft tissues that causes significant connective tissue and bone destruction.5 The bacteria form complex biofilms that are resistant to host defense systems.7 Periodontal infections and inflammation can have profound influence on tooth loss and general health.4,5,6 Data from randomized controlled clinical trials have shown that periodontal therapy is effective as long as patients comply with post-treatment maintenance programs.8,9 Table 4 summarizes some of the basic concepts.

CONSULT WITH YOUR PERIODONTIST

You should have a relationship with a periodontist where you can contact him or her, explain the situation, and ask for advice on treating the patient in your office. You can find the names of local periodontists at the California Society of Periodontists website (www.calperio.org). You can also use the pullout specialty referral guide printed in the Summer 2009 issue of Dental Dimensions. Even if the patient refuses referral, consultation with your periodontist can be a valuable adjunct to your practice. Periodontists and general dentists have a long history of working together as a team, and periodontal diseases now have an elevated significance because of their affects on general health.

TREATMENT OPTIONS FOR CHRONIC PERIODONTITIS

Encourage and teach good oral hygiene practices and consider the use of antimicrobial mouth rinses.

Scaling and root planning has been shown to be effective in reducing moderate depth pockets, and this can be employed as an initial response for a diagnosis of chronic periodontitis.[7,8,9] This always needs to be followed by an assessment of the results of the procedure.

Patients can be placed on a periodontal maintenance program with hygiene appointments every three months.[10] Supportive periodontal maintenance has been shown to be effective in reducing disease progression.[8]

Local delivery antimicrobial agents (LDAs) such as minocycline (Arestin) or doxycycline (Atridox) can be added to root planning or maintenance procedures for pockets which continue to bleed on probing and are 5 mm or greater.. These site specific treatments can be repeated at maintenance appointments if needed. These produce a modest reduction in pocket depth (0.25 mm to 0.5 mm) which is a fraction of the reported mean 1.45 mm of pocket depth reduction achieved with scaling and root planing alone.[11]

Consider systemic antibiotic therapy for patients with continuing loss of periodontal attachment.[12] Antibiotics should be considered as an adjunct to mechanical periodontal debridement. Common antibiotic therapies are presented in Table 5.

Consider host modulation therapy for chronic periodontitis that does not seem stable with your other therapy.[13] You can prescribe 20 mg of doxycyline twice per day. This will reduce the patient's upregulation of matrix metalloproteinases (MMP) which contribute to the tissue destruction. Three 12-month studies combined scaling and root planning, dental prophylaxis, and 20 mg doxycyline twice per day. There were small but statistically significant improvements with the 20 mg doxycyline groups. In the studies, patients were on the medication for at least four months.

Consider extraction of teeth with deep pockets that bleed on probing if the patient is unable or unwilling to have surgical treatment. This should improve their health, and reduce the chance of having emergency abscesses.

SOME FINAL THOUGHTS

If you are trying to maintain a generalized chronic periodontal case without pocket reduction or regenerative surgery, every maintenance appointment will require anesthesia or be painful to the patient. This can create a patient compliance problem. In addition, assessment of disease progress will be difficult because of the large number of remaining sites with pockets. Teeth with deep pockets that bleed on probing are prone to getting abscesses that require emergency care.

Where possible, I have tried to provide references that are open access on the Internet so that the reader can easily get more detailed information.

Dr. Amundsen's questions are important and practical questions that affect the dental and systemic health of our patients.

TABLE 1
COMPONENTS OF A PERIODONTAL EXAM1

1. Medical history.
2. Dental history including the chief complaint or reason for the visit.
3. Extraoral examination including temporomandibular apparatus.
4. Intraoral tissues and structures.
5. Teeth and their replacements.
6. Current radiographs based on the diagnostic needs of the patient.
7. Presence and distribution of plaque and calculus.
8. Periodontal soft tissues, including peri-implant tissues.
9. Probing depths, location of gingival margin, and the presence of bleeding on probing.
10. Mucogingival relationships, significant gingival recession, abnormal frenulum.
11. Presence, location, and extent of furcation invasions.

1Adapted from American Academy of Periodontology. Parameters on Comprehensive Periodontal Examination. JPeriodontol 2000;71:848. Parameters of Care Supplement. www.perio.org.

TABLE 2
CLASSIFICATION OF PERIODONTAL DISEASE.

