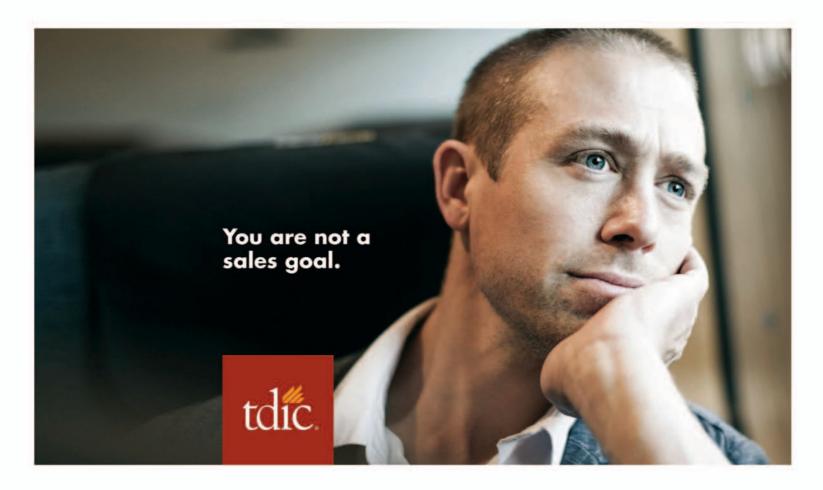
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Winter 2015





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Dental **Dimension**S

In This Issue

Winter 2015

Volume XLIX Number 1

From the Desk of the Editor	4
President's Message	6
Trustees' Report	8
General Meeting Preview & Review	9
How to Select a Financial Advisor and Grow	10
Dentistry's Legislative Achievements in 2014	12
SFVDS Annual Holiday Social	14
Repair of Peri-Implant Bone Loss	16
SFVDS Oral Surgeon Members	20
Antelope Valley Report • Glendale/Burbank/Foothills Report	22

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: shukandds@gmail.com

or contact the dental society office at 818-576-0116

Dental Dimension

On The Cover.....

Incoming president, Michael S. Simmons, DMD, presents a plaque of appreciation from the 2014 board of directers to outgoing president, Mahrouz Cohen, DDS at the 2015 installation dinner held at Maggiano's restaurant in Woodland Hills.

New Members

CDA Member James Wood, DDS, was elected to the CA State Addembly in November, 2014. See the exxclusive interview with Dr. Wood on page 4.

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ADA American Dental





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From the Desk of the Editor

I hope you all had a wonderful and fun-filled holiday season with your loved ones and are back to your practices energized to take on all the blessings and challenges that 2015 has to offer!

As you may know, after a long campaign, Dr. Jim Wood, a general dentist in Northern California, was elected to represent District 2 in the California Assembly in the November, 2014 elections. The SFVDS political action committee supported Jim financially and Jim was the only dentist to be elected to the CA legislature. Jim Wood was gracious enough to agree to be interviewed over the phone by me and our ED, Andy Ozols. We compiled the questions based on contributions from our board of directors. While it was a privilege to interview our new Assemblyman, I am very excited about the prospects of some positive developments that Jim will be able to bring for our profession while working in Sacramento. I hope you enjoy reading the interview, just as much as I enjoyed conducting it!

Cheers, Shukan Kanuga DDS, MSD.



Dr. Jim Wood Interview

11/9/2014

1. Jim, how did your involvement in CDA leadership influence your decision to participate in the political arena?

JW: "The defining moment for me was being involved with the CDA Council on

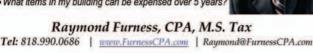
Legislation in 1998. That got me interested in the workings of the capital, which inspired me to get on my local planning commission in 2002. Then I ran for city council in 2006 but overall, the experience with CDA was like a "springboard" for me. I thank the CDA for their support and inspiration, which helped me launch into this.

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- How do I deduct 100% of the cost of a home repair?
- How do I deduct \$50,000 for the cost of my vehicle?
- What items in my building can be expensed over 5 years?



2. Do you have concerns about efforts to institute mid-level dental providers in CA? What is your better solution to the access-to-care problem?

JW: Yes, I have concerns about the concept of mid-level providers. As the only health care provider in the Assembly, I will have the opportunity to explain why it is not a viable idea that will not work well. Being in the majority party will be a plus.

I will be representing a district which is very rural. I intend to set up a pilot program to identify providers who want to serve in underserved areas and a mechanism to help them with their educational loans, etc. The problem affects all health care providers including physicians, nurses and physical therapists. The Affordable Care Act (ACA) is good for kids, but in rural communities it is a different set of issues.

3. What do you plan to do to utilize the new graduates of the six CA dental schools to help ease access to care and help them pay their student loan debt?

JW: There is a great opportunity here. There are some community clinics in our district, which bring senior dental students from UCSF to practice. I am not sure at this point on how to lessen the student debt as it also applies to medicine, PT, and nursing, so we need to look at this from a much broader scale. It is a multi-faceted problem that affects how health-care is delivered. I intend to look at it broadly once in office.

4. How do you manage to be so involved and still run your practice?

JW: I sold my practice late last year. I realized I couldn't be successful at doing both at the level I expect of myself. The size of my district made it very difficult to politic and come back after three days of campaigning to see patients. My life has been a "juggling act" for the past decade. I am a pretty good time manager and that's how it has all worked out.

5. Is there any way you can probe the dental insurance companies' reimbursement practices?

JW: I am interested in this and concerned that reimbursements are being reduced unilaterally. Dental insurance doesn't fall under the state insurance commissioner. I will be able to have influence with Medi-Cal, but for private insurance it's too early for me to know the details. The new medical loss ratio (MLR) law pushed by CDA should work out well – especially since the insurers fought it so hard. MLR will be helpful in keeping premiums in check.

Continues on the page 5

6. California will have a mandatory labor law of paid sick leave for employees starting June, 2015. As a small business owner, it seems like more and more restrictive laws are being passed that affect dentists. What is your opinion?

JW: I agree that dentists will be hurt. In my practice, I had three part-time dental hygienists, so I would have been forced to pay sick leave to employees who work only 1-2 days/week. This would have be an unfair burden. The unintended consequences will be discussed over time. With newer classes of politicians coming to Sacramento, they are bringing small-business perspectives with them. This is important since it applies to all employers and not just larger ones. We will see if we can pass an amendment on this labor law.

7. The State of California reinstated adult Denti-Cal coverage in May, 2014, however the program lacks many of the essential needed procedures like posterior RCT and partial dentures to mention a couple. In addition the reimbursement rate remains very low and discourages participation by dentists. Assemblyman, what will you do in pushing improvement to the program in next year's budget?

