BULLETIN OF THE SAN FERNANDO VALLEY DENTAL SOCIETY

DENTAL DIMENSIONS

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Winter 2013

SFVDS 2013 President & President Elect

- Offering a Discount Dental Plan
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- Treatment Protocols for Decay Risk Categories
- What's New in Pediatric Dentistry

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DENTAL DIMENSIONS

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9205 Alabama Ave., Suite B
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Office: (818) 576-0116
Fax: (818) 576-0122
E-mail: exec.sfvds@sbcglobal.net
Web Site: www.sfvds.org

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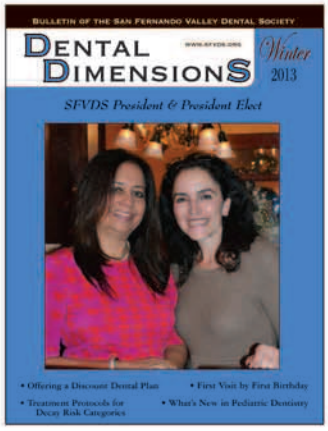
In This Issue

Winter 2013

Volume XLVII Number 1

On The Cover.....



(l-r) 2013 SFVDS President, Dr. Nita Dixit and 2013 President-elect, Dr. Mahrouz Cohen

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

From the Desk of the Editor

As we transition into 2013 we are already seeing a lot of changes for this year.

The Affordable Care Act (ACA) will begin implementation in phases in 2013. California law makers approved the plan proposed by Governor Jerry Brown to move 870,000 children covered by the Healthy Families program into Medi-Cal, which has one of the nation's lowest paying reimbursement rates. The Jan 1st phase-in has been postponed to March 1, 2013 due to concerns from health plans over the willingness and availability of doctors to transition from Healthy Families to the lower paying Medi-Cal program. The CDA and ADA will continue to monitor how this act will affect dentistry in the coming months. You can find current information at www.ada.org/advocacy.

There is much discussion and debate on the Medical Device Tax and what aspects of this will be applicable to dentistry. Based on the ruling issued by the U.S. Internal Revenue Service (IRS) and on the U.S. Food and Drug Administration's listing from 21 CFR 872, Subparts B, D, and E, those medical/dental devices subject to the 2.3 percent tax as of Jan. 1, 2013, appear to include restorative materials, hand instruments, endodontic filling materials, and other devices we use in our practices such as articulators, implants, bone grafting materials, X-ray holding and positioning devices and dental burs. Direct restorations, laboratory-fabricated restorations, and laboratory-fabricated prostheses, will likely not be taxed, although the IRS reserves the right to tax any devices. Consequently, it appears we will not be responsible for charging and collecting this tax from our patients, however, our cost will go up as a result of manufacturers charging us the medical device tax. This is based on information available as of Dec 26, 2012 and could change as efforts to exempt dentistry, delay enforcement or otherwise affect the ruling are currently underway. Look for further updates from the CDA and ADA and participate in contacting our legislators when necessary to keep this tax from impacting our practices.

You will read about the many changes at our local society level in this issue's columns from our president, Dr. Nita Dixit, our executive director, Andy Ozols, as well as news at the state level from our legislative chair, Dr. James Mertzel and our CDA Trustee, Dr. Gary Herman. We look forward to hearing from our newly elected CDA Trustee, Dr. George Maranon, in future issues.

I have served as your editor for five years and will be transitioning out of this role to begin serving as SFVDS Secretary for 2013 and moving up the chairs in subsequent years. I am pleased to announce that Dr. Shukan Kanuga is coming on board as the associate editor of Dental Dimensions. She is a board-certified pediatric dentist practicing in West Hills and Valencia. She serves on staff at the UCLA School of Dentistry and as an Evidence Reviewer for the ADA. She has written articles for Dental Dimensions in the past and is one of the authors for this issue's clinical topic of pediatric dentistry. I look forward to her input and working with her on making our publication even better for our readers. Many hands make light work and I encourage any of you having an interest in writing or editing to submit your names and get involved on our editorial committee.

As we begin another year, facing the challenges of our practices, it is important to take time to be involved in the activities your dental society is working hard to provide for you, our members. The outstanding CE courses, the member socials, the numerous community service events and the important political activities we are involved with, all provide an opportunity to get out and meet other dentists as well as to promote our profession. As individual dentists, we may be limited in what we can do, but as a group we can accomplish much. Consider volunteering at one of our events or joining a committee at the dental society. I have found the value of volunteering to be worth many fold the time I have invested. Try it yourself and you'll understand what we are all talking about.

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

From the Desk of the President

I have been the President for 17 days as I write this column. The Installation and Board Meeting on Dec.4th was a special event as Dr. Carol Summerhays, CDA past-president and our trustee to ADA graciously agreed to serve as the installing officer.
Dr. Summerhays' address was very inspirational as was her gift to me. The books she gifted me were 'The Race to Relevance' and 'The End of Membership as we know it'. Having been a member and Chair of the Council on Membership at CDA for six years, membership relevance is a subject after my own heart. I was very proud to have chaired the Practice Support Center (PSC) Workgroup at CDA and had seen it evolve from a focus group to launch and become the success it has been. PSC is a great member benefit and is being emulated by ADA and other state organizations.

Our Society's relevance to its members is a crucial issue, and if we as an organization are to remain viable, we need to pay attention and be ready to change.

With the support of the board I would like to appoint a task force to evaluate the relevance of membership to our members, especially our younger members, who face different challenges in this new work environment and are graduating with large debts.

There have been a few changes to the Board of Directors- Dr. Richard Hoefke decided to retire as the Chair of Peer Review Committee and will be replaced by Dr. Alan Lewis. They have both served the committee for many years and we as a component are fortunate to have members with such experience. Dr. Susan Jarakian has agreed to be the Chair of the New Dentist Committee and Dr. Mark Amundsen will co-chair the Leadership Development Committee (LDC) with Dr. Gerald Gelfand. Dr. Chi Leung of Glendale will be our liaison to the Foothills/Burbank/Glendale area.

In the interest of providing continuity, there is a new Program Committee, which will be headed by Dr. Afshin Mazdey and will organize our continuing education general meetings. Dr. Jim Jensvold will lead the efforts of our Val-D-PAC and Dr. George Maranon is our new trustee to CDA.

I have already met with several committee chairs and attended one committee meeting to be familiar with and coordinate their efforts. We are fortunate to have such dedicated and experienced members on the board and I look forward to a great year ahead.

I have tried to encourage the committees to recruit more members so that they can step up and be part of the leadership at our component. As members, you will get more out of your membership if you choose to get involved. Apart from a sense of kinship and support, it is an opportunity for self-growth and the ability to influence the future of our profession. I would encourage you to contact our Executive Director or Leadership Development Committee and explore how you can be part of leadership at our component. Just as I am building on the work put in by past leadership, I see it as part of our job to provide the framework for future leaders to shine.

As part of our community outreach efforts, I plan to get our Foundation off to a good start. In addition to the Give Kids a Smile events, I would like to emphasize education and prevention with respect to good oral health.

Please look out for SFVDS Foundation events and help support our efforts.

I look forward to your feedback and will keep you updated on our activities throughout the year. I hope you all have a happy and healthy 2013 and I look forward to seeing you at our events.

Best wishes,
Nita Dixit, DDS

From the Desk of the Executive Director

As you read this your dental society, like you, is settling in to the new year. The board of directors has a new executive committee, a new Trustee to CDA, and a few new members who bring new strengths and ideas to the board. The office staff are pretty well settled into the dental society's new offices in Chatsworth, though like all moves, plenty still remains in boxes and are being sorted out little by little. I'm sure you all know what that is like. If you haven't had a chance to stop by the new offices, please do so at you convenience. We are here Monday through Friday, from 9 AM to 5 PM and welcome you all, even without calling ahead. If you haven't already done so, please make note of our new address and phone numbers, which you will find on the Table of Contents page.

