

Wisdom



Official Publication of the New Jersey Academy of General Dentistry

IN THIS ISSUE:

Airway Assessment
of the Dental Patient
Conservative Direct
Dental Restorations

April 2005

Volume 2 Number 1

The Western Essex Dental Association

proudly presents:

Ms. Suzanne Boswell

***“Unmasking Your Mystery Patients:
How to Gain and Retain Patients in Challenging Times”***

Wednesday, May 18, 2005
The Montclair Golf Club, West Orange, NJ
8:00am – 9:00am Registration and
continental breakfast
9:00am – 12:00pm Seminar
CEU Credits - 3



Tuition

\$165 for dentists

\$65 each additional staff member

The Western Essex Dental Association cordially invites you and your entire dental team to a morning out of the office. Please join us on Wednesday, May 18, 2005, at our annual spring seminar as we welcome Ms. Suzanne Boswell. Suzanne brings more than 30 years of public relations experience in a wide variety of fields. She is featured on the ADA video, *“The Patient Friendly Office,”* and is known for high content, high-energy presentations. This seminar is intended for the entire dental team. A continental breakfast will be served during registration. 3 CEU hours.

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Official Publication of the New Jersey Academy of General Dentistry

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Message from the President



Scott M. Dubowsky, DMD, FAGD
President

As I hit the ground running after taking the gavel from Dr. Lou Ghisalberti, I was reminded of the adage that the only constant in life is change. In order to not merely survive but to flourish in today's world, we must be able to keep an open mind while retaining core values.

It is evident to me that our organization like so many others must grapple with these issues almost daily while at the same time we must also meet similar challenges not only in our offices but also in our private lives.

The past several years have been especially tumultuous for the NJAGD. We have gone through three management changes before coming home to the NJDA team. We have been very pleased with our new relationship with the NJDA and we are now poised to work together to create innovative directions for the NJAGD. Look for new programs that we

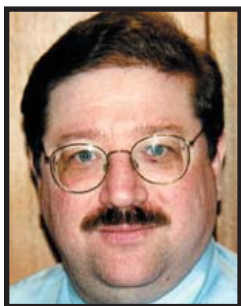
will be developing in the coming years. Our first project is a "Study Club" designed to bring cost-effective continuing education into your neighborhood.

I would be remiss if I didn't thank all of the previous officers and board members who have worked tirelessly to grow and maintain our organization. I would especially like to thank Dr. Luigi Ghisalberti for all of his efforts.

I would also take note of the candidacy of our current national trustee, Dr. Vincent Mayher, who is running for national vice president of the AGD. "Vinnie" is another example of the high caliber leaders the NJAGD produces.

Finally I would also take time to recognize and thank our supportive families who also make all our efforts possible. Without their help, we just could not get it done. 🍷

In My Opinion...



Evan Spivack, DDS, FAGD
Editor

Since its inception, the Academy of General Dentistry has been a leader and a champion of excellence in continuing dental education. As the years passed, the Academy began to offer more benefits to an ever-expanding and diversified membership, and has embarked on projects, through the Foundation, to benefit not only dentistry, but the patients we serve, as well.

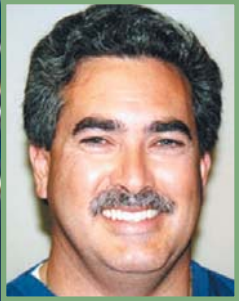
Now, the Academy is looking to take the next step in its evolution. The Strategic Futures Initiative is designed to re-focus the attention and resources of the Academy and its greatest resource—the member dentists—towards the challenges that we will meet in the years ahead. The AGD is seeking to improve upon its role as the representative voice of the general dentist.

What, exactly, does the general dentist want the AGD to stand for and work towards? As a diverse group of individuals, with differing perspectives and experiences, the answer will

be different depending on who answers this question. Right now, it is important that we all consider the answer to this important question. Is the priority of the AGD solely continuing education? Should there be a push towards improved access to care for the many dentally underserved adults and children in our communities? Should we focus on various legislative agendas? If so, which ones?