JW: I will be the voice to explain, not only the dental, but also the medical perspective to the rest of the legislature. There is significant federal money available, some matching, some not. I will emphasize that cost-effectiveness of early treatment as prevention is way more cost-effective than the proposed "band-aid" approaches in the long run. Proper dental care will reduce other state burdens elsewhere. Pediatrician, Dr. Richard Pan (elected to the CA Senate), will be a colleague and I can collaborate with him to get the rest of the legislature to understand the issues.

8. With the Affordable Care Act, there will be one million additional children under Denti-Cal. A majority of pediatric dental offices delivering contemporary, comprehensive, compassionate care cannot afford to provide this much needed treatment to an additional million CA children. The result will be a lack of dental homes, untreated dental disease or mistreatment/overtreatment of many of these children, or by general dentists posing to be "childrens' dental offices" across the state. Do you see Denti-Cal, with one of the lowest reimbursement rates in the nation, as well as several other loopholes, ever catching up with states like Texas who have successfully implemented the program to be a "win-win" for the providers as

well as the patients? If yes, how do you plan to achieve it?

JW: You nailed it right on the head. If there is good data out there to support



this model, we should be learning from those states. If TX has been successful and has made it work for their kids, we should look and learn. We clearly have a lot of work to do and it cannot happen overnight. I am in a good position going in compared to other legislators as I am well-connected with several legislators, and with all that support, I am hoping to accomplish things relatively quickly. I will have ADA and CDA working with me on this. While I cannot solve it alone, with support I will work collaboratively with everyone to make the system as good as it can be. The change in term limits will hopefully give me the opportunity to work on problems and solve the problems which take time. I am confident in seeing an achievable solution on the horizon. I will work to educate my colleagues on the costs and expenses of running a dental practice and how unviable it is to operate with the currently miniscule Denti-Cal reimburse-

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From the Desk of the President

In contemporary lore, Punxsutawney Phil's weather predictions are sought as counsel on whether spring will come early. In SFVDS lore, "Brombergtawney Mike's" prediction for a successful upcoming year in your local dental society was sought and we are happy to say that the prediction for 2015 is stellar! Whereas the StormFax Weather Almanac records kept since 1887, show Punxsutawney Phil's weather predictions have been correct only 39% of the time, we have good reason to believe that "Brombergtawney Mike's" predictions are as reliable as a single canal, anterior, straight root endo on a good day by a qualified and seasoned SFVDS dentist.

With that clarification, let me expound on what your SFVDS accomplished in 2014 and what the goals are for 2015 within our strategic plan, and why it looks to be a stellar year. 2014 was indeed a great tear under the leadership of President, Dr. Mahrouz Cohen, and Executive Director, Andy Ozols.

The SFVDS had the best attendance ever as a result of Dr. Afshin Mazdey's CE program, which included settling into our new home in Chatsworth and providing THREE hands-on courses, ranging from Botox on humans to Periodontal surgery exercises on pigs in our new facility. We provided several free CE seminars including two very well attended 'Pinhole Techniques'.

We developed approximately \$50,000 in donations and had an incredible celebration fundraiser party for our charitable foundation. Through the SFVDS Foundation's community outreach in 2014, we helped numerous veterans, children and indigent adults with free dental care. We procured some portable equipment from a local dental supply company, Pearson Dental, which will help us provide free dental care to those unable to make it out of their homes. We were also very fortunate to receive valuable gifts and dental supplies from both Patterson Dental and Henry Schein Dental, which will further enable us to provide free dental care. In addition, we invited our members to volunteer to provide dental care to the needy and expand our ability to refer more extensive needs to members' dental offices.

2014 allowed us to have our 3rd annual 'Afternoon Tea Party' and 2nd annual 'Diversity Forum', both spearheaded by Dr. Karin Irani. Both programs received coveted ADA Golden Apple awards and both were attended by dental leaders from across the U.S. who came both to speak and also to listen.

Along the way, we received six grants from ADA and five from CDA for membership recruitment and retention programs. We worked successfully in collaboration to defeat proposition 46 (Submitted by trial lawyers to increase trial lawyers' potential damage awards in medico-legal cases), and we submitted three resolutions to the CDA House of Delegates out of a total of 18 total resolutions. All three of our resolutions were presented phenomenally by our SFVDS delegation, heard and discussed at length, and all three resolutions were moved forward to an assessment phase by the respective CDA entities.

We also continued in our television commercial to generate local

referrals and inform the public of our ADA affiliation, and new public service announcements on oral health in various languages through the work product of Dr. Jorge Alvarez. Our efforts are now both recognized by the ADA, and duplicated by many other state and local dental societies.

The response to our outreach efforts at the SFVDS has been overwhelming and whereas ADA membership numbers are flat, your SFVDS membership numbers continue to climb upwards. The numbers speak for themselves as the average increase in members is about four members per CDA component, the SFVDS recruited 28 new members (700% more than the average). The continued growth of the SFVDS is no accident but the result of hard work by your volunteer leadership including Dr. Anette Masters and many others, and the exceptional staffing team we have to support them.

We, on the board of directors thank each of you that volunteered in 2014 on a committee or served to help the needy in one or more of our outreach programs. You are the stars of our very vibrant dental society which is a leader among the 32 components that make up the CDA. We are looking for more stars, more donations of time and funding to our charitable programs, and to give you the opportunity to give back to the great profession that has supported you. These are incredible opportunities that teach you to become a leader, to share your experience and to engage others.

Below is a list of our existing committee chairs/leaders and their office contact information. Make it your new year's resolution to get more involved by calling one or more of the chairs/leaders to get acquainted, to share your interests and to see if you can be another contributing committee member, and grow into the leader and leadership position that awaits you.

818.340.4110
818.887.7172
661.295.8288
818.345.3366
818.989.3357
818.346.6282
818.506.2424
818.352.3174
818.996.4412
661.252.9658
818.986.4131
818.990.0900

<u>Program Committee</u> Alfred Penhaskashi, DDS

818.788.7091

So why is 2015 going to be stellar and what are the big plans and goals for the 2015 year? If you knew the talent on your board or directors and administrative staff like I know them, this answer would be self-evident, so I invite you to meet them at every opportunity, social or CE event. Here is a list of goals set by your incoming president to make 2015 a great year and please avail yourself of these opportunities for your own growth:

- 1) To have a new graduate dentist member (in practice less than 10 years) on each and every committee. Recent grads are our future and we need to enable them to become the best leaders they can, through training and mentorship. If you are a new dentist member contact Dr. Birva Joshi-Jones to help you with the first step of your journey as an SFVDS leader. At least one new member dentist will be appointed to serve on each and every committee.
- 2) Board approval to add a new, part-time young staff member -someone who speaks Facebook, can Tweet, Instagram, web blog, flip flop or utilize whatever techno-jargon is necessary to effectively reach our graduating dentists.
- 3) More CE opportunities, including study clubs and adding CE to our DD publication to accompany worthy scientific articles as they run. (see page 11)
- 4) Strive to establish more authenticity in all we do. This includes adding a little more British flair to our Afternoon Tea Party.
- 5) Create a more enriching diversity forum with more diversity education and with the goal of increasing more dentist members from segregated ethnic groups.
- 6) Increased efficiency at board meetings so they do not last past our usual bedtimes.
- 7) Increased outreach to other neighboring component leaders to collaborate on and share know-how on successful programs.
- 8) Increased outreach to all other nearby CDA components and non-component dental groups to increase attendance at more shared events, especially social events where we can interact.
- 9) Best hosting of the 2015 All Component Caucus, which we are honored to organize. It is our turn to host it and we will represent the SFVDS well.
- 10) Growth of our charitable arm, the SFVDS Foundation to build off our enormously successful 1st annual Veteran's Smile Day program and the increased delivery of free care to needy adults and children that fall between the cracks of current dental health care programs. My goal this year is to generate Foundation revenues in excess of \$100,000 and to spend a commensurate amount on providing volunteer dentists, venues and opportunities to deliver care to the needy.