2013 will continue to be another year of continued services to our members and our community. We are planning a wide variety of member events, including some for which grant proposals to the ADA have been submitted. Our events will include zone meetings, a great lineup of CE meetings, member socials and opportunities for community service events like Give Kids a Smile, Health Fair participation and together with the other LA County dental societies, making a huge impact on oral health at the county-wide, Care Harbor event, held at the LA Sports Arena.

Speaking of Give Kids a Smile, if you haven't signed on to participate in this ADA sponsored national event that takes place during the month of February, please do so immediately. Help us screen and refer to follow-up care, the more than 3,000 needy children we reach every year. Volunteers are needed not only for the screening phase of this program, but also to provide the follow-up, restorative care needed by many of these poor children in the comfort of your own office. Please call Bella in the central office to participate (818.576.0116)

The new year is also bringing us the opportunity to potentially utilize our two-year old Political Action Committee (Val-D-PAC) to support local politicos vying for local office, including the election of a new mayor in the City of Los Angeles. The check-off box on your dues statements has allowed many members the convenience of making a contribution to Val-D-PAC along with their annual dues, and has allowed the resources of our PAC to slowly, but steadily grow. If you have not yet contributed, please consider doing so this year.

In addition, our foundation is planning its first annual fundraiser for 2013. The purpose of the fundraiser is to generate the resources anticipated to expand our dental society's community services, not only to underserved children, but also to reach out to adults and seniors in need. Since the state's cutback in adult Denti-Cal in 2009, and the effects of the great recession, there are far too many adults lacking oral health care, including seniors cooped up in nursing and convalescent homes with virtually no access to dental care.

Please also accept my thanks for updating and sending back your office update sheets, which are necessary in order for us to make the proper referrals to the public when they call for a referral.

In closing, I would again request that you promptly read the emails sent to you from the central office. Emails still remain the preferred method of communications, particularly for events and volunteer opportunities that arise quickly. Also, the board of directors uses email to ask for and coordinate your help, to persuade legislators to vote in favor of dentistry's needs.

I wish you all a happy and healthy new year!
Andy

Jim Wood, DDS for State Assembly in 2014

By: Jim Mertzel, DDS

The California Dental Association has been very fortunate over the past 14 years having had a member of CDA serving in the CA State Legislature. Sam Aanestad and presently Bill Emerson have been instrumental in helping to promote legislation beneficial to our profession. Dr. Aanestad, an Oral Surgeon, was term limited out after serving in both the Assembly and then in the State Senate. Dr. Emmerson, an Orthodontist, served in the State Assembly and is presently a State Senator. As term limits will affect all presently serving legislators, it is imperative for us, as dentists, to assure that our interests will continue to be served on the state level.

Fortunately we will have the opportunity in the next State Assembly race in 2014 to lend our support to another of our members, Dr. Jim Wood. Dr. Wood has served both our profession and his community extremely well. He earned a Bachelor of Science degree from UC Riverside and his D.D.S. degree from Loma Linda School of Dentistry. In addition to maintaining a family practice in Cloverdale, CA, he has distinguished himself as an expert in forensic dentistry earning many commendations and serving to help identify victims in many situations, most notable after 9/11 and after Hurricane Katrina. I personally have had the opportunity to serve with Jim when he participated as Chairman of the California Dental Association's Political Action Committee as well as a member of the CDA's Government Affairs Council. I would describe Jim as an individual who allows others to speak first, collecting his thoughts, and then, with wisdom, in a quiet manner, with persuasive arguments, is very capable of influencing individuals to his point of view.

He has proven himself on the political scene as well. He has served on the City of Cloverdale General Plan Advisory Council, and is presently serving his second term as a member of the City of Healdsburg City Council and as their Mayor for 2010.

As dentists we need to encourage members of our profession to get involved with our federal and state government so our collective voice can be heard, AND once we have found someone well qualified, someone we can be proud to represent us, WE HAVE AN OBLIGATION TO THAT INDIVIDUAL TO PROVIDE OUR VOCAL AND, MOST IMPORTANTLY, OUR FINANCIAL SUPPORT.

One of the realities of running for political office is that if a candidate can, early in the race, demonstrate that he/she has strong financial backing, he can then dissuade other candidates from entering the race. You will be proud to have Dr. Jim Wood to represent us in Sacramento. I urge you to send a check to help him in his campaign.

James Wood for Assembly:
102 South Main Street, Cloverdale, CA 95425
Email: jwooddds@comcast .net

Thank You,
James E Mertzel
Legislative Chairman SFVDS

Report from the Trustees

Gary Herman, DDS

This will likely be my last report, since, historically, this task falls to the junior trustee from our component. For that reason, but really for many more important ones, I am especially happy to welcome our new trustee, George Maranon, as my partner in representing you at CDA. George was officially installed at the November Board of Trustees meeting following the House of Delegates in Newport Beach.

Since my last report, the Board of Trustees has received the report from the Process Review Subcommittee, evaluating the actions CDA took that contributed to member dissatisfaction related to Access to Care issues.
I believe that CDA has taken these recommendations to heart and there is strong evidence that changes are already being put into effect. This process will take a good deal of time, however I am convinced that the Board will continue to provide oversight to prevent similar problems from reoccuring in the future.

Suggested future development of the Practice Support Center/CDA Compass was reviewed. This appears to be a strong member benefit and is a focus of CDA's desire to connect with younger dentists as an incentive to increase recruitment and retention of that demographic. CDA will be spending some of your dues dollars to increase the value of these services.
Finally, we are still fighting the Fluoridation Battle. After a nearly 10-year long fight, CDA had to abandon efforts to fluoridate Watsonville, due to the extremely high cost of the final program. We are hopeful that Santa Clara/San Jose will move forward toward fluoridation this year. We are also fighting to prevent defluoridation of a number of small communities.
Have a Happy New Year.

General Meetings - Preview

FEBRUARY 20, 2013

Building Your Practice through Endodontics
Speaker: John West, DDS, MSD

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

Endodontic skills, techniques, and instruments are often evolving faster than we can master them. How is this process made easy, successful, productive, and profitable for the general practitioner. Dr. West will teach you how to enjoy doing clinical endo, that achieves the sustaining principles of biologic success and patient comfort.

MARCH 27, 2013

Esthetic Materials, Techniques and Prevention
Speaker: Gerald Kugel, DDS

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

This course will highlight the latest information and evidence on a variety of esthetic dentistry related topics. Aimed at dentists and their staff, this course will provide relevant clinical information to assist dentists in their everyday practice.

APRIL 17, 2013

CA Dental Practice Act, Infection Control and an OSHA Refresher
Speaker: Ms. Diane Morgan-Arnes, CDA

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

Ms. Morgan-Arnes will conduct a fun and interesting presentation on these required courses for license renewal – and will include a refresher on OSHA requirements for the dental office.

General Meeting Review

November 7, 2012

Biomimetic and Minimally Invasive Dentistry
Randy Shoup,DDS

Dr. Shoup described the new understanding of microbial biofilm and lectured on how to assign risk categories to each patient and how to apply the appropriate protocols for both the prevention of disease and the restoration of the damage. Attendees were able to view video presentations of live patient treatments using the microscope and the air abrasion unit. He described and demonstrated the advantages of inlay and onlay restorations for even the most compromised dentition.

January 16, 2013

Take 5: The Top 5 Practice Management Skill You Need to Compete in 2013
Ms. Katherine Eitel

Ms. Eitel discussed four easy steps to converting patients on the phone, questions that must be asked to get treatment accepted, and the key to making good financial arrangements. She reviewed tips for marketing in the digital age, and a simple and easy hygiene handoff every time.