It is up to each of us to actively inform the leadership of our Academy as to how we wish to answer the question of what the Academy will evolve into. Send your thoughts via e-mail or post to the Academy officers, to the trustees, to the regional directors. Send your thoughts to our NJAGD leaders. Let us know, on the New Jersey level, what you want from the organization, from CE, from this journal. No matter which way you choose, make your voice heard. The AGD is truly an organization of and for its members. Here's your chance to help us prove it. 🍌

AGD Puts You in the Driver's Seat in Chicago



Manuel Cordero, DDS, MAGD
Regional Director, NJAGD (Region IV)

It's not too often that you are invited into the inner circle that's responsible for making the decisions of the organization to which you belong. The AGD is doing just that. We have begun a process in which your ideas and opinions can be known and heard in order to identify and direct our organization's efforts into the future.

By the time this gets to press, AGD will have extended an open invitation to members who are leaders, members who are students, dental educators and corporate leaders to come to Chicago for an unprecedented meeting on April 15-17, 2005. The Academy allowed all participants to have an equal and fair opportunity to have their ideas heard in an effort to implement what will be known as our plan for AGD2010 Innovation through Involvement. It was up to the participants to determine which of the following goals will be given priority and planned attention.

Goals

- **Image** — The image of general dentists will reflect the value of AGD to the public and the dental community.
- **Governance** — AGD governance will be nimble to allow decisions to be made quickly and effectively.
- **Membership** — Membership in AGD will be valued and inclusive of all members of the general dentistry community.
- **Continuing Education (Standard Bearer)** — AGD will be an organization that incorporates the general dentistry community in educational excellence.
- **Continuing Education (CE Producer)** — AGD will be the leading-edge organization for producing continuing education.
- **Advocacy** — AGD will be the recognized voice of issues related to general dentistry.
- **Communications** — Communications with members, constituents and stakeholders will be timely and effective.

- **Finance** — AGD will have the financial resources to accomplish its goals.

Attendees were also able to express opinions about our core values.

Core Values: To E.D.U.C.A.T.E.:

- Excellence in oral health care
- Diversity
- Universal acceptance as gatekeeper role of general dentist
- Continuous life-long learning
- Advocacy
- Teamwork; camaraderie; mentorship
- Ethical, honest and credible behavior

With so many changes in society, our profession and the CE marketplace, we must evolve and adapt in order to positively embrace the future.

Our leadership has demonstrated uncommon valor in tackling the issues that have plagued the AGD over the past 20 years. For the first time we, the membership-at-large, have been asked for our input into the most memorable attempt to respond to the needs of our members. Our president, Dr. Thomas Howley, has demonstrated a great commitment in executing what many have yearned for, but were unable to accomplish. He is embracing change based on market research, which represents the true opinions and needs of our stakeholders. Our leaders and staff are willing to take a chance on the future, now it is up to you to be part of it. I hope some of you had the opportunity to participate.

Stay tuned for more information about the strategic plan and how it will impact and facilitate positive change within the AGD. For those of you that made the trek to Chicago, thank you. Your decision to step up and lead is admirable. 🙌

NJAGD Gavel is Passed to Dubowsky

On Wednesday, April 6, 2005, the New Jersey Academy of General Dentistry swore in a new president, Dr. Scott Dubowsky.