In this regard, we have already received a tentative commitment from Bill Handel, a prominent radio talk show host on AM 640 (KFI), to MC the event. It is my hope that all SFVDS members will attend this year.

As President of the SFVDS in 2015, I am also forming two new Ad Hoc committees and would welcome your input and volunteerism.

Committee #1 SFVDS Historical Committee: is to recount the history of the SFVDS. We have had 77 past Presidents,

each with a legacy they passed on and each

with at least one notable contribution, and probably many stories that should be shared. We want to record that history and share those memories. Our story is still being told but we must capture the past now while we still have glimpses of it. Please send in your recollections to executive director Andy Ozols and please call if you would like to be a member of the SFVDS Historical Committee.

Committee #2 Big Brother/Big-Sister Committee (BB/BS Committee): is to enable a mentorship program for any SFVDS member that wants a seasoned or veteran dentist to act as a mentor. This can be for specialists or general dentists and you can volunteer as a mentor or request one. Not everyone is blessed with such a relationship to learn from and we want to provide this opportunity for those that have interest. Those offering to provide or receive mentorship in the practice of dentistry should please sign up with the BB/BS Committee. If you are seeking mentorship for a leadership role please contact our executive director, Andy Ozols.

In conclusion the SFVDS is a thriving, vital and dynamic dental society. We seek more of the same from our members at large. If you have something to contribute or give back to your community we are there to support and enable you. One of our long term goals is to increase the scope of practice of dentistry which enables you as the individual dentist. Only organized dentistry as a group has the ability to make such substantial changes against other prevailing market forces.

Together we stand strong and can make a difference. Together we can improve the world of dentistry. Don't let another year slip by. Call us and get engaged with your existing leaders and learn why and how they have accomplished so much. It is an honor to serve you this year and I will do my best to enable your individual evolution and the greater progress and growth of our society.

Best wishes for a healthy, happy and stellar 2015 year.

Michael S. Simmons, DMD 2015 SFVDS President



Trustees' Report

By: Martin Countney, DDS

Brief summary of the October 2014 California Dental Association (CDA) Board of Trustees (BOT) meeting

CDA Strategic Plan. The board amended and approved the CDA strategic plan, which included a revised mission statement, goals, objectives and strategies.

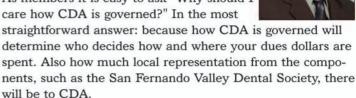
The CDA mission statement was changed from "The California Dental Association is committed to the success of our members in service to their patients and the public," to "Helping Our Members Flourish".

Governance Review Advisory Committee (GRAC) -Following up on the Board of Trustees' (BOT) August, 2014 agreement on the measurement standards of good governance (the metrics) the board discussed the opportunities for improvement, considering each of the 18 metrics and the opportunities they present. The board subsequently approved presenting the amended opportunities for improvement to the House of Delegates in the format of a knowl-

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edge-based discussion.

As members it is easy to ask "Why should I care how CDA is governed?" In the most



Brief summary of the November 2014 BOT meeting

After the CDA House of Delegates approved the creation of a new CDA entity, a dental management services organization, the incorporation papers were signed by CDA president Walter Weber, DDS. As CDA continues its leadership in member benefits, you can expect the same great value that you get from The Dentists' Insurance Company (TDIC).

The Dentists Service Company (TDSC) is anticipated to provide the same level of management, practice advising, large group purchasing power benefits, and services that multi-state and multi-location dental corporations enjoy. There will be a mix of services included with CDA membership, as well as expanded services for an additional fee.

Prop 46, the MICRA reform ballot measure was defeated and the Board heard the summary of the strategies for the future of this issue.

At the board meeting it was announced that long time CDA government relations expert, Liz Snow, will be joining newly elected Assemblyman Jim Woods', DDS staff as his chief of staff. Her knowledge of California government and her Sacramento relations will be missed by CDA.

The BOT in closed session heard an update on the CDA action against Delta Dental of California.

Correction

In the directory of Periodontist members, on page 19 of the Fall, 2014 issue, a line separating the listing for Dr. Linda Axman and Dr. Moshe Benarroch was inadvertently left out creating the impression that both doctors worked out of the same office. Dr. Axman is retired and Dr. Benarroch is in a solo practice. Our apologies for any confusion this may have caused.

ONTARIO 4580 Ontario Mills Parkway

VISALIA 8344 W. Mineral King

SAN DIEGO 333 H Street, Chula Vista, CA

General Meetings- Preview

SCHEDULE OF 2015 CE COURSES

JAN 14	BRIAN LESAGE, DDS	MINIMALLY INVASIVE DENTISTRY: EVERYDAY SYSTEMS FOR ALL CERAMIC RESTORATIONS
FEB 11	HESSAM NOWZARI, DDS	IMPLANT FAILURES AND HOW TO AVOID THEM
MARCH 11	ALAN FELSENFELD, DDS	ORAL SURGERY FOR THE GENERAL PRACTITIONER
APRIL15	Nancy Dewhirst, RDH	CA DENTAL PRACTICE ACT AND INFECTION CONTROL
JUNE 10	PARISH SEDGIZADEH, DDS	ORAL PATHOLOGY AND MEDICINE
SEPT 16	BOB HALE, DDS	RECONSTRUCTIVE SURGERY
Ост 14	WILLIAM MOORHEAD, DDS	TECHNOLOGY AND A PAPERLESS OFFICE
NOVEMBER 18	RAYMOND BERTOLLOTTI, DDS	DENTAL MATERIALS & BONDING

NOTE: HANDS-ON COURSES FOR 2015 ARE CURRENTLY BEING FINALIZED. WATCH YOUR EMAIL FOR NOTICES OF THESE COURSES.

General Meeting Review

November 19, 2014
Oral Surgery for the General Dentist
Bach Le, DDS

In the last CE meeting of the year, this course was designed for

9

the general dentist who wanted to expand their oral surgical experience and better understand and manage dentoalveolar surgical problems. The objective of the course was to offer the dental practitioner an opportunity to better understand proper management of the medically compromised patient and included a comprehensive discussion on extraction site management. The discussion also included topics on minimally invasive extraction techniques, socket preservation, a decision tree on immediate versus delayed implant placement, management of complications, and much more.