The SFVDS Annual Joint Board Meeting and Installation Dinner

Taking place on Tuesday, December 4, 2012 at Maggiano's Little Italy restaurant in Woodland Hills, past CDA president, Dr. Carol Summerhays performed the installation duties for the evening.
In addition, termed-out CDA Trustee, Dr. Alan Stein and former, long term, Peer Review committee chair, Dr. Richard Hoefke, were honored for their many years of service to the SFVDS membership, as was Dr. Mehran Abbassian for his countless hours of work as the General Contractor on our new building.

Outgoing SFVDS President, Afshin Mazdey, DDS & incoming President, Nita Dixit, DDS

(l-r) Executive Director, Andy Ozols presented Immediate Past-President, Mehran Abbassian, DDS with a tool kit of his own, including a "Mehran the Builder" doll as a thanks for his work as the new SFVDS building's General Contractor.
Bottom: Dr. Mazdey presents Dr. Abbassian a gift card to his favorite store, Golfsmith, as the board's thank you for work on the new building

Outgoing President, Dr. Afshin Mazdey with his wife Azita

Outgoing President, Dr. Afshin Mazdey, presents the gavel to incoming President, Dr. Nita Dixit.

(top) l-r; Outgoing President, Dr. Afshin Mazdey, president Dr. Alan Stein, outgoing CDA Trustee, with the board's thanks and a gift of a Santa Barbara Wine Country Tour.
(bottom) l-r; Dr. Richard Hoefe outgoing Peer Review Chair, accepts the board's plaque of appreciation from outgoing President, Dr. Afshin Mazdey

Dr. Carol Summerhays (at podium), CDA Past-President, installs the SFVDS 2013 officers: (l-r) Dr. Nita Dixit, President; Dr. Afshin Mazdey, Immediate Past-President; Dr. Mahrouz Cohen, President-Elect; Dr. Anita Rathee, Secretary; and Dr. Michael Simmons, Treasurer.

First visit by the first birthday!

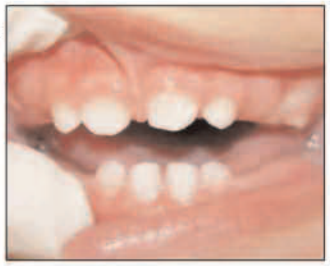
Most of us would agree, 'When should little Johnny start seeing the dentist?', is one of the most commonly encountered questions; together with others like, 'when will he get his first tooth', 'when can I start brushing his teeth'. The answer to these and many more similar questions lie in the highly important 'Age 1 dental visit'! The American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and the American Academy of Pediatrics all recommend establishing a dental home by age one.

Numerous reports confirm that despite published professional association recommendations that the first dental visit occur at about age one year, the majority of children do not have their first visit until an older age. Unfortunately, adherence to this professional recommendation is low, in part because of the medical and dental practitioners' and caregivers' attitudes.

Streptococcus mutans start colonizing the teeth as early as the eruption of the first tooth which is generally between six to 12 months of age. **1 + 1 = ZERO. ONE dental visit when there's ONE tooth can equal ZERO cavities!** The year one dental visit can be a more economic option for our patient families in the long run. A study in the journal Pediatrics showed that children who have their first dental visit before age one have 40 percent lower dental costs in their first five years than children who do not, due to the cost of dental and medical procedures that may be necessary as a result of poor oral health. Establishing a dental home by age one has other advantages besides the obvious prevention of dental disease and traumatic injuries. A child who has been seeing a dentist early on is less likely to develop dental fear and anxiety and more likely to grow up with positive dental visits. Haven't most of us seen a toddler who knocked off or broke his tooth by falling in the playground or hitting his mouth against a coffee table? If that visit is his first dental visit, he is bound to build unpleasant memories of visiting a dentist! On the other hand, he may be way more at ease in an emergency if he has an established dental home where he has had a couple of happy 'well child visits'!

What does the 'Age 1 dental visit' entail?

The goal of this visit for the dentist and the dental team is to help the family establish good habits early on; a solid foundation with well-balanced nutrition, good home oral care and regular dental visits. The focus is on prevention of dental disease, especially Early Childhood Caries in this highly susceptible population. Discussing the role of on-demand breast or bottle-feeding beyond age one, the role of sweetened beverages, fermentable carbohydrates and frequency of snacking on the caries process comprise the most crucial piece of this jigsaw puzzle. Brushing every night with a smear of Fluoride containing toothpaste with demonstration of technique is the other important piece. Anticipatory guidance is given to the parents in terms of what oral changes/teeth eruption can be expected in the months to follow before their next check-up visit. The dental anticipatory guidance is replicated after the medical model. This initial appointment gives the health professional an opportunity to guide the parent through important oral health information. The areas of discussion are dental developmental milestones, oral hygiene, diet, oral habits including pacifier/thumb/finger sucking, trauma prevention, and fluoride in its systemic and topical uses, and expectations of behavior during dental appointments. These are modified at each appointment to be age appropriate for the child. Caries risk assessment is done after a thorough dietary analysis, oral hygiene, medical history, family history and an oral exam which enables the dentist to determine if the infant is at low, moderate or high risk for caries. The recall interval is established based on the caries risk of the child.



The Exam Technique

The knee to knee technique is recommended for infants' and toddlers' dental exam. The dentist sits in front of the parent. Both the parent and the dentist face each other with the knees in close proximity. The infant is placed on the parent's lap facing the parent. The child's legs should be wrapped around the parent's waist. This position enables the child to face the parent, and allows the parent to hold the hands if necessary and the dentist to do a thorough and comprehensive oral exam. The cognitive development of a child under three is not enough for the dentist to expect cooperation; the child in this age group is unable to comprehend the tell-show-do behavior management technique. The parents are prepared about the possibility of the child crying, a normal behavior for this 'pre co-operative' age. Extra-oral and intra-oral soft tissue exam is done using a dental operatory light and mouth mirror; oral hygiene is assessed based on the gingival health and plaque levels, dental development is checked based on the eruption.

Knee to Knee Exam Technique

Infants and toddlers frequently will continually moisten their lips with their tongue or the moisture of milk/liquids on

the corners of their lips can harbor a Candida- albicans infection. Any signs of early childhood caries including demineralization or frank cavitation are noted. A tooth brush prophylaxis is generally sufficient at this visit and has a two-fold advantage - acclimatize the child with brushing and the taste of the prophy paste and demonstrate the brushing technique to the parents. Parents are encouraged to use this knee to knee technique or the lap technique to brush the child's teeth at home as 'he fights when I try to brush his teeth' is a very common concern of the parents! Fluoride varnish is applied after rinsing and drying the teeth with a gauze. Fluoride varnish which has 22,500 ppm Fluoride ion (22.5 times the toothpaste Fluoride) helps form Fluorapatite which is more resistant to demineralization than hydroxyapatite. Besides the preventive treatment, Fluoride varnish application is supported by a large body of evidence as a therapeutic modality in incipient caries lesions in high caries risk children. The findings of the exam are discussed with the parents with an emphasis on prevention, dietary habits and the importance of periodic exams.

Identification of Caries

The dentition should be evaluated for stains, white spot lesions, or actual cavitations. In order to visualize the surfaces of the teeth, it may be necessary to wipe any plaque present on the surface with a gauze. The white spot lesion appears to have a very chalky appearance and indicate signs of early demineralization. Early intervention will prevent frank cavitations.

The management of early childhood caries in this age group involves preventive modalities like oral hygiene and nutritional counseling with an in-depth discussion on the role of sugar and fermentable carbohydrates in this infectious disease process followed by sequential restorative treatment visits using appropriate non-pharmacologic and/or pharamacologic behavior management catered to the individual patient based on multiple factors including age, level of co-operation, anxiety, prior dental experiences etc. Timely referral to a pediatric dentist is advisable when the treatment or patient management is deemed beyond the scope of the general dentist's practice.