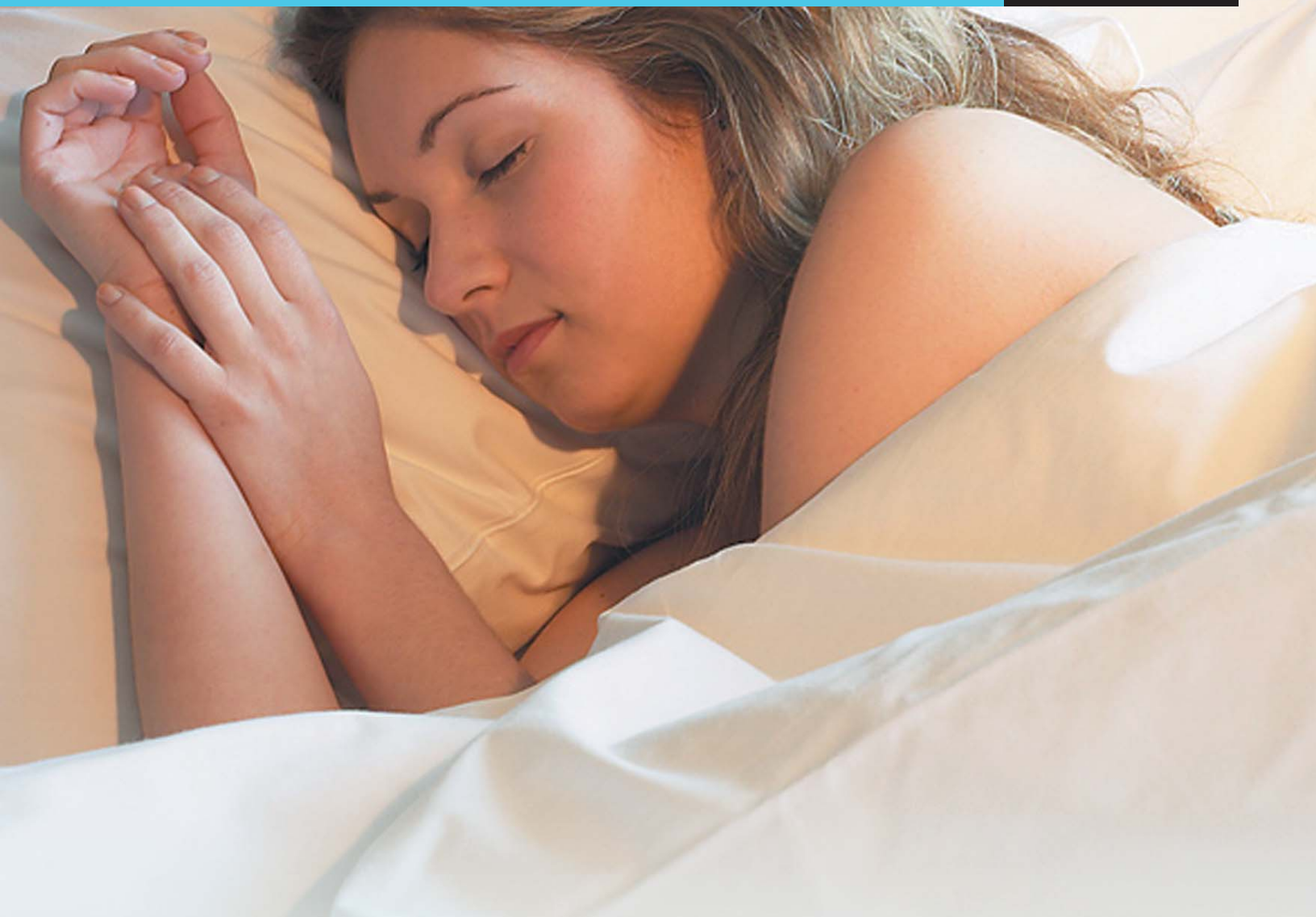
“It is a pleasure to pass the gavel to such a capable member of our organization,” said, Immediate Past President Dr. Lou Ghisalberti. “Scott will continue to many positive aspects of NJAGD as well as provide his own leadership style and initiatives.”

Scott M. Dubowsky, DMD, FAGD was born and raised in Bayonne where he also practices as a second-generation dentist.

He has an AB from Syracuse University and received a DMD from The University of Pennsylvania in 1975.