How to Select a Financial Advisor and Grow

Joan, a dentist for 15 years, was referred to Steve, an accountant, by her close friend from dental school. Joan had been feeling that she was not advancing financially even though she was working harder than ever before. Joan had tried searching the internet for solutions to various ways of increasing her dental revenue and saving on taxes. After many hours, Joan was overwhelmed.

For many of us, the free flow of information serves to benefit both our personal and professional lives. However, with so much information on the internet, sometimes it is hard to separate real information from misinformation.

For instance, a quick Google search for "Tax Advisor in Los Angeles" generates more than 2,000,000 results. With all these results, how can you choose the advisor that is right for you?

During her introductory meeting with Steve, Joan expressed her desire to attain financial independence and stability, but realized that nearly half of her income goes to income tax, social security tax, Medicare tax, etc. Steve chuckled and said "they never told you in dental school about your 'silent partner'?" Joan looked puzzled and said "I don't understand, what partner?" Steve jokingly said, "Uncle Sam of course, your 50% silent partner."

Sam explained, "it is very difficult to be a great business person and a great dentist at the same time. I've seen two types of professionals in the dental world: the type that is a businessperson first and dentist second; and the type that is a dentist first and foremost, but struggles financially through his/her retirement years."

A good advisor can be your coach and guide to financial freedom. Such advisors provide you with their years of expertise, while allowing you to focus on your profession. Hiring an advisor could be the best investment you make toward your success. Therefore, spending the time to find the right match for you is an endeavor that cannot and should not be put off.

Steve continued to share more pearls of wisdom. He explained that "some dentists stumble into a dental practice that is run like a business, and those dentists tend to do exceedingly well; but most dentists, just stumble ... they stumble into age 70, with no savings, a practice that is dwindling and a murky financial future."

Joan asked "so how do I know you're the right advisor for me; how does a dentist differentiate between advisors, they all have seemingly impressive credentials." Steve sat back in his chair and said, "Well, certainly it would be great if you hired us, but even if you don't, let me at least help you become an educated consumer of tax, accounting and financial services. Whoever you hire must have a deep understanding of dental practices. The advisor must also be a great communicator, able to engage clients in meaningful dialogue regarding the various interrelated components of a dentist's personal and business finances, including tax saving ideas, investment choices, maintaining adequate cash flow, insurance coverage, asset preservation/protection and wills, trusts and estate planning. These components are each specialties in and of themselves, but must all work in sync to serve your needs and future success. A qualified advisor should have strong relationships with specialists in all these related fields and act as your quarterback, coordinating these services for your best interest."

Joan said, "Wow, I had no idea there was that much to consider... Ok, suppose I've met with five advisors and they all seem to be about the same, and I still can't decide, what then?" Steve smiled and said, "Well, then, at that point just go with your gut feeling... ask yourself, which one felt right, which one seems easy to talk to, which one was interested in me and eager to work with me, which one would most likely put my interests first? Usually, when you use these litmus tests, only one will emerge from the crowd. Use your instincts to tell you which is the best choice."

What Steve was saying is that your advisor's personality must be compatible with yours. An internet search and initial telephone conversation can help serve as a starting point to determine if an advisor has the proper credentials, and more importantly, if he/she can trigger you to think about the overall picture of your finances. Usually, a 15 to 30 minute telephone conversation is sufficient to determine if you want to take the next step and schedule a meeting.

Steve continued, "... during your meeting, ask about specific situations such as: how can I lower my tax liability, what advantages are there in making certain dental office equipment purchases, or do you handle IRS audits and what are your expectations of me? A qualified advisor will not only answer your questions and help you understand what can be accomplished, but will ask you questions that will help establish your attainable goals and objectives. During this meeting you should also ask about fees."

Steve explained, "most firms charge by the hour, while others ask for a monthly retainer. Remember, that lower hourly fees do not always equal lower overall fees. An experienced advisor might take 15 minutes to complete the same task that an inexperienced advisor would take 45 minutes to

complete. The hourly fee model can reward inefficiency. Also, a true professional only operates under an 'engagement' letter or agreement, which details the work to be done and the fees to be charged. This ensures you and your advisor have the same expectations and helps prevent misunderstandings and hard feelings."

Steve further explained "... it is not enough to simply send your tax advisor your handwritten notes about your income and expenses, or show up with a box of bank statements and receipts. The better you maintain your records, the less time your advisor has to spend on that, and the lower your fees will be; meaning, take the time to set up an accounting and practice management software system. Otherwise, you will be assured of mutual frustration."

Joan said, "OK, I think things are beginning to clear up for me. I guess that it would be a good idea for me to meet with my advisor periodically to review my financial statements and see where my money is going. Shouldn't my adviser go above and beyond, suggesting alternative ways of cutting costs and acting as a sounding board for any ideas or questions I may have?

Steve began to see Joan's face light up and said, "... of course, now you are beginning to see that a good advisor can help you and your business in ways you never



dreamed possible. Spending the time to find the right match for you will ensure that you will spend less time worrying about your finances and perhaps lead a happier personal and professional life."

Raymond Furness has a private CPA practice in Encino, CA. He has been the SFVDS' independent accountant since 2011. Ray earned a degree in Economics with an emphasis in Accounting from the University of California at Santa Barbara, worked at Smith Barney as a financial analyst and worked for one of the largest entertainment CPA firms in the industry, Nigro, Karlin & Segal.

Ray received his Master degree from California State University, Northridge's MST (Masters of Science in Taxation) program. He has conducted forensic and investigative accounting for the US Bankruptcy court and teaches Federal Income Tax Law at UCLA. He can be reached at 818.990.0686

NEW: Member Benefit-CE credit through Dental Dimensions

In the Fall, 2014 issue of Dental Dimensions, beginning on page 13, the article titled, "Dentistry and Medicine: Overlapping issues of Endothelial Function" now can be utilized to earn two free hours of clinical CE credit. Members are reminded that the CE article may be read on the SFVDS website at http://sfvds.org/images/news/Complete issue.pdf

Your answers should be up to one paragraph long and will be graded by the author of the article Please FAX your answers to the SFVDS central office at (818) 576-0122

- 1) What is the endothelium?
- 2) List 3 roles of the endothelium.
- 3) Why is elasticity of the endothelium important?
- 4) What is the connection of endothelium to periodontal disease?
- 5) What is the purported mechanism by which sleep apnea affects the endothelium?
- 6) What has erectile dysfunction have to do with the endothelium?
- 7) How can endothelial dysfunction be measured?
- 8) How is an aneurysm different to endothelial dysfunction?
- 9) What impact can dentists have on improving endothelial dysfunction?
- 10) List five systemic disorders linked to periodontal disease and to sleep disordered breathing (10 total - some systemic disorders can be linked to both PD and SDB).