Maxillary incisors in a two year old with Severe Early Childhood Caries (S-ECC) restored with composite crowns

As practitioners of evidence- based dentistry, let's join hands in propagating the highly important message of establishing a dental home by age 1 and let's open the doors of our practices to this highly vulnerable patient population! Collectively, we can play a pivotal role in raising individuals who value oral health as an important part of their general health and look forward to their dental visits, eradicating the fear for dentists!

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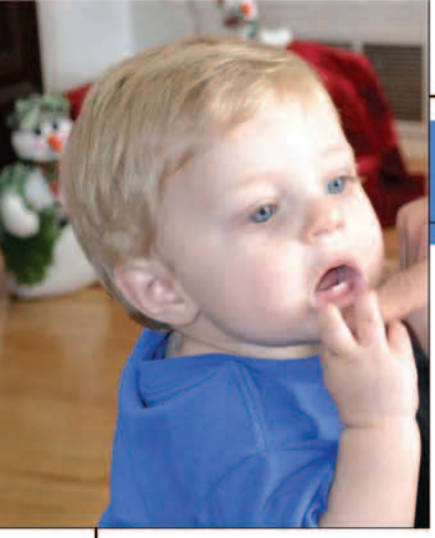
Shukan Kanuga DDS, MSD is a board-certified pediatric dentist practicing in West Hills and Valencia. She earned her DDS from UCLA School of dentistry followed by a year of general practice residency at Rancho Los Amigos National Rehabilitation Center. She graduated with a certificate and master's degree in pediatric dentistry from the University of Washington School of Dentistry in Seattle. She is also a lecturer at the UCLA School of Dentistry, an Evidence Reviewer for the ADA and will be serving as an associate editor with the San Fernando Valley Dental Society. She lives in Porter Ranch with her two young children and husband. You may contact Dr.Kanuga at shukandds@gmail.com.



WHAT'S NEW IN PEDIATRIC DENTISTRY?

Just as the practice of General dentistry has changed to include more implants and differing kinds of materials, so has the practice of Pediatric Dentistry as we approach 2013. These changes can be divided into three broad categories: assessment, diagnosis, and materials.

Assessment

When is the first dental visit recommended? Both the American Academy of Pediatric Dentistry and American Academy of Pediatrics now recommend six months after the first tooth erupts and no later than one year of age. While this may seem young to many parents, national studies have shown that cavities are increasing in preschool aged children. More than one in four children in the United States has had at least one cavity by the age of four years. Infant oral exams are more of a discussion of what is to come and to answer any questions from the parents, this is termed anticipatory guidance. Much of a first exam is covered in the accompanying article. An infant oral exam should include:

- Review of child's medical history
- CAMBRA or Caries Management By Risk Assessment
  - o See CDA Journal, Oct 2010
- Respond to questions and concerns from the parent
- How to care for the infant or toddler's mouth
- Proper use of fluoride dentifrice
- Review of fluoride exposure and discussion of fluoride supplementation
- Oral habits, including thumb and finger sucking
- Accident prevention and how to contact the office in case of an accident
  - o See www.dental traumaguide.org
- Teething and milestones of development
- Occlusion if sufficient teeth are present
- Risk factors which affect cavities, such as diet, hygiene
- Transmission of mutans streptococci and prevention of transmission
- Application of a fluoride varnish

Diagnosis

Diagnosis and treatment planning has not changed much since practitioners graduated from dental schools, however, the obvious introduction of digital radiography has changed the means of diagnosis. Extraoral bitewing radiograph systems, such as Planmecca, have enabled the pediatric dentist to diagnose interproximal lesions in pre-cooperative, younger patients. These images appear as panoramic views without the anterior sextant and while have limited resolution are diagnostic for dental caries.

Diagnosis of occlusal caries with the use of laser fluorescence devices, DiagnoDent, for example, has made the detection of early lesions possible. DiagnoDent utilizes a 655 nm diode laser which measures laser fluorescence and then quantifies the reflected laser light energy. A healthy tooth has little or no fluorescence. In a carious area, laser fluoresces proportionately to the degree of the cares. Early carious lesions can be restored with minimally invasive dental techniques which may not require local anesthetic and may preserve more natural tooth structure. DiagnoDent does have its limitations. Readings are disrupted by saliva, plaque, calculus, Prophy paste, existing composite, sealant, ceramics and cements.

Materials

Much can be said about current dental materials and the pediatric dental patient. There exist many more esthetic options to the traditional amalgam and stainless steel crown restorations.

Intracoronal restoration materials have vastly improved. Along the continuum from glass ionomer to composite there are a number of well proven restorative materials:

- Glass ionomers: Ketac (ESPE), Fuji II LC (GC)
- Resin-modified Glass Ionomers: Photac-Fill (ESPE), Fuji IX (GC), Vitrimer Tri-Cure (3M)
- Polyacid-modified resin composite (often called compomers): Dyract (Caulk), Hytac (ESPE)
- Nano-Ionomer: Ketac-Nano (ESPE)
- Resin composites: Filtek Supreme ultra, Filtek Z250

Many of the long term color stability, reliability, and durability problems have now been solved with these current materials, making them viable alternatives to the traditional restorative materials. Flowable components are available in many of these systems and have made improvement to the integrity of the margins of restorations. Radio-opaque bonding agents have made diagnosis of recurrent decay easier and surer.

A most welcome addition to the pediatric dentistry restorative array has been preveneered stainless steel crowns for primary anterior and posterior teeth. A number of companies (Nusmile, Cheng Crowns, Kinder Crowns, EZ Pedo Crowns, and Pedo Natural Crown) now provide stainless steel crowns with preveneered facing cover the labial, incisal, mesial, and distal aspects. The difference in prepara-

tion of these crowns is similar to the difference between preparation for anterior full gold crowns and porcelain fused to metal crowns. There is much more reduction of the enamel and there is always the possibility of nerve exposure. However, these esthetic primary tooth crowns have provided the much needed esthetic alternative in both the anterior and posterior tooth areas. Lately these companies have introduced a full porcelain type of crown - the zirconium crown - for both the anterior and posterior crowns.

Finally, the concept and method of the traditional pulpotomy is changing. We now refer to the "spectrum of pulp therapy". Spectrum of pulp refers to three different dental procedures: indirect pulp cap, pulpotomy and pulpectomy.

Indirect pulp cap is the removal of most, but not all, caries. One does not enter the pulp while all the decay is thoroughly removed from the dentoenamel junction (DEJ) leaving only a small amount of caries on the pulpal floor. The area is then covered by calcium hydroxide followed by a glass ionomer cement and then an appropriate restoration is placed - amalgam, or composite, or a crown - sealing the tooth from bacterial contamination. The indirect pulp cap mimics the natural healing response and tertiary dentin is formed. Tertiary dentin is dentin which is sclerotic and less permeable. Key to success of indirect pulp cap is accurate diagnosis - there must be no history of spontaneous pain, or clinical or radiographic sign that the infection has left the tooth. The presence of mobility, sensitivity to percussion, extra or intra-oral swelling, parulis or fistula, peri-radicular radiolucency on the x-ray indicate a necrotic pulp and/or abscess and indirect pulp cap is contra-indicated. The primary tooth must be treated by pulpectomy or extraction. Current medicaments for indirect pulp cap include calcium hydroxide paste and Vitrebond plus. The manufacturer, ESPE, states that Vitrebond plus exhibits fluoride release similar to traditional glass ionomer which makes it ideal for indirect pulp capping.