Dr. Dubowsky entered private practice in 1976 after completing a general practice residency at Metropolitan Hospital Center in New York City. He is on the attending staff of Bayonne Medical Center and is an assistant clinical professor at the NYU College of Dentistry. He has served both the AGD and ADA in both national and local positions. He shares his life with wife, Carol, to whom he has been married for thirty-three years. They have three grown sons, one daughter-in-law, and Snickers, their Springer Spaniel. 🐾





Airway Assessment of the Dental Patient

Edward Spiegel, DDS

Yosh Jefferson, DMD

Jennifer Krahe

Shirty-three percent of the United States' adult population and significant percentages of adolescents and children suffer from airway constriction or obstruction during sleep. These airway blockages result in Sleep Disordered Breathing (SDB). SDB consists of a range of respiratory disorders occurring during sleep that seem harmless, like snoring, but in reality can be chronic breathing

problems, such as obstructive sleep apnea, with many dangerous implications. Emerging research points to SDB as an epidemic: the alarming connections between obesity, cardiovascular disease, pregnancy complications, Attention Deficit/Hyperactivity Disorder, menopause, sexual dysfunction, and death due to the existence of sleep breathing disorders.

In 1997, Young et al reported in the journal *Sleep* that 93% of adult females and 82% of adult males “with moderate to severe Sleep Apnea Syndrome had not been clinically diagnosed.” In an issue of *Chest*, in 2003, Netzer et al predicted, “primary care physicians in the United States and Europe will encounter a high demand for services to confirm or manage sleep apnea, sleepiness, and obesity.”

SDB is divided into three subgroups, each more severe than the last: snoring, Upper Airway Resistance Syndrome (UARS), and Obstructive Sleep Apnea (OSA). Snoring is a sign of the onset or existence of a sleep breathing disorder. The sounds of snoring occur when the collapse of the airway's soft tissue, which rest on each other, block the airway and vibrate as air is forced through the small space that is left. UARS, as its name implies, involves airway resistance—more severe than snoring but less severe than OSA. It is more common in young women and marked by accompanying asthma, gastroesophageal reflux, and depression. OSA is the most severe sleep breathing disorder, causing periodic airway collapse that cuts airflow off completely. Choking, jerking awake, gasping for air, and abdominal spasming during sleep are all signs that an apneic event is occurring. Daytime tiredness and morning headaches are two of the clearest indications of OSA.

There are myriad risk factors and implications of SDB. They run through a variety of demographics, as obvious to our common sense as that of the obese and the elderly. However, less obvious populations affected include children, young women with asthma, and those with genetic disorders such as Down syndrome. Evidence-Based Medicine points to a number of studies published in credible, peer-reviewed journals validating this assertion:

Sleep Disordered Breathing: Risk Factors

- Obesity
- Age
- Cardiovascular Disease
- Pulmonary Disease

- Polycystic Ovarian Syndrome
- Menopause
- Hormone imbalance/deficiency
- Facial deformity
- Genetic disorder
- Malocclusion of teeth (bruxism, ineffective orthodontic work, etc)
- Temporomandibular joint disorder

Sleep Disordered Breathing: Implications

- Insulin resistance
- Impaired glucose metabolism/endocrine function
- Retardation of the fetus during pregnancy
- Cardiovascular Disease
- Hypertension
- Coronary Artery Disease
- Ischemic Stroke
- Alzheimer's Disease (due to the production of Apolipoprotein)
- Vascular headaches
- Attention Deficit/Hyperactivity Disorder
- Sexual Dysfunction

As dental professionals, we are well situated to meet the demand for successful management of sleep breathing disorders. We have the knowledge necessary to provide effective treatment for those individuals suffering from SDB because our area of expertise is the orofacial area: the mouth and the dentition. Directly connected to their physiology is the oral airway. Malocclusion, enlarged tonsils or adenoids, bad orthodontic work, obesity, and even malformation of the face can cause airway obstruction. As such, airway assessment in the dental office has proved to be a crucial part of recognizing airway obstruction and objectively measuring the treatment success of airway pathology.