CDA HAS WORKED HARD FOR ITS MEMBERS IN 2014

With 2014 now behind us, CDA would like to provide a recap of what was truly a banner year for CDA's advocacy program. In a year where we faced severe threats that we had to defend against, we were also able to achieve substantial proactive victories. Our accomplishments in 2014 include:

Proposition 46

CDA and a coalition of more than 600 organizations consisting of health providers, business, labor, local governments, community clinics and many others worked for a year and a half to educate voters about the dangers and true intent of Proposition 46. On Election Day, 67 percent of voters opposed the measure – an extraordinary vote total.

While proponents attempted to confuse voters with provisions on drug testing of physicians and prescription drug monitoring, we made clear that the main goal of the triallawyer backed measure was to quadruple the cap on noneconomic damages under the Medical Injury Compensation Reform Act (MICRA). The No on 46 campaign was a sophisticated, multifaceted effort that included statewide TV and radio ads, extensive social media and press outreach, and a robust grassroots outreach program. The campaign provided informational materials at no cost, and CDA members played a crucial role in distributing these to patients in their offices and informing colleagues of the measure's potential impact. That kind of activism throughout our coalition contributed in a major way to the margin of victory. From the beginning, the No campaign sought a landslide win to discourage similar ballot measure attempts in the future, and we have made a strong statement about our commitment to protecting MICRA.

AB 1962 - Dental Plan Accountability

This year CDA sponsored AB 1962, authored by Assembly member Nancy Skinner (D-Berkeley). This legislation was signed into law in September and will bring increased transparency and accountability to dental plans in California. The bill creates standardized requirements for dental plans to annually disclose to state regulators how they spend patient premium revenue. It also puts the state on a path to adopt a minimum percentage of premium revenue that dental plans must spend directly on patient care. AB 1962 brings dental plan reporting requirements to the same level that currently exists for medical plans and declares the Legislature's intent to adopt a formal MLR standard for dental plans effective January 1, 2018.

Dental Director

CDA's access to care plan prioritizes above all else the need

for a comprehensive state oral health program led by a state dental director. Since the development of that plan over two years ago, CDA actively engaged the Governor's administration about the importance of hiring a licensed dentist with extensive experience in state oral health programs to organize and execute essential dental public health functions; someone who also has experience in leveraging state resources, securing federal funding and improving the delivery of dental disease prevention to vulnerable Californians. This goal was realized this year when the Governor released his 2014-15 budget revisions in April, which called for ongoing funding for a state dental director and an epidemiologist in the Department of Public Health to establish a state oral health program. The dental director will be specifically charged with developing a burden of disease report, leading the collaborative process to create a state oral health plan and managing the ongoing implementation of that plan. The dental director's role will also include working to secure funding for prevention-focused oral health and essential disease prevention services, particularly for children. The funding was incorporated into the 2014-15 state budget that took effect July 1, and the positions should be filled by the end of the year. In 2015, CDA will be an active participant in the stakeholder process to develop a state oral health

Dental Hygiene Committee of California (DHCC) Sunset Review

The DHCC was established in 2009 under the jurisdiction of the Dental Board of California (DBC) to regulate licensure, enforcement and education of dental hygienists. State law establishes a "sunset" review process by which the Legislature periodically conducts a formal evaluation of each state licensing body to assess its performance, determine whether it should continue and whether any changes should be made. Early in this year's DHCC sunset review process, the DHCC and the California Dental Hygienists Association proposed substantial policy changes, including: reducing oversight of certain dental hygienist duties by moving local anesthesia, nitrous oxide and soft-tissue curettage from direct to general supervision duties; deleting the requirement that registered dental hygienists in alternative practice (RDHAPs) obtain a dentist's prescription in order to continue providing services to new patients after 18 months; formally removing the committee from the DBC's jurisdiction and changing the committee to a board; and eliminating the requirement that any recommendations by the DHCC for scope of practice changes be submitted to the DBC. CDA advocated strongly against these unjustified proposals and the Legislature rejected these changes, extending the DHCC for another four years without any expansion of the

committee's authority or the hygiene profession's scope of practice.

Denti-Cal

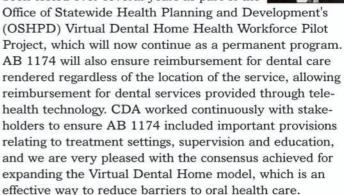
Last year, the state began implementing the 10 percent Denti-Cal provider reimbursement rate cut adopted in the 2011 budget, which had been delayed due to a legal challenge mounted by CDA and other health care organizations. CDA successfully prevented implementation of the "clawback" of dental provider payments that would have been retroactively applied dating back to June 2011, ensuring dentists are not forced to return funds received over the previous two years. However, providers still face the 10 percent rate cut going forward, and California already had among the lowest provider reimbursement rates in the country prior to the cut. With the implementation of the Affordable Care Act and its expanded coverage for millions of children and adults, CDA continues to highlight how California cannot afford to lose any providers willing to serve these patients as they gain much-needed dental coverage. CDA was successful in advocating for budget language that requires the Department of Health Care Services (DHCS) to establish a list of performance measures to evaluate utilization, access, availability and effectiveness of the Denti-Cal program, which should help demonstrate the impact of low rates.

Additionally, CDA played a leading role this year addressing the growing crisis around access to Denti-Cal services provided under general anesthesia, which many facilities statewide have either reduced or discontinued due to inadequate reimbursement rates. CDA is a convener of a working group that includes DHCS and other stakeholders to develop treatment protocols for patients in need of these services with the goal of ensuring patients have access to care in the proper setting. CDA also led an administrative services work group with a focus on increasing Denti-Cal rates for inoffice general anesthesia treatment. DHCS is considering targeted rate increases for the administration's January budget proposal.

AB 1174 - Virtual Dental Home

After two years of discussions, CDA and a variety of stake-holders were ultimately able to reach a consensus on expanding the Virtual Dental Home model. AB 1174 (Bocanegra), signed into law in September, will allow certain expanded duties (determining radiograph needs and placing protective restorations, known as interim therapeutic restorations, under the diagnosis and direction of a dentist) for registered dental hygienists, registered dental hygienists in alternative practice and registered dental assistants in extended functions in a Virtual Dental Home setting (community clinics, nursing homes, preschools, etc.) using

telehealth technology. Such functions have been tested over several years as part of the



Health Care Reform - Covered California

As California approaches the second full year of implementation of the Affordable Care Act (ACA), California's Health Benefit Exchange Board is making changes to how dental benefits will be offered in 2015 through Covered California, the state's online insurance marketplace.