Pulpotomy is the removal of all coronal pulp, but leaves radicular pulp tissue while fixing the top most portion of that radicular pulp. The pulpotomy procedure is indicated when caries removal results in pulp exposure in a primary tooth with a normal pulp or reversible pulpitis or after a traumatic pulp exposure. In the presence of a necrotic pulp and/or abscess, pulpotomy is contraindicated. Pulpectomy or extraction of the primary tooth is the treatment of choice in these cases. Since the discussion of the 1990's regarding the toxicity of formocresol, there have been numerous studies regarding alternatives to formocresol. While the efficacy and safety of formocresol has been highly debated, see CDA Journal, February 2010 and comments in April and May, there may now appear to be viable alternatives to formocresol. Among the medicaments mentioned are MTA, ferric sulfate, and low energy electrosurgery or hyfercation. One of the keys to success of pulpotomy treatment is adequate hemostasis of the pulp stumps at the pulp canal orifice followed by sealing of the pulp chamber with a full coverage crown.

Pulpectomy is indicated when there is a history of spontaneous pain and there is chronic inflammation or necrosis of the radicular pulp. Following rubber dam isolation, the pulp canals are debrided and cleansed with files. The canals are then rinsed with sodium hypochlorite and dried with paper points as is the usual fashion with root canal therapy. Iodoform paste, Vitapex (NeoDental) is then injected to the apex while slowly withdrawing the application syringe. While many of these materials report excellent success and compare very favorable to established techniques, most are highly technique sensitive and like any new and different technique, should be investigated thoroughly before implementation into your practice.

The practice of Pediatric Dentistry has been evolving significantly in the last ten years. I have just mentioned the areas of assessment, diagnosis and materials. Yet to be discussed is utilization of auxiliaries and pharmacological advances in sedation dentistry which fall into the category of advanced dental techniques and have appropriate licensing and continuing education requirements. However, the specialty of Pediatric Dentistry welcomes the participation of general dentists and the establishment of a dental home for all children from birth through adolescence.

David A. Chin, DDS is an American Board of Pediatric Dentistry certified pediatric dentist who has been in practice in the La Canada-Glendale area since 1988. He also has an academic appointment as Lecturer at UCLA School of Dentistry. He graduated from Northwestern University School of Dentistry and obtained his certificate in Pediatric Dentistry from UCLA. His office practices all phases of dentistry for infants, children and adolescents, including prevention, restorative care, and sedation dentistry.
He can be reached at: 1808 Verdugo Blvd., Glendale, CA (818) 790-6721

SFVDS Pediatric Dentists

Carla Abboud, DDS
23838 Valencia Blvd, Ste 300
Valencia, CA 91355-5334
(661) 259-2960

Christine Armenian, DDS
1201 N. Pacific Ave, Ste 101
Glendale, CA 91202-3824
(818) 244-5052

Suzanne Berger, DDS
28040 Dorothy Dr, Ste 201
Agoura Hills, CA 91301-4916
(818) 889-2061

Anthony Catalano, DDS
Retired

David Chin, DDS
1808 Verdugo Blvd, Ste 312
Glendale, CA 91208-1456
(818) 790-6721

Eun Chung DDS
13320 Riverside Dr. Ste. 202
Sherman Oaks CA 91423-
(818) 789-3844

Edward Dove, DDS
20523 Devonshire St. Ste
Chatsworth, CA 91311
(818) 773-0911

Ninus Ebrahimi, DDS
23969 Newhall Ranch Rd.
Valencia, CA 91355
(661) 284-3764

Christopher Ezzat, DDS
27450 Tourney Rd., Ste 200
Valencia CA 91355-5623
(661) 253-9009

Steven Fujimoto, DDS
6325 Topanga Canyon Blvd, Ste 518
Woodland Hills, CA 91367-2049
(818) 567-0809

Faina Gelman, DDS
368 N. Kanan Rd.
Oak Park, CA 91377
(818) 889-5440

Jonathan Gidan, DDS
12840 Riverside Dr, Ste 508
Valley Village, CA 91607-3339
(818) 506-2424

David Good, DDS
Retired

Laura Greenwald, DDS
20523 Devonshire St
Chatsworth, CA 91311
(818) 773-0911

Tiffany Ham DDS
2201 Balfour Rd, Ste A
Brentwood, CA 94513-4927
(925) 308-7608

Heidi Hame, DDS
43731 15th St W Suite C
Lancaster, CA 93534-4785
(661) 949-0120

Lecia Harmer, DDS
19510 Ventura Blvd., Suite 207
Tarzana, CA 91356-2947
(818) 708-2393

Stephen Hirano, DDS
11239 Tampa Ave, Ste 208
Northridge, CA 91326
(818) 368-6266

Stephen Howard, DDS
18411 Clark St, Ste 306
Tarzana, CA 91356-3544
(818) 343-9119

Susan Jarakian, DDS
Ste 207 18531 Roscoe Blvd
Northridge, CA 91324-5968
(818) 772-1800

Shukan Kanugan, DDS, MSD
7345 Medical Center Dr., Ste 330
West Hills, CA 91307-1963
(818) 346-6282

Rose Kim, DDS
27885 Smyth Dr
Valencia, CA 91355-4011
(818) 846-8564

Gerald Kirshbaum, DDS
5400 Balboa Blvd, #308
Encino, CA 91316
(818) 788-8840

Jill Lasky, DDS
19510 Ventura Blvd, Ste 207
Tarzana, CA 91356-2947
(818) 708-2393

Martin Lasky, DDS
19510 Ventura Blvd, Ste 207
Tarzana, CA 91356-2947
(818) 708-2393

Michael Lasky, DDS
19510 Ventura Blvd, Ste 207
Tarzana, CA 91356-2947
(818) 708-2393

Khanh Le, DDS
7052 Owensmouth Ave
Canoga Park, CA 91303-2005
(818) 713-8034

Rebecca Lee-Pair, DDS
11200 Corbin Ave, #108
Northridge, CA 91326-4120
(818) 831-8252

Linda Lott, DDS
28040 Dorothy Drive, Ste 201
Agoura Hills, CA 91301-4916
(818) 889-2061

Charles Low, DDS
2258 Foothill Blvd., Ste 800
La Canada, CA 91011-1474
(818) 236-3636

Natalie Mansour, DMD
709 S. Central Ave, Ste A
Glendale, CA 91204-2010
(818) 500-7330

Amy Monti, DDS
18580 Via Princessa
Santa Clarita, CA 91387-8329
(310) 923-3056

Kathleen Mulcahey, DDS
27885 Smyth Dr.
Valencia, CA 91355-4011
(661) 294-1800

Judith Pabst, DDS
7345 Medical Center Dr., Ste 330
West Hills, CA 91307-1963
(818) 346-6282

Continued on page 15

Joey Pedram, DDS
368 N. Kanan Rd.
Oak Park, CA 91377
(818) 889-5440

Zinnia Regala, DDS
2625 W. Alameda Ave, Ste 216
Burbank, CA 91505-4823

Marvin Rosenberg, DDS
12840 Riverside Drive, Ste 504
Valley Village, CA 91607-3354
(818) 505-9095

Herbert Rosenstein, DDS
Retired

Janet Schrodi, DDS
17411 Chatsworth Street
Granada Hills, CA 91344-7612
(818) 360-2131

Dean Schweitzer, DDS
23838 Valencia Bl., Ste 300
Valencia, CA 91355-5334
(661) 259-2960

Joseph Sciarra, DDS
22554 Ventura Blvd, Ste 102
Woodland Hills, CA 91364-1433
(818) 224-2970

Shohreh Selki, DDS
16101 Ventura Bl., Ste 305
Encino, CA 91436-2514
(818) 501-3333

Haleh Shaheedy, DMD
19963 Ventura Blvd
Woodland Hills, CA 91364-2631
(818) 703-0234

Mahvash Shayan, DDS
23101 Sherman Place, #201
West Hills, CA 91307
(818) 716-8424

Ronald Singer, DDS
25880 Tournament Rd, Ste 216
Valencia, CA 91355-2840
(661) 259-6142

Ronald Strauss, DDS
19231 Victory Blvd, Ste 215
Reseda, CA 91335-6337
(818) 776-8600

Peter Suh, DMD
1346 Foothill Bl, Ste 305
La Canada Flintridge, CA 91011-2155
(818) 790-5959

Michelle To, DDS
13320 Riverside Dr. #202
Sherman Oaks, CA 91423
(818) 789-3844

Charles Udolph, DDS
Retired

Behrouz Vafamansouri, DDS
4341 Laurel Canyon
Studio City, CA 91604
(818) 761-3230

Stephen Willens, DDS
3923 W Burbank Blvd
Burbank, CA 91505-2118
(818) 846-1733

PLANS DON'T ALWAYS ALLOW ASSIGNMENT OF BENEFITS

By: CDA Practice Support Center

When accepting a new patient into my practice, I routinely have them complete an assignment-of-benefits form to allow me to obtain reimbursement directly from their insurance plan. However, some plans reject the assignment of benefits and continue to reimburse the patient directly. Is this legal?