As demand grows for treatment of sleep breathing disorders, dentists should be prepared to increase patients' awareness of SDB, asserting the importance of dental management of the airway. The dentist should be first to assess the airway and first to identify airway obstruction. 🦷

Conservative Direct Dental Restorations

Gerald Greitzer, DDS

In 1833 the Brothers Crocour first brought mercury/silver amalgam fillings to the United States. Since that time, amalgam had been considered the standard of care for direct dental restorations. Also since 1833, there has been an ongoing amalgam war. In 1839 Dr. Chapin A. Harris, in his address to the graduating class of the Baltimore Dental School, declared, "Amalgam is one of the most abominable articles for filling teeth that could be employed." In 1843 amalgam use was considered "malpractice." The year 1845 brought the "Amalgam Pledge" not to place amalgam. Any dentist refusing to sign the Pledge was banned from the dental society. More recently, the concept that many diseases develop as a result of mercury burden has stirred great debate throughout the medical and dental world.¹ Many states here in America, as well as several countries world wide, have established legislation governing the use, placement, disposal and handling of mercury amalgam.² It has been estimated that as many as 95% of amalgam-filled teeth have dentin and enamel cracks and fractures. Approximately 13% of amalgam-filled teeth present with Cracked Tooth Syndrome.³ Efforts are being made to ban mercury amalgam as a treatment modality. The war still rages on!

In an effort to create more cosmetic restorations various forms of composite substances have been developed for direct restorations. In 1955, Dr. Michael Buonocore began his research into the possibility of acid etching enamel to create a bond between tooth structure and plastic fillings. In the 1960s, Adaptic? composite was introduced as a substitute for amalgam. Over the last four decades, dental adhesives and composites have evolved dramatically to the point where, in 2002, bonded composite use has surpassed that of amalgam!

Much negative publicity has been presented concerning possible health complications associated with amalgam fillings.⁴ Also,

cosmetic dentistry has been brought to the forefront through lay publications, the media, and the dental profession itself. The public is aware that there may be health considerations with amalgam fillings and that there are more cosmetic methods for the conservative restoration of teeth. More and more patients request cosmetic tooth colored restorations and more and more legislative restrictions are being passed concerning amalgam. The removal of amalgam, as well as placement, however requires meticulous protocol-viz., isolation with rubber dam or similar product, copious water flow, a high-volume evacuation system, removal of amalgam in large pieces wherever possible, and proper scrap disposal. Amalgam is not medical waste but is Biohazard material and must be treated as such! It has often been quipped that the reason we place amalgam in the mouth is because anywhere else it's a biohazard.

Are You Prepared?

Unfortunately converting a dental practice from amalgam to composite based is not as simple as merely purchasing a kit of composite and adhesive. Placing long lasting, sensitive-free, attractive composite restorations require a completely different technique from that which has been used for the tooth preparation and packing of amalgam.

Cavity Preparation:

"Standard G.V. Black" preparations for the treatment of cariously affected teeth is not required or recommended when placing bonded composite restorations. Outline form, retention form, resistance form and convenience form, the first four steps in Dr. Black's protocol for cavity preparation suggested for amalgam fillings, unnecessarily remove otherwise healthy tooth structure. Conservative cavity preparation, removing compromised dentin and enamel, is all that is required for direct composite restorations. Caries determine



Amalgam with secondary caries



Amalgam removed



3 dimensional matrix & ring

outline form. Retention form is built in via adhesive bonding. Preservation of healthy tooth structure provides resistance. Modern delivery systems for composites provide convenience. Caries removal, verified with caries disclosing solution, is still required – in most instances. In an asymptomatic tooth it is beneficial to disinfect the last remnants of affected dentin either with NaOCl, chlorhexidine, or alcohol, rather than create a mechanical exposure!⁵ As long as the peripheral bonded seal is intact, the small amount of caries remaining is nutriment free and non-active.

Finishing and toileting the cavity preparation:

It has been shown that beveling of the cavo-surface margin is beneficial to increase bond strength.⁶ All handpieces deliver some amount of oil via the air-water spray.⁷ Therefore it is essential to remove any traces of contaminants, caries detector, oil, etc., with a brief alcohol scrub prior to applying the adhesive.