California will now require all medical plans sold in the Exchange to include pediatric dental benefits, and medical plans will be partnering with separate dental plans to provide these benefits. This will ensure that all children who get their health coverage through the Exchange will also get dental coverage, and the cost of that "embedded" coverage will be eligible for federal subsidies to families that qualify. (In 2014, when the pediatric dental benefit was an optional purchase, less than one third of the children who bought medical coverage also purchased stand-alone dental coverage, and the purchase of that coverage was not subsidy-eligible due to federal Internal Revenue Service rules).

Proposition 65 Notice Requirements

The state Office of Environmental Health Hazard Assessment (OEHHA) continued discussions this year on possible changes to warning notices required under Proposition 65, which requires businesses to provide "clear and reasonable warning" if a product or business location may expose employees or customers to a chemical known to the state to cause cancer or reproductive toxicity. CDA has continued to submit comments to OEHHA and had positive conversations with OEHHA staff about ensuring that any changes to Proposition 65 requirements do not create any new threats or re-open the existing restorative materials warning notice that has protected dentists from litigation for the past 10 years. OEHHA's regulatory process should conclude by the end of 2015 and, if there are any changes to the notice requirements for dentists, CDA will inform all members and make sure they know how to comply.

Networking at the party. (Far left, Dr. Mahfouz Gereis, SFVDS Ethics Chair, 4th from the right, incoming SFVDS President, Dr. Michael S. Simmons)



Dr. Gereis (I) with Dr. Chi Leung and Dr. Mark Amundsen, and Dr. Kishore Shah sharing in conversation and good ea

> Linda Brown, AiMy Nguyen and Gina Wood of Told Properties smile for the camera

SFVDS Annual Holiday Party

On December 12, 2014 the membership of the SFVDS was invited to our annual, informal, holiday social at the central office in Chatsworth. 60-70 members and guests attended and were treated to a buffet of great food and desserts, a terrific DJ, beer and wine and lots of networking and dancing. The photos on these two pages will give readers some idea of the fun we had from 6:30 to about 11PM.

If you missed this social, make a note in your calendars to join us again this coming December 4, 2015 for another

great get-together.



Members enjoying the party



Incoming president, Michael S. Simmons, DMD and his wife, Pamela

Lining up for the buffet





Cliff Hauser, owner of Kunau & Kilne Practice Sales dances with some of the ladies.



When the lights went down, the dancing really took off.



(l-r) Drs Amundsen and Masters dance with Dr. Maytesan's staff.

SFVDS Video Production Expert, Keith Bowden takes his turn in the dance circle



The dance circle proved to be quite popular with everyone.



The evening's DJ.





Hands up at the dance circle.

Repair of Peri-implant Bone Loss After Occlusal Adjustment - A Case Report

Merin RL. Repiar of peri-implant bone loss after occlusal adjustment. A case report. JADA 2014;145(10):1058-62. Copyright © 2014 American Dental Association. All rights reserved. Reproduced with permission.

ABSTRACT

Background. Peri-implantitis generally is attributed to a bacterial challenge, with occlusion being a modifying factor. The author presents a case of peri-implant marginal bone loss that was treated successfully with only occlusal adjustment. Case Description. A 63-year-old female patient with a history of bruxism reported for a yearly perio-dontal examination 38 months after restoration of an implant in the tooth no. 30 position. A radiograph indicated that this implant had significant peri-implant bone loss. The evaluation showed very heavy occlusion on the implant restoration, and the author performed an occlusal adjustment. A radiograph obtained five months later showed significant repair of the lost alveolar bone.

<u>Conclusions and Practical Implications</u>. Patients with dental implants require periodic examination and maintenance therapy to prevent peri-implantitis. The examination should include a periodontal, prosthetic, radiographic and occlusal evaluation.

<u>Key Words</u>. Peri-implantitis; peri-implant bone loss; occlusion and dental implants; bruxism and dental implants; occlusal overload and dental implants; occlusal adjustment and dental implants.

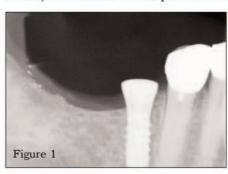
JADA 2014;145(10):1058-1062. doi:10.14219/jada.2014.65

The maintenance of healthy marginal soft tissue and bone around dental implants requires control of bacterial and mechanical factors.1 Peri-implantitis is a significant risk for dental implants, with a reported incidence of 18.8 percent of patients and 9.6 percent of implants.² Peri-implantitis is characterized by progressive bone loss beyond physiological bone remodeling, bleeding or suppuration on probing (or both) and pocket depths greater than 4 millimeters. 1-3 Marginal peri-implantitis generally is regarded as a biofilmmediated disease, and controversy exists regarding the relationship between occlusal overload and peri-implant disease.1 Because of the difficulty in defining occlusal overload, clinical and experimental studies have produced conflicting results. The case of marginal peri-implant bone loss I describe in this article did not involve all the signs of periimplantitis, because the patient had neither bleeding on probing nor pockets greater than 4 mm. I treated the bone loss only with occlusal adjustment, and repair was radiographically evident five months later. The purpose of this

case report is to show that heavy occlusion can become a primary factor in marginal peri-implant bone loss around an osseointegrated implant.

CASE REPORT

I placed a dental implant (SLA, Straumann, Andover, Mass.) in the tooth no. 30 position in November 2009

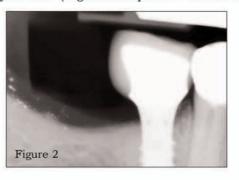


(Figure 1. Placement of implant at tooth site no. 30 in November 2009). The female patient was 60 years old, had a history of bruxism and had lost teeth owing to fractures and caries. I placed a standard conical

abutment, and her general dentist placed a cement-retained restoration on the implant in February 2010. The implant looked good clinically and on the radiographs obtained approximately one year later (Figure 2. Implant at tooth site

no. 30 one year after crown placement).

In March 2011, I extracted tooth no. 29 owing to caries and fracture. I made no attempt to place an implant immediately because of



the proximity of the root to the mandibular canal. I placed an implant (SLA, Straumann) in the tooth no. 29 position in October 2011 (Figure 3. Placement of implant at tooth site



no. 29 October 2011), and the radiograph showed physiological remodeling of the distal surface of tooth site no. 29 because of the extraction performed seven months earlier. It also showed possible crestal bone changes on the distal surface of

the implant at tooth site no. 30. Her general dentist restored the implant three months later with a conical abutment and a cement-retained crown

Continues on page 17

Robert L. Merin, DDS, MS



(Figure 4. Implants at tooth sites no. 29 and no. 30 three months after crown placement on implant at tooth site no.29). Because there were no gingival changes on the

implant at tooth site no. 30, I interpreted the radiographic changes as normal remodeling on the polished implant surface.