While at first glance it may appear that a signed authorization for assignment of benefits from a patient, or policyholder, should be sufficient in securing reimbursement directly from a patient's plan, this may not be the case. In fact, a plan may not be legally required to accept assignment of benefits even when requested directly by the policyholder. Some plans, including managed care and self-funded plans, may include contract provisions that preclude benefits from being assigned. There are no federal or California laws in place requiring recognition of assignment of benefits.

Why don't all dental benefit plans accept assignment of benefits? Despite the fact that assignment of benefits does not, in and of itself, change the actual amount reimbursed by the plan, it is clearly seen as a benefit to the provider and as such, is often reserved for those providers who have contracted with the plan. Plans hope that by offering assignment of benefits only to their contracted providers, dentists will have yet another reason to contract with the plan. Plans hope that the convenience of being reimbursed directly will ultimately sway the dentist toward signing a contract.

While there are benefits to the provider when an assignment of benefits is accepted, this discussion would not be complete without considering the disadvantages. Providers who are not contracted with a patient's plan, but have accepted assignment of benefits for that plan, may find themselves in a tug-of-war with the plan when attempting to obtain reimbursement. It is recommended that providers consider the specific plan in question before determining whether assignment of benefits would be beneficial. For example, plans that are routinely late in making payments or frequently lose claims and/or supporting documentation, or, simply claim that the information was never received may be more responsive to their subscriber's request for reimbursement. In these cases, the provider may be better served by providing the claim information directly to the patient and instructing him or her on how to file the claim with the carrier and then bill the patient for the treatment directly.

A patient who experience difficulties in obtaining reimbursement from a plan will be much more likely to inform his or her benefits administrator and/or switch to a plan that pays in a more efficient manner.

WHAT TO DO WHEN A PATIENT ASKS FOR A REFUND

After completing treatment on a rather difficult patient, the patient calls to complain about the services. The patient states that they are going to another dentist to have the treatment redone and demands a full refund. Rather than deal with this difficult situation, the dentist refunds the money and gladly sends them to another dentist. Several months later, the dentist receives a notification from the patient's insurance carrier that the patient has filed a complaint. After reviewing documentation and radiographs, the insurance company agrees the treatment needs to be redone and requests the dentist refund the money back to the insurance company so the benefit will be available again to the patient. How does this happen?

Before refunding any money to a patient, determine how the treatment was paid. Did an insurance carrier pay for all of the treatment or a portion? How much did the patient pay towards the treatment? Once the financial history is reconciled, it is the dental office's responsibility to refund money to the appropriate parties. If an insurance company paid, then their portion must be refunded to them. A phone call to the carrier's customer service department or quality review department should provide you with the protocol for refunding the insurance company's portion of the fee. Generally, when a dental insurance carrier receives a refund from a dentist, the benefit is made available again to the patient.

Many patients may request the full refund be sent to them instead of the insurance company. However, since the treatment was paid by the insurance company, the refund must be sent to the appropriate party. Once patients understand the plan renews benefits, they consider the advantage it affords them and see the wisdom in returning the insurance portion directly to the insurance company.

Prior to refunding the patient for services rendered, determine if all efforts have been made to address the patient's complaint. Make certain you understand what the patient is asking for and determine if the patient made the payment or if an insurance plan did. Clear communication between the dentist and the patient is essential. Do not forget to document objectively and factually, any discussions you have with the patient specific to treatment concerns. It is suggested to contact your liability insurance to address any quality of care concerns. You may also contact your liability carrier to ask about a release or liability form.

Before issuing a refund:

- Make certain you understand the patient's request
- Determine where payment for the treatment came from
- Check with the plan to determine their refund protocol
- Document the discussion with the patient
- Contact liability insurance if a quality of care issue
- Document the refund
- Have the patient sign the refund documentation
- Copy the patient on any correspondence regarding the refund
- Confirm the plan adjustment is made on the next EOB

Use the form on the opposite page when refunding money to an insurance carrier.

Documentation of Refund to the Dental Plan

Treatment:

Date of Service: From: To:

Nature of Complaint:

Dates of discussion with the patient:

Mutually agreed resolution:

Fee charged: $

Patient payment: $

Insurance payment: $

Refund amount: $

Refund amount to the patient:	$	Date:
Refund amount to the carrier:	$	Date:
Refund transferred to another Dentist:	$	Date:
Outstanding balance of patient:	$	Date:
Refund credited balance:	$	Date:

What % of the full treatment does this incomplete portion represent?

1/3 of fees:

1/2 of fees:

2/3 of fees:

Patient Signature Date

April 2011

OFFERING A DISCOUNT DENTAL PLAN IN THE PRACTICE

By: CDA Practice Support Center

With a continued flat economy, dentists are looking for ways to encourage patients, particularly those with limited coverage or no coverage at all, to seek the care they need. This has resulted in some practices considering innovative approaches to help patients who are not covered by dental insurance.

One approach generating some interest is the establishment of a discount payment arrangement within practices, whereby the uninsured patient pays for treatment out of pocket, but is offered a means of paying fees that are below the dentist's standard customary rates. Dentists are informed enough to call such arrangements "discount dental plans," limited to patients in the practice, and CDA has received an increasing number of calls inquiring how such a plan might be established.

The inquiries usually run something like this: A practice is considering offering patients a discount on all dental care, usually by subscription for a nominal annual fee, and the inquirer wants to know whether this kind of arrangement is allowed.

First, dentists considering such an arrangement for their cash-pay patients need to know that the California Department of Managed Health Care has taken it upon itself to regulate discount health plans in California. The discount plans the department would regulate are large, regional (sometimes statewide), commercial businesses which have developed substantial networks of providers willing to extend a discount to consumers who buy-into the discount plan. Simply put, a discount health plan functions something like a discount or wholesale warehouse retailer: The consumer purchases an annual membership, and then can purchase goods and services at a significant discount to regular retail prices. Without the membership, access to the discount is not available.

The Department of Managed Health Care is concerned about how such discount health plans are marketed; specifically, that they are not marketed to sound like they are risk-bearing insurance products. In discount plans, the patient bears the risk. There are no claims submitted for treatment – the plan pays nothing, but the patient does experience a savings on care. The department is also concerned that a discount health plan's network of providers is authentic (usually meaning that the plan has some sort of agreement with its network of providers to notify subscribers of discounted care available through those providers). Also, the department is concerned that the advertised discounts are actual discounts – that if a discount health plan is claiming that a patient can save, for example, 15% on the cost of care, they are actually experiencing a 15% savings off of the providers' usual and customary fees.

Large, regional, commercial ventures marketing discount plans are required to be licensed by the Department of Managed Health Care under the authority of the Knox-Keene Act. Small, practice-based discount arrangements may not rise to the level of having to be licensed as a Knox-Keene plan, but the department would like to review such discount designs a practice may have, just to make sure.