1. Gingivitis
2. Chronic periodontitis (replaces term adult periodontitis)
3. Aggressive periodontitis (replaces term early-onset periodontitis)
4. Periodontitis as a manifestation of systemic diseases
5. Necrotizing periodontal diseases
6. Abscesses of the periodontium
7. Periodontitis associated with endodontic lesions

3Adapted from American Academy of Periodontology. Academy Report, Position Paper, Diagnosis of Periodontal Diseases. J Periodontol 2003:74:1237-1247. www.perio.org.

TABLE 3
CASE TYPES FOR THIRD-PARTY INSURANCE PAYMENTS3

Case Type I	Gingivitis
Case Type II	Mild Periodontitis
Case Type III	Moderate Periodontitis
Case Type IV	Advanced Periodontitis
Case Type V	Refractory Periodontitis

3Adapted from American Academy of Periodontology. Academy Report, Position Paper, Diagnosis of Periodontal Diseases. J Periodontol 2003:74:1237-1247. www.perio.org.

TABLE 4
BASIC CONCEPTS OF PERIODONTAL DISEASES AND TREATMENT[4,5,6,7,8,9]

1. Periodontal infections are polymicrobial.
2. The causative agents are part of the indigenous (normal) microbiota.
3. The amount of dental plaque is of etiologic importance.
4. Some bacteria in dental plaque are more pathogenic than others.
5. Dental plaques are highly organized bacterial biofilms.
6. Only about 50% of the oral microbiota can be grown in the laboratory.
7. Most of the tissue destruction is host mediated and not due to bacterial toxins.
8. Untreated periodontitis may affect heart disease, nonhemorrhagic strokes, adverse birth outcomes, metabolic diabetes control, gastric ulcers, and other inflammatory mediated diseases.
9. Periodontal treatment is effective as long as patients comply with post-treatment maintenance programs.

TABLE 5
COMMON ANTIBIOTIC THERAPIES IN THE TREATMENT OF PERIODONTITIS12

Antibiotic	Adult Dosage
Metronidazole	500 mg/t.id./8 days
Clindamycin	300 mg/t.i.d./8 days
Doxycyline	100 mg/q;d./21 days
Ciprofloxacin	500 mg/b.i.d./8 days
Azithromycin	500 mg/q;d./4-7 days
Metronidazole + amoxicillin	250 mg/t.i.d./8 days of each drug
Metronidazole + ciprofloxacin	500 mg/b.id./8 days of each drug

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The Economy May Be Down . . . But You Don't Have To Be!

By: CDA Practice Support Center

For many dentists, gone are the days when your heart rate increased from having too many patients on the schedule and you thought to yourself, "If I could just stop to breathe during the day!" Now many practices face the opposite problem of holes in the schedule, which makes us all think, "Be careful what you wish for." But rather than letting the economy bring you down, turn what may be a slow time in your practice into an opportunity.

Unfortunately, we can't control the economy, so get out of the negative rut and focus on what you can manage – your practice systems, patient service and staff training.

Less productive times can be your opportunity to implement policies and invest in your team so that when market conditions do turn, your practice will function better than ever.

Here are some "bad economy-busting" tips to keep your team productive during less productive times:

TIP #1: Follow up with unaccepted treatment plans

How often do you hear from patients, "I need to get back to you after the holidays" or "I need to wait until I get my tax return, I'll call you then"? If you and your staff wait for the phone to ring, you may be waiting for awhile. Patients are the most motivated to schedule treatment that they ever will be when they are in your practice. Once a patient walks out the door, all the other expenses in that person's life become your competition and it is up to you and your team to make dentistry important.

Not that we want to compare dentistry to buying a new car, but car salesmen do get the "value building" concept right – they don't let you forget how much you wanted that car when you were at the dealership test-driving it. Instead of giving patients the opportunity to say, "I'll call you when I'm ready," make it part of your treatment plan discussion to say, "I understand you need some time. I'd like to follow-up with you in a few days to see if you have any additional questions."

TIP #2: Invite uncertain patients back for second consultative appointments

In a down economy, even financially stable patients may need time to think about treatment. The message everywhere you look, whether you have money in the bank or not, is to "save, save, save." If you find that your schedule has more openings than you would prefer, rather than dwelling in the economy blues, schedule patients for a 20-minute consultative appointment to build value for the treatment plan and answer any questions or concerns the patient may have. This will show your patients that you are not trying to "sell" dentistry, but rather are genuinely concerned for their oral health. After all, the consultation is complimentary one-on-one time with the doctor – there are not many health professionals today who offer that service.