The patient reported for a periodontal examination 14 months after the restoration of the dental implant at tooth site no. 29 and 38 months after restoration of the implant at tooth site no. 30. She was on a six-month maintenance schedule with her primary-care dentist. Patients routinely are recalled to my practice one year after implant restoration for a clinical and radiographic examination, and in this case the one-year appointment was primarily for the purpose of checking the restoration at tooth site no. 29. The radiograph (Figure 5. Implant at tooth site no. 30, shown 38



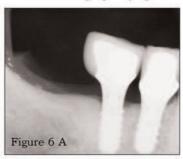
months after restoration of the dental implant and 14 months after restoration of the implant at the tooth site no. 29. Note the marginal bone loss on the implant at tooth site no. 30. An occlusal adjustment was per-

formed on the crown at tooth site no. 30) revealed that the implant at tooth site no. 29 had adequate marginal bone, but the implant at tooth site no. 30 had significant peri-implant bone loss. Periodontal pocket depths around tooth no. 30 in the April 2, 2013, readings had increased about 1 mm from those at the previous examination, but the sulci were tight, with the deepest measurement being 4 mm on the mesial aspect. There was no bleeding were at the level of the implant crown margins. There was no evidence of excess cement on clinical and radiographic evaluation. The patient had a history of heavy bruxism and said she was not wearing her occlusal bite guard on a regular basis. When I used blue occlusal paper on the restoration of the implant at tooth site no. 30, there were heavy markings on all occluding surfaces, both in centric occlusion and in lateral excursions. This included heavy markings on the working and nonworking inclines. The occlusal scheme on the implant crown at tooth site no. 30 was a narrow buccolingual table with a relatively flat anatomy to match the opposing teeth.

I informed the patient of the peri-implant bone loss on tooth no. 30 and adjusted the occlusion. The occlusal adjustment consisted of grinding the areas of heavy blue

markings until there was only light centric contact. I notified her general dentist of the problem and asked him to keep the patient on her regular maintenance schedule and encourage her to wear her bite guard. The patient was scheduled to see her general dentist for prophylaxis in two weeks. I asked the patient to return in four months for an evaluation of the bone loss at tooth site no. 30, and I told her that peri-implant surgery likely would be necessary.

The patient returned for examination five months later, and new radiographs (Figure 6. Radiographs of the implant





at tooth site no. 30 five months after occlusal adjustment. Note the repair of missing bone. A. Periapical radiograph. B. Parallel radiograph) revealed marginal bone repair around the implant at tooth site no. 30. The gingival margins showed about 1.5 mm of recession on the lingual aspect and 1 mm on the buccal aspect as measured from the implant crown margins. The patient said she was not wearing her occlusal bite guard on a regular basis. I asked both the patient and her dentist about the nature of the maintenance that was per-

formed around the implants. Biofilm control, in the form of brushing and flossing by the patient, and prophylaxis by the dental hygienist under the supervision of the dentist were the only treatment measures implemented. The patient did not have any significant subgingival instrumentation on the two implant fixtures during the dental prophylaxis appointment because the sulci were tight without inflammation or bleeding on probing. I questioned her primary-care dentist several times about the type of treatment the patient received at the prophylaxis appoint-ment. The dentist indicated that the patient received no local or systemic antibiotics or antimicrobial agents.

DISCUSSION

This case report shows improvement of peri-implant bone loss with occlusal adjustment as the only treatment. A review of the literature revealed two case reports of peri-

Continues on page 18

Repair of Peri-implant Bone Loss After Occlusal Adjustment - A Case Report

implant bone regeneration after the elimination of traumatic occlusion. 4,5 One involved the same type of implant and was treated by means of both occlusal adjustment and perimplant autogenous bone grafting surgery. The other case report involved machined-surface implants that were subject to excessive forces owing to an unstable removable prosthesis, and correction of the problem involved splinting six implants and replacing the removable prosthesis. In this study, the radiographic bone lesions started to heal within three months.

Although there is strong evidence that bacterial insult is the primary cause of peri-implantitis,¹ there is conflicting evidence concerning the role of bruxism and occlusal overload on dental implants.⁶⁻¹⁰ There are two animal studies in which the investigators reported bone loss around overloaded implants in the absence of infection.^{11,12} One of these was in a monkey model¹¹ and the other was in a rat model.¹² In a 2012 review of animal studies of occlusal overload and implant bone loss, Naert and colleagues⁹ concluded that overload in an uninflamed peri-implant environment did not affect osseointegration negatively and even was anabolic. However, supraocclusal contacts in the presence of inflammation significantly increased plaque-induced bone resorption.⁹

In a systematic review of studies involving humans, researchers found occlusal overload to be correlated positively with peri-implant bone loss, but they still considered poor oral hygiene a key causative factor. ¹³ Because most implant clinical trials have excluded participants who have bruxism, data regarding the cause-and-effect relationship between bruxism and implant failure are limited. ¹⁴ However, there are many articles based primarily on expert opinion and case reports in which the authors recommend management protocols for patients with bruxism or occlusal overload. ^{4,5,8,13-15}

This case had some of the features of peri-implantitis, such as the marginal bone loss, but was missing the deep pockets with bleeding on probing. Because of the shape of the implant crown on tooth no.30, mesial and distal probing depths are difficult to measure, and the depth changes may not have been related to the repair of the bone loss. Investigators in systematic reviews have suggested that nonsurgical therapy has not been effective for the treatment of peri-implantitis. ^{1,16} However, the patient in this case was treated only with occlusal adjustment. Perhaps I discovered the case presented, which I diagnosed by means of a periodic radiograph, before the marginal inflammatory component could merge with the peri-implant bone loss to produce irreversible peri-implantitis.

There are limitations in the interpretation of the findings presented. First, this is a retrospective case report and was Continued from page 18

not designed to show the effects of occlusion on dental implants. Because there were no controls, I do not know whether the bone defect would have improved without treatment. The nonstandardized radiographs I used in this case cannot be used to assess bone level changes and repair of lost bone accurately. Standardized imaging with digital subtraction analysis would be ideal, but it is not available in most clinical situations. Nonetheless, there is a clear suggestion that the bone has shown destruction and repair, although the precise magnitude of the changes cannot be determined.

Heavy occlusal forces on the implant at tooth site no. 30 may have occurred first during the 10 months when tooth site no. 29 was not in occlusion. In hindsight, it is possible that an occlusal adjustment of the crown on the implant at tooth site no. 30 at the time the radiograph in Figure 4 was obtained may have prevented the radiographic changes seen in Figure 5.

CONCLUSION

This case shows that radiographically evident bone loss can occur without significant gingival symptoms and that implants require periodic examination that includes periodontal, prosthetic, radiographic and occlusal evaluation. I hope that this case report will encourage more research on the role of occlusal overload in relation to marginal perimplant bone loss and peri-implantitis.