In summary, the department regulates discount plans because of concerns about how such plans are marketed, whether the provider network is legitimate, and whether the discounts are real. A dental practice seeking to establish an in-practice discount arrangement for cash-paying patients will typically avoid the concerns the department has about large commercial discount plans.

If a dental practice simply wants to reward long-standing cash-pay patients, and does so without charging the patient what amounts to a subscription fee for "membership," there's likely no concern the department would have. If the in-practice discount arrangement is to be offered on a subscription basis, the department will want to know how the discounted is marketed; and if it's marketed beyond the practice itself, the plan may rise to a level of concern that the department will want the practice to license the proposal as a discount health plan.

Dentists should note that in informing patients, or prospective patients, that discounts are available for cash-pay patients, Section 1051 of the regulations to the Dental Practice Act require that certain information be made available to patients. An advertisement of a discount must: list the dollar amount of the non-discounted fee for the service; list either the dollar amount of the discount fee or the percentage of the discount for the specific service; inform of the length of time, if any, the discount will be honored; list verifiable fees pursuant to Section 651 of the Business and Professions Code; and identify specific groups who qualify for the discount or any other terms and conditions or restrictions for qualifying for the discount.

The department has asked any dentist who wishes to establish a discount payment arrangement for patients to contact the California Department of Managed Health Care, Division of Licensing at (916) 324-9046.

Updated December 2012

For more information on this or other dental benefit payment issues, contact the CDA Practice Support Center at 866.232.6362

Treatment Protocols for Decay Risk Categories

By: Randy Shoup, DDS

In a previous article (Risk Categories for Dental Decay, Spring 2012, Dental Dimensions) we discussed risk categories. This article will address the materials used for each of the risk categories.

There are several programs that have extensive research and testing as the basis for the products they use. Dr. Kim Kutch's CarieFree line of products is recognized as an industry leader. What I will discuss is a program that has been established and used extensively in my general private practice with outstanding results. There is a meaningful process that must be followed to gain optimum results and there is purpose in the timing of the therapies.

Any program is only as successful as the amount of patient compliance. Behavior modification is paramount in realizing the best results.

Where to Begin:

To start with patients should be using a sonic toothbrush. The hygiene department administers these programs and insures the patient has adequate supplies.

The sequence of events for high risk decay programs is as follows:

STEP-1-Diet Counseling

Supplies needed: Carbonated beverage pH chart.

Duration of therapy: Life-time

Therapy: Carbonated beverages include all the varieties of colas, sport drinks, energy drinks, flavored waters and water additives. The patient is educated that these products all exist with a pH of between 2.0 pH and 3.88 pH.

Human adult teeth demineralize at a pH lower than 5.5 and deciduous teeth demineralize at a pH lower than 6.2. The acidity of the western diet gives an acidic charge to the microbial biofilm pushing the tooth toward demineralization.

Benefits: Patients will have a lifelong uphill battle against decay with an ongoing consumption of highly acidic food products. Most systemic disease processes occur only in an acidotic environment. Patients can make massive improvements to their health both dentally and systemically by completely eliminating carbonated/acidic beverages from the diet.

STEP-2 pH balancing

Supplies needed: Arm and Hammer baking soda

Duration of therapy: 14 days

Therapy: The patient is instructed to use a small plastic dish and using tap water and the baking soda create a thick paste. The patient is instructed to follow the hygienist's instructions for normal brushing and flossing before going to bed. At the completion of the normal routine the patient is instructed to dip the tooth brush into the baking soda paste and apply the paste to all surfaces of all the teeth. The patient is allowed to expectorate as much as they like but absolutely no rinsing, no swishing and no last drink of water. The baking soda is applied to the teeth three times in succession. After the third application the patient is instructed to expectorate as completely as possible but again no rinsing of the paste off the teeth. The patient is directed to go to bed with the baking soda coating the teeth.

Benefits: It is the acidic nature of the microbial biofilm that creates the conditions necessary for all decay. While sleeping the salivary flow reduces down to almost zero. Saliva is the body's only method of trying to buffer the acid charged biofilm. The application of the baking soda acts as an acid "sponge". The biofilm receives an alkaline charge and changes the pH gradient in the biofilm. The acidophilic and acidogenic bacteria that preferentially select and create the acidic biofilm cannot exist in the alkaline environment. This therapy shifts the biofilm pH toward alkaline which favors commensal bacterial species. This therapy coupled with a reduction in dietary acid consumption is highly effective in significantly altering the pH environment of the biofilm.

STEP-3 General Antimicrobial Therapy and Targeted Therapy

Supplies needed: Chlorohexidine gluconate .12%, Licorice root extract suckers, Xylitol gum and mints

Duration of therapy: 10 days

Therapy: Chlorohexidine gluconate .12% (CHX) – The patient follows the hygiene protocols for morning and before bed mouth care. In the morning and evening at completion of the mouth care the patient uses two cap full's of the CHX mouthwash, swishing and spreading the CHX over all teeth surfaces. If the patient has the ability we recommend they use their tooth brush to actually scrub the CHX in. The patient is allowed to expectorate but not rinse or swish water after the CHX application. The patient uses one cap full followed by the second.

Benefits: CHX is an excellent general antimicrobial and attacks bacteria on all surfaces of the mouth.

Supplies needed: Dr. John's Licorice Root Extract Suckers

Therapy: Licorice root extract suckers

The licorice root extract has a selective target on the cell wall of the strep mutans bacteria. The extract changes the cell wall integrity and permeability. The strep Mutans bacteria are selectively killed by this exposure. Dr. John's company produces the suckers in packages of 20. One sucker should be consumed in the morning and a second sucker consumed in the afternoon. This is a 10 day therapy.

Benefits: Selectively killing strep Mutans bacteria. At the end of 10 days there can be an 80% reduction in the CFU's of strep Mutans.

Supplies needed: Epic Gum and Mints or Squigle Toothpaste (36% Xylitol)

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Treatment Protocols for Decay Risk Categories

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Therapy: Xylitol gum and mints
Xylitol is a polyol or sugar alcohol. The patient needs six exposures of the Xylitol per day. An exposure is chewing a stick of gum, eating a Xylitol mint, or ingesting food that contains Xylitol instead of regular sucrose or fructose. Each day for the 10 days the patient needs three exposures in the morning and three exposures before bed. The patient is instructed to chew the Xylitol gum immediately after every meal (breakfast, lunch and dinner) as well as after every snack.
Benefits: Acidogenic bacteria ingest Xylitol molecules during normal feeding. The bacteria gain no nutritional value or energy from the Xylitol and simply excrete the digested Xylitol. Since the bacteria gain no energy if the bacteria can be fed a steady diet of Xylitol it will in essence starve to death. During this process the bacteria does not produce acid as a by product of the Xylitol digestion. Without digestion and acid production the biofilm becomes more alkaline thus shifting from a demineralization to a remineralization driven process.
On an ongoing basis Xylitol is excellent in dramatically reducing the acid production in the biofilm. Beyond this initial protocol we highly recommend Xylitol on a daily basis of six exposures per day with the emphasis of gum after each meal.

STEP-4 Remineralization Fluoride Therapy
Supplies needed: Fluoride varnish, topical fluoride gel
Duration of therapy: 14 days
Therapy:
Fluoride varnish is a 5% NaF (22,600 ppmF). Fluoride varnish has replaced all other in-office fluoride applications. All risk category decay patients receive fluoride varnish application at each hygiene visit. The frequency varies from every six months for lower risk, four months for moderate risk, and every three months for high risk.
Home fluoride gel is used with moderate risk patients and applied by tooth brush at night immediately after mouth care and before bed. Patients are again instructed to apply the gel then expectorate with no rinsing, swishing, or drinking water. High risk patients apply the gel using soft custom trays. The trays are loaded per hygienist instructions and worn for 30 minutes twice daily.
Benefits: Fluoride is readily absorbed into the tooth in the enviornment of a neutral or alkaline pH. Fluoride is a negatively charged ion and creates a negative charged surface on the tooth and within the enamel pores (channels).