TIP #3: Maximize your morning huddles

Use this less productive time to enhance your morning huddles. Make sure you and your team carefully review every patient scheduled that day in detail. See if any patients scheduled in hygiene have restorative treatment pending, and block out the doctor's schedule to have an extended exam with those patients. Check to see if patients scheduled have family members who are overdue for treatment – sometimes your biggest advocate will be the spouse of the patient who is overdue for hygiene or hasn't scheduled an appointment to have those lingering cavities filled. Read your personal notes to see if there are any events, anniversaries or celebrations coming up in your patients' lives. You never know who would be interested in teeth whitening or veneers as a big event approaches. Review patients' dental benefit coverage to see who has pending treatment that can be covered by dental benefits. Patients look to you to keep track of their coverage and rely on you and your staff to help them maximize their dental benefits.

TIP #4: Make personal phone calls to patients

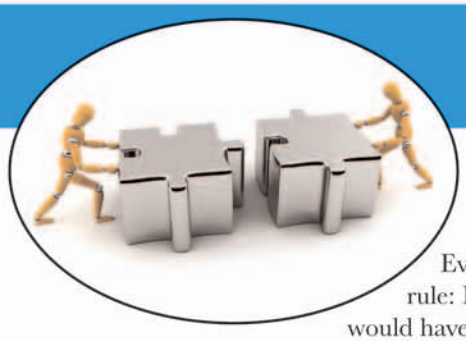
A personal phone call will always be better received than an automated message or postcard. Although automated calls and postcards are nice conveniences when the practice is booming, take time during this slower time for you and your staff to personally call patients. You can make phone calls to patients who are overdue for their hygiene recare appointments, calls to all new patients after their initial consultation to thank them for coming to the practice, calls to patients after larger restorative cases to see how they are feeling, and finally calls to patients after cosmetic services to see if they are happy with the results.

TIP #5: Develop Job Descriptions and Training Manuals

The most common excuse from practice owners who lack

Continued on page 19

Professional Courtesy Please



By: Carla Christensen Risk Management Analyst, TDIC

Everyone knows the golden rule: Do unto others as you would have them do unto you. According to a recent survey by the American Dental Association (ADA) Council on Member Insurance and Retirement Programs of 15 companies who underwrite dental professional liability insurance, many dentists do not adhere to this principle with regard to their colleagues. When asked about communication problems, the insurance companies scored intraprofessional criticism 7.7 out of 10 or "very common."

Regardless of the reason a patient has presented to your practice, be thoughtful before making observations related to any previous treatment. Clarity, compassion, integrity and accountability are the cornerstones of clinical communication, with documentation a firm foundation. A dentist who openly criticizes a colleague's efforts and then offers to 'correct' the treatment may be construed as unethical and opportunistic; the only motive is to increase his or her income. The ADA Principles of Ethics and Code of Professional Conduct notes "where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements." Some states codes of ethics have similar provisions.

If you notice what appears to be questionable dentistry during the exam, do not say, "I would not have done that." The patient may have altered facts or withheld information critical to your assessment. Instead, you could say "Before giving my opinion, I'll need to discuss treatment history with your current (or former) dentist."Extend colleagues professional courtesy and contact the previous clinician to ask questions and discuss any concerns.

Once you reach the prior dentist, ask open-ended questions to initiate the discussion such as "I recently had Jane Doe in my chair and she indicated she is a previous patient of yours. What can you tell me about the bridge spanning teeth Nos. 4-7?" Record the discussion in the patient's chart. This demonstrates acting "in such a manner as to maintain or elevate the esteem of the profession," (ADA Principles) as well as due diligence in making an informed decision on how to treat the patient.

What if the criticism is justifiable? No ADA ethical obligation exists for a dentist to call prior work substandard. The dentist must know all the facts, not just what is first observed or what the patient states. Dentists must have a reasonable basis to believe their criticism of a colleague's work is true. Communicating an obvious deviation from the standard of care should not unjustly imply mistreatment. Member dentists are obligated to make truthful, informed and justifiable comments based upon their local, state or national association code of ethics. There is a difference between an unsatisfactory outcome of appropriate dental treatment and an inadequate outcome related to treatment which falls below the standard of care. Stop and think about the most ethically appropriate response and apply the golden rule before conveying concerns to the patient.