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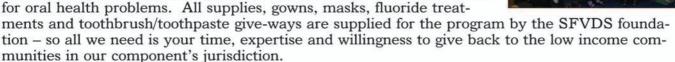
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Give Kids a Smile CALL FOR VOLUNTEERS

February, 2015 is again SFVDS' annual Give Kids A Smile program month and we need your help. ADA American Dental Association Volunteers are needed for every weekday during

February to visit pre-schools, Head Start centers, community centers and a variety of non-profit organizations to educate and screen children for oral health problems. All supplies, gowns, masks, fluoride treat-



Volunteers are needed for both on-site screenings and follow-up in members' office for those children needing follow-up care. In particular need are general and pediatric dentists, although other specialists are encourage to participate in the screening process as well.

Please join our most successful community service program of the year and help to screen and correct the oral health problems of more than 3,000 children who have been scheduled to be seen. All children will have parental release forms signed and basic treatment plans completed for referral to members' dental offices for follow-up.

Please contact Bella at the SFVDS central office (818.576.0116) to sign on and for scheduling that meets with your otherwise busy schedules.



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Urata, Mark, DDS 1146 N. Brand Blvd., Glendale, CA 91202-2504 (818) 241-4217 fax (818) 241-4983

Waugh, Ralph, DDS

Weiner, Jay, DDS

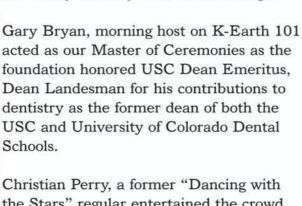


2015 SFVDS president Michael S. Simmons, DMD and wife Pamela as 'Sony & Cher

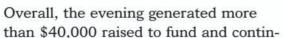
A Very Successful SFVDS Foundation Party

On Friday, October 24, 2014, 138 members and their guests enjoyed a night of 70's entertainment, a fine dinner, silent and live auctions, top three best costume cash prizes,

a photo booth and lots of dancing (spurred on by plenty of wine and beer) at the Porter Valley Country Club in Northridge.



the Stars" regular entertained the crowd with both a performance with his partner and in leading the dance floor in learning a few 70's dances.



ue the foundation's programs to serve the homeless, seniors, homebound and adults with no dental coverage. Thank you to all of those who participated in making this event a smashing success, not

only with their



"Dancing With the Stars", Christian Perry and his partner demonstrate some 70's moves for the crowd.





"Dancing With the Stars", Christian Perry and his partner lead the dance floor crowd in 70's dance instruction



A look at the silent auction offerings at this year's fundraiser

attendance, but also for their generous donations to the foundation's worthy efforts to help those who cannot otherwise afford much needed dental care!

The photos on this page will give you a flavor of the evening's fun and hopefully encourage more members to attend next year's fundraiser, scheduled for Friday, October 23, 2015. Please mark your calendars now and watch your emails for details including the location and theme for this year's celebration.

Antelope Valley Report

By: Kathy McKay

Happy 2015 from the Antelope Valley!

HI DESERT CHILDREN'S DENTAL CLINIC

The clinic has been providing free dental services to low income children in the Antelope Valley since 1986. We would like to thank all of our participating general dentists who participate in this program.

SCHOOL SCREENINGS

The AV school screenings are in full swing; our goal is to visit 50 local elementary schools during the 2014-2015 school year. To date, we have visited 16 schools and have screened approximately 1,500 fourth grade students.

CPR CERTIFICATION AVAILABLE

CPR Certification is available for SFVDS members 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 at 661-273-1750. When



you schedule a CPR Certification in your office, \$5 of the fee per participant is donated to the SFVDS Foundation.

GLENDALE/BURBANK/FOOTHILLS REPORT

By: Chi Leung, DDS

Happy New Year!

I would like to extend my gratitude for ADA/CDA's support and funding. Recently, I've been visiting some of the offices in the Foothill/Glendale area with the intention of retaining members and inviting more dentists to join. This was a great opportunity to meet more dentists in the Glendale/Burbank/Foothills area.



Visiting with Dr. Beatriz Tobon.

2015 will be a year of rapid change. We're planning on introducing new programs this year, such as a CPR and additional zone meeting

schedules in the Foothill/Glendale area. Please make sure to keep an eye out for emails announcing the details and embark with us on this journey.



With Dr. Nissan Odabashian in his office.

Welcome New Members

Adam Adamonis, DDS General UCLA, 2013

Nazafarin Rafieyan, DDS 13603 Van Nuvs Blvd. Pacoima, CA 91331 818.834.009 General

Sergey Lokot, DDS 5364 Balboa Blvd., #233 Encino, CA 91316

Mindy Garfinkle, DDS 255 Blueberry Ln. Apt B Thousand Oaks, CA 91360 Mohsen Roshanaei, DDS 27552 Sierra Hwy

Canyon Country, CA 91351

Dina Mejia, DDS

2700 Colorado Blvd. Ste 263 Los Angeles, CA 90041

General 818-471-8681

Tufts University, 2009

Viral Patel, DDS 8349 Reseda Blvd. Ste. E Northridge, CA 91324

General 818-341-5959

Nair Hosp Dntl College,

India, 1979

Shandra Suktalordcheep,

755 W. Rancho Vista Blvd Palmdale, CA 93551

Pediatric UCLA, 2007

Arin Hayrapetian, DDS 18121 Chatsworth St Granada Hills, CA 91344 General

818-491-0056 UCSF, 2011

Maral Khazali, DDS

General USC, 2012 David J. Beber, DDS 19528 Ventura Blvd., Suite # 201 Tarzana, CA 91356 General 818.881.6780



USC, 1975

MEMORIAN: William "Bill" Holve was born October 13,1920 in Fullerton, California at home on the family orange grove. At a very early age this "So Cal" farm boy from rural Orange County was involved on the orange grove and all things of the outdoors.

In his late teens, his interest in science and a favored cousin sparked an interest in dentistry.

During World War II, already drafted by the Navy, he graduated from the University of Southern California School of Dentistry, class of 1943. During those Navy years, he met and married the love of his life, Evelyn Munson.

In 1950 they moved to the San Fernando Valley and bought a house in an old walnut grove where they raised three children. Beginning in those early Valley years, he worked in dental society administration including the formation of the SFVDS. He further expanded his involvement in the citrus industry and all forms of family sport.

In 1961-62 he was elected president of the SFVDS and in 2008 he was honored by the SFVDS for 65 years of service to dentistry and the community. Retiring that year, his greatest joy came from family, especially his grandchildren and great grandchildren.

He was pre-deceased by Evelyn after 67 years of marriage and is survived by daughters Janet and Susan and son Greg.

CLASSIFIED ADS

Space for rent in a Specialty Office in Encino, available up to 4 days a week for an Oral Surgeon, Prosthodontist or Endodontist. Please call 818-517-5112 for additional information.

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To apply, please email CV to jboyce@kosservices.com or call 312.274.4520.

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Lan Su, DMD, PhD, Diplomate, American Board of Oral & Maxillofacial Pathology 31332 Via Colinas, Suite 109 Westlake Village, CA 91362 Telephone: 818-865-1039 www.oralpathmed.com

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