ACP/CPP Paste
Supplies needed: ACP, CPP containing gels or creams
Duration of therapy: 14 days
Therapy:
Many products contain amorphous calcium phosphate (ACP) and Casein phosphopeptide (CPP). This combination delivers calcium and phosphate to rebuild the demineralized enamel. The patient is directed to completely stop the fluoride therapy prior to beginning the ACP/CPP therapy. The negative charge of the fluoride will bind to the positive charges of the ACP/CPP and bind before the molecules/ions can soak into the tooth. The previous fluoride therapy created a negative surface on the tooth that "attracts" the positive charge of the ACP/CPP complex.
The paste is applied to the teeth nightly before bed with the paste allowed to remain on the teeth as with the other therapies.
For high risk patients soft rubber delivery trays are used twice daily for 30 minutes each time.
Benefits: The chemistry of remineralization is complex and delicate. Exotic methods must be created if the fluoride and ACP/CPP complex is to be combined in the same product. There is a benefit to precharging the tooth with fluoride then allow the application of the ACP/CPP complex.

Please address your questions or comments to: randyshoupdds@hotmail.com

Upcoming events – 2013

February:

All Month: Give Kids A Smile
20 - CE Meeting: John West, DDS:
Endodontics for the General Dentist
26 – SFVDS Board of Directors meeting*
TBD – Schlep and Shred: Santa Clarita Valley

March:

6 - CPR renewal - (Encino)
7 – Job Fair
19 – SFVDS Board of Directors meeting*
27 – CE Meeting: Gerald Kugel, DDS:
Esthetic Materials. Techniques and Prevention

April:

11 – 13 CDA Presents: Anaheim
17 – CE Meeting: Diane Morgan-Arnes:
CA Dental Practice Act and Infection Control
and OSHA Refresher
18 – All Component New Dentist Social
23 – SFVDS Board of Directors meeting*

May:

TBD – CPR renewal (Encino)
2 – Speed pairing (Woodland Hills)
9 – Zone Meeting (Lancaster)
14 – SFVDS Board of Directors meeting*

June:

TBD – Schlep and Shred/Open House*
4 – SFVDS Board of Director meeting*
TBD – Job Fair
13 – Zone Meeting (West Hills)
19 – CE Meeting: Ed Hewlett, DDS: Dental
Materials Update – What's New

July:

TBD – CPR Renewal (Encino)
18 – New Dentists Social

August:

1 – Zone Meeting (Studio City)
15-17 CDA Presents: San Francisco

September:

TBD – CPR Renewal (Encino)
12 – Diversity Forum
18 – CE Meeting: Saj Jivraj, DDS:
Esthetic Implant Dentistry
21 – Afternoon Tea: Challenges of Being a
Female Dentist
24 – SFVDS Board of Directors meeting*

October:

31-Nov 5: ADA Annual Conference, New Orleans
3 – Speed pairing
TBD – Schlep and Shred: Studio City
16 – CE Meeting: Charles Wakefield, DDS:
Treating the Geriatric Patient and an
Update on Oral Pathology
22 – SFVDS Board of Directors meeting*
25 – All Component Caucus (LAX)

November:

TBD – CPR (Encino)
6 – SFVDS' Delegates meeting/Caucus
15-17: CDA House of Delegates meeting:
Sacramento
19 – SFVDS Board of Directors meeting*

December:

5 – SFVDS Holiday Social
10 – SFVDS Board of Directors Installation Dinner

(All dates and locations are tentative.
Please watch your emails for details)

* Central Office, Chatsworth

Antelope Valley Report

By: Char Brash

Each year 500,000 children miss at least one day of school due to poor oral health !

The statistics are alarming … 10% of the children screened have never seen a dentist; 20% have not seen a dentist in more than a year; and a large percentage need extensive dental care. Research shows that tooth decay is the most common disease among children in the United States.

2012-2013 SCHOOL SCREENINGS

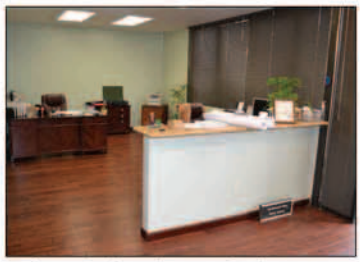
To date SFVDS members in the Antelope Valley have visited 27 elementary schools and have screened more than 5,000 4th grade students.

CPR Certification is available for SFVDS member at a cost of $35 per person. If you are interested in scheduling a class, contact Bella at the central office @ 818.576.0116 or Eric Sarkissian @ 661. 273.1750. When you schedule a CPR Certification in your office, $5 of the fee per participant is donated to the SFVDS Foundation.

SFVDS' New Office

(l-r) Executive Director, Andy Ozols, Immediate Past-President and our General Contractor, Dr. Mehran Abbassian, & President Dr. Afshin Mazdey, cut the ribbon to the new SFVDS office ahead of the November Board of Directors Meeting

Some of the members who came to the SFVDS' new office open house, held on Saturday December 1, 2012



(top) A view of the reception area of the new SFVDS office.
(bottom) The open house cake-before it was devoured by SFVDS members.

Board members prepare for their first board meeting at the new SFVDS board room

Welcome New Members

Daniel J. Iannotti, DDS
General
SUNY, Stony Brook, 2010

Michael Goren, DDS
14256 Ventura Blvd, Unit 1
Sherman Oaks, CA 91423
818.902.9999
General
Creighton University, 2005

James M. Kanda
3043 Foothill Blvd, #1
La Crescenta, CA 91214
818.249.5900
General
USC, 1983

Zarrin Golshani, DDS
General
University of Texas- Houston, 2011

Leo Aghajanian, DDS
411 N Central Ave, Ste 245
Glendale, CA 91206
818.265.2259
General
UCLA, 2006

Miganoush Ghookasian, DDS
General
NYU, 2011

Quan Tran, DDS
1647 E Palmdale Blvd, Ste K
Palmdale, CA 93550
General
661.273.5301
Boston University, 2000

Emad Ammar, DDS
175 N. Pennsylvania Ave, Ste 5
Glendora, CA 91741
Periodontics
626.335.6888
USC, 1994

Alexis Moore, DDS
23838 Valencia Blvd
Valencia, CA 91355
Endodontics
661.254.1924
Harvard School of Dental Medicine, 2012

David Vaysleyb, DDS
General
UOP, 2012

Martin Galstyan, DDS
General
UOP, 2012

Mohammed Husain, DDS
General
UCLA, 2011

Susanna Gukasov, DDS
25937 The Old Road
Stevenson Ranch, CA 91381
General
661.799.1991
USC, 2012

Ali-Reza Etemadieh, DDS
609 S Glendale Ave
Glendale, CA 91205
General
800.734.7475
Loma Linda, 2012

Maryam Ajami, DDS
General
UOP, 2012

Fouy K. Chau, DDS
Orthodontics
UCLA, 2009

Enrique A. Argueta, DDS
13215 Van Nuys Blvd
Pacoima, CA 91331
General
USC, 2012

Nazafarin Rafieyan, DDS
3003 Van Nuys Blvd
Pacoima, CA 91331
General
818.834.0011
Karnataka State, India, 1992

CLASSIFIED ADS

Practice for sale: Encino, CA Listing Price $544,900 (2012 coll: $605,000). Owner retiring; 30 years of Goodwill. Fantastic General and Cosmetic Dental Practice opportunity. Great long-term lease, views, 4 ops, 1,100 sq. ft. No HMO's. 3 1/2 days/week. All privates, PPO's. Refers out endo, surgery. Call: 818-707-2345. or email: xeeleex@yahoo.com. No agents, please.

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

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

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