If you have any questions or are unsure how to handle a potential situation in your practice, please call TDIC's Risk Management Advice Line at 800.733.0634.

The Economy May Be Down . . . But You Don't Have To Be! - Continued from page 18

systems and training guides is "I just don't have time in the day to train my staff." Well, now is the time if you have a break in your day. Instead of rushing to your office in between patients to check e-mail or read the latest publication, use your down time to draft job descriptions for your staff. If you already have job descriptions, take it a step further and develop a "new employee orientation" manual and training guidelines for each area of the practice. Take a look at the resources on cdacompass.com, and take the time to customize them for use in your practice.

If your staff has down time, ask them to start drafting "standard operating procedures" for their roles in the practice. A front office staff member may start by documenting the process of scheduling a new patient and the information that should be collected and prepared for every new patient. The financial coordinator may document the financial consultation, from preparing the financial agreement, to the scripts used during the consultation, all the way to the end where the patient selects a payment option. Your dental assistant may document your inventory system and create a checklist of the steps involved in placing orders and stocking the supply room. And finally, your hygienist may document the practice's periodontal management protocol and standard guidelines for communicating hygiene treatment plans to patients.

It is easy to get caught up in the "bad economy" media hype that surrounds us all. But challenge yourself to take a new approach – it will raise your spirits, energize your staff, and show your patients the value of your practice.

2010: A YEAR TO CONTINUE INVESTING IN YOUR PRACTICE

By: Arthur S. Wiederman, CPA CFP

Although the significant incentives provided by Congress for 2009 have expired, 2010 still provides ample opportunity to invest in your dental practice and have the government pay for part of the cost. I truly believe that together with dental education, the ability to lead a team and properly communicate with patients, that technology is one of the keys to success in dentistry today.

Invest With the Help of Section 179

Section 179 of the Internal Revenue Code has been in the law for many years. It allows small business owners to write off their purchase of equipment and furnishings placed in service during the year instead of depreciating that equipment. For 2010 the amount is a healthy $134,000. This will more than cover the purchase of CAD-CAM technologies, most digital X-Ray equipment or other items.

Property that qualifies for the Section 179 deduction is generally tangible personal property placed in service during the taxable year (though it does not have to be paid for during the year). Land, improvements to land and structural components of a building generally do not qualify. Most all dental equipment, furniture, fixtures and the like will qualify.

For example, assume you purchased a new dental chair for $6,000. Normally, you would capitalize the chair and depreciate it over five years, so in the first year the deduction would be $1,200 (20% depreciation in the first year). With the Section 179 deduction you can deduct the entire $6,000 – REGARDLESS OF WHETHER YOU PAID FOR IT!

Well-Timed Purchases Can Maximize Deductions

If you are planning a new office opening or a move for later in 2010, theoretically you could open a new office on December 27th, place in service four new treatment rooms of equipment with a cost of $105,000, finance the purchase over five or seven years with your first payment in January, 2011 and – as long as the equipment is installed and ready to use by December 31st – you get a write-off of $105,000 WITHOUT PAYING OUT A DIME THIS YEAR!

If you're building a new office, it typically takes 3-6 months to complete once you begin construction (depending on your landlord, contractor, architect, and other build-out factors). So if you are planning to move into your office in late 2010 and you are having four treatment rooms equipped, you could open the new office the week between Christmas and New Year's, install your new computer system ($20,000), two new rooms of equipment ($50,000), and the office furniture ($20,000) – and then the first week of January install the second two rooms of equipment ($50,000), and additional dental equipment ($50,000). In this scenario you would have a Section 179 deduction for 2010 of $90,000.

Benefits of a Cost Segregation Study

If you are constructing a new office building or buying or leasing a shell to build out, you can benefit significantly from a cost segregation study. By segregating the costs of your project based on certain engineering specifications, you can often convert as much as 30-40% of the project cost from the "buildings" category (which has to be written off over 39 years) to the "personal property "category (which can be written off over five years and qualifies for the Section 179 deduction). If you are spending more than $150,000 on a building project (not including actual dental equipment and furnishings) you should seriously consider a study.

Say for example you spent $400,000 on the build-out of a new office. With a cost segregation study, you could take perhaps 30% of this cost ($120,000) and convert it from 39-year depreciation (about $3,000 per year in write-off) to a Section 179 deduction, which is potentially a complete write-off in the year the office is placed in service. This is a difference of $117,000 which, at a 40% marginal income tax rate, would save $46,800 in taxes. Depending on the size of your office project, a cost segregation study can be performed for as little as $3,000 to $5,000 – a minimal investment for such a significant potential return.

The bottom line is that if your practice profit is expected to go up this year, reinvesting in your business with timely planning of equipment purchases can provide immediate gains that can be critical to your success while maintaining the value of your practice over the long term.

And finally – proper tax planning for your practice is very important, so do consider working with a CPA who specializes in your field.

Arthur S. Wiederman, CPA, CFP, is President of Wiederman & Associates in Tustin, California, a CPA firm working exclusively with dentists. Art can be reached at dental-cpa@wiederman-associates.com or 714.259.0505.

Recession-Proof Your Practice Through Patient Retention In Hygiene

By: Mike Elster

One of the most overlooked aspects in a dental practice is the opportunity to maximize patient retention in hygiene. It's up to you and your team to establish the importance of a hygiene appointment to the patient, ensure adequate time is available to appoint patients from your patient base, and make time for new patients. Doing this successfully is one of the keys to making your practice thrive now and grow in the future—and it is absolutely possible, even during challenging economic times!

By making sure patients understand the value of the preventative care they receive during their hygiene visits, they will better understand the importance of honoring their appointments. Taking time to educate the patient about their clinical needs will allow them to see the value of a treatment plan and increase the likelihood of case acceptance. An active retention strategy will increase your hygiene production, and result in higher case acceptance and production in clinical care.

Without a strategy in place, the best you can hope for is to maintain the status quo. Consider for example a practice with an active base of 1500 patients and an 85% retention rate that on average gains 12 new patients per month. Each year that practice is losing 225 patients while gaining just 144, for a net loss of 81 patients each year. And this does not take into consideration statistics showing the average practice loses five patients each month due to natural causes such as death or moving.

In conjunction with a retention strategy, you need to make sure your schedule has room to accommodate your patients. Consider the same practice with 1500 active patients and one hygienist working four days per week, or 32 weekly hours. Over six months that hygienist has room for 768 one-hour appointments (32 hours per week X 24 weeks). However, if the active base for this practice is 1500 charts, it should be scheduling 1500 appointments per six months. This means the practice is allowing 732 hygiene appointments to slip through the cracks (1500 possible – 768 actual). If this practice is losing 732 appointments, and conservatively charges $75 per hygiene visit, the lost revenue from those missed visits over one year is $109,800 (732 appointments X 2 per year X $75).

Because you harvest clinical dentistry from hygiene, you are missing an opportunity to diagnose patients for clinical care if low retention is not keeping patients in your practice. Continuing the example above with 732 outstanding appointments, if only half of them were to accept a very conservative $200 treatment plan for the year, an additional $73,200 of revenue would be generated (366 X $200). Add that to the $109,800 from the hygiene gap for a total of $183,000 in missed revenue.

By increasing retention in the above practice to 93%, a realistic goal if the correct systems are in place, the practice would lose only 105 patients per year while gaining 144, for a net growth of 39 patients, or 78 annual appointments. This translates to an increase of almost seven hygiene appointments per month. Multiply that figure by your hygiene rate and the financial benefit of a proactive retention strategy becomes clear. And while you may have an increase to fixed expenses after adding hygiene days to accommodate the increase in retention, this will be more than offset by the increased revenue from hygiene and clinical production.

Hygiene care is as important as any restorative treatment performed in the practice. However, in many practices the activities of hygiene are perceived as routine. Often, the only team discussions about hygiene are focused on systems and strategies to maximize scheduling and productivity, and the front desk is typically charged with appointing new patients 'for a cleaning.'

Cleaning, a friendly term adopted for its gentle connotation, has lulled everyone into believing that hygiene care is less important than other treatment needed by patients. In reality, cleaning is only appropriate to describe regular daily homecare that occurs between ongoing clinical visits. When the practice does not impress on patients the proper value of hygiene care, the gap is reflected in the hygiene schedule.

You can start educating your patients today by modifying the language you use. During their appointments discuss the importance of regular hygiene treatment. Change the way they think about hygiene by helping them realize there is more to their visit than getting their teeth 'cleaned.'

Appointment reminder calls are another opportunity to modify your language. The worst thing that can be said is: "This is _____ calling from Dr. _____ office, and I'm calling to confirm your cleaning appointment…" Why confirm an appointment the patient already has scheduled? The initial act of appointing is the confirmation! The call is done as a courtesy, to remind them of the appointment they scheduled. Using the word 'cleaning' diminishes the value of the service. This gives patients an out—and they take full advantage of it by re-scheduling or canceling, don't they? Instead consider using this communication: "This is _____ calling from Dr. _____ office, and I'm calling as a courtesy to remind you of the preventative care appointment in hygiene you have scheduled for Wednesday at 9am. We have reserved an operatory for you and we look forward to seeing you then."

If you are experiencing downtime now and have gaps in your schedule, this is one easy way to implement an immediate and proactive change to your practice's approach to patient retention. Taking proactive steps now by educating your patients will increase retention and lead to the growth of your practice with informed patients who value the services you provide.

Practices that create the right value for hygiene often enjoy a level of practice growth that far exceeds their expectations—even during challenging economic times like these!

Editor's Note: For a further discussion about these issues or anything else related to your practice's business, feel free to contact Mike Elster, Regional Manager for Mercer Advisors at (800)-444-6162, or by email at michael.elster@merceradvisors.com.

Antelope Valley Report

By: Char Brash

The Antelope Valley component of the San Fernando Valley Dental Society will be actively promoting the ADA Program "Give Kids A Smile" (GKAS) during February 2010. Last year we worked with the Greater Los Angeles Girl Scouts. More than 2,500 girl scouts were given the opportunity to enter an essay contest, which focused on the importance of oral health.

Presently, the program is in the planning stages and will take place during February 2010. It is exciting to report that the girl scouts will again be participating and that the program is expanding to include some local school districts. In January, posters and essay entry information were delivered, and in February, a group of local dentists will be providing free dental screenings to kids through the school districts' Headstart Programs. All of the participants and their families will be invited to an Award Ceremony in March, where prizes will be presented to the essay winners.

A great deal of pride comes from being part of this program, and we look forward to additional success in the future.

Welcome New Members

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Orthodontics
Harvard School of Dentistry, 2009

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General Practice
Centro Escolar, Philippines, 1981

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Announcements

Maribel Corona-Regalado - 1975- 2009

We mourn the passing of one of our own in the dental community in the San Fernando Valley. Maribel started as a dental assistant and went on to become a hygienist. Her calm grace and radiant smile will not be forgotten. Maribel leaves behind her husband, Estevan, 2 year old twins- Iziah and Jakeb and 3-month old Luke. A memorial fund has been set up for her three young boys and donations payable to "Corona" may be sent to:

Mari Corona Memorial Fund
c/o Studio City Dental Group
12840 Riverside Dr., Suite 508 • Studio City, CA 91607

A New Baby!
Nathan Sciarra arrived on November 12, 2009 and weighed 7lbs 9 oz. and wa 20.5 inches long. Nathan is the first grandchild for member Dr. Joe Sciarra
Congratulations!

San Fernando Valley Dental Society
22110 Clarendon Street, Suite 101
Woodland Hills, CA 91367

DATED MATERIAL

Trigeminal Neuralgia Treatment with GAMMA KNIFE RADIOSURGERY

TRIGEMINAL NEURALGIA Facts:

- Characterized by brief attacks of severe electric shock-like pain (with rapid onset and abrupt end) on the face
- Pain is usually on one side of the face, about 10 percent of patients have pain on both sides
- Stimuli may trigger an attack (touch, cold, eating, brushing hair, etc.)
- More frequent in women and people over 50
- If medications are unable to control the pain or if they cause intolerable side effects, interventional treatment may be indicated
- Such intervention may include microvascular decompression, rhizotomy, or Gamma Knife Radiosurgery
- Gamma Knife Radiosurgery is the least invasive method for treating this condition and results in comparable outcomes

GAMMA KNIFE Facts:

- Northridge Hospital has the only Gamma Knife in the San Fernando Valley
- Our physicians have treated more than 550 patients
- Radiation conforms to the shape of the lesion or tumor while sparing the surrounding tissue

Trigeminal Neuralgia Support Group at Northridge Hospital
In partnership with the Trigeminal Neuralgia Association

Patients can obtain information, encouragement and treatment options by calling **(818) 885-8500, ext. 2565**

Gamma Knife Center
(818) 885-5432

Northridge Hospital Medical Center
A member of CHW
www.NorthridgeHospital.org