Placing the composite(s):

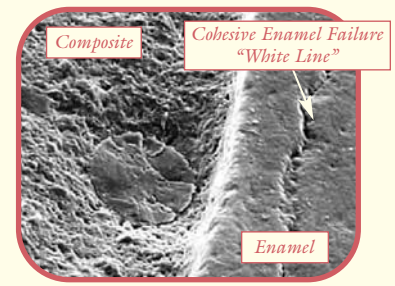
For class II restorations, a three-dimensionally contoured matrix system, such as the Composi-Tight G-Ring[®] system from Garrison Dental Solutions, will create ideally shaped contact areas that are tight and yet flossable. (Isolite™ removed for photographs)

When applying the dentin-enamel adhesive, follow the manufacturer's instructions. The use of desensitizing agents is neither necessary nor recommended when using self etching bonding adhesives.⁸ After proper polymerization of the adhesive, about 2 mm of flowable composite should be placed on all dentin surfaces as well as the matrix band/cavo-surface interface to ensure a perfect gap-free contact between dentin and composite. The layer of flowable composite may be polymerized rapidly. Paste composite is then packed in layers, no thicker than 2 mm, and fully polymerized. As the modulus of enamel is extremely high, approximately (70gPa) as compared to dentin (28gPa), and therefore very unforgiving, the final layer of composite at the enamel-composite interface must be slowly polymerized to prevent strain development as a result of inherent composite shrinkage. Rapid polymerization fails to dissipate strain resulting in failure of either the composite-enamel interface or cohesive failure of the enamel peripheral to the composite.⁷

Various methods of polymerization of the final composite layer to delay the gel phase and thereby reducing strain and subsequent "white line" have been suggested. Ramp Curing



Stained "White Line"



Composite

Cohesive Enamel Failure "White Line"

Enamel

— where the intensity of the polymerization light gradually increases over time to full power; Step Curing — where the light source starts at low intensity for a period of time and then jumps to full strength; Pulse Curing — a brief, two-second (+/-), pulse of light is applied, carving is started. Two minutes after the initial pulse has been applied a second pulse is applied, carving completed. Two minutes after the second pulse the composite is fully polymerized as per manufacturer's recommendation. Research indicates that the Pulse Curing technique is preferable in eliminating white line development. Actually there are three separate forms of white lines. They are cohesive fracture of enamel, composite-enamel interface separation, and refractive light phenomenon. This third white line is visual only and of no consequence. High intensity polymerization lights (PAC, laser, etc.) when used as per manufacturer's recommendations, have been shown to fail to fully polymerize composites, can cause increased shrinkage strain thereby propagating white lines, and do not save the amount of time attributed to their use by their manufacturers and sales reps.⁹ Anatomy carving can be done with diamonds or carbides, such as Brassler[®] 30, 15, and 10Im diamonds (red stripe, yellow stripe and white stripe). Polishing is achieved with abrasive impregnated brushes, such as Jiffy Brushes[®] from Ultradent, and assorted rubber abrasive points, cups and discs, which are available from numerous manufacturers. Following full polymerization, carving and polishing, the surface of the composite should be sealed with an adhesive and sealer of your choice. This fills micro pores in the composite surface and enhances wear resistance.¹⁰

There has been some controversy concerning the longevity of direct-placed composites relative to amalgam. This is a consideration of the past.¹¹ Although composites have not been in use as long as amalgam, many operators can show twenty year success with rather large composite restorations.



Flowable composite placed



Paste composite finished and sealed



Heliomolar DO #20 18-year recall!



This is what the patients want



This is what the patients deserve!

Conclusions:

It has been shown that when properly handled, today's composites are long lasting, non-irritating, conservative, cosmetic alternatives to that which our predecessors used for direct restoration of teeth. While amalgam has served fairly well over the years, the evolution of composites and adhesives, coupled with the ongoing concern over the possible dangers of mercury, seem to indicate that perhaps it is time for amalgam to step aside and let new and better technology take its place in the service of our patients. ♥

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Hear De! Hear De!

Calling All Authors

The editorial staff of NJAGD's publication, *Wisdom*, is always looking for articles contributed by our members. Whether your contribution is large or small, it will go far towards helping make *Wisdom* an outstanding publication of which we can all be proud.

Articles may be letters or opinion pieces, scientific articles, helpful clinical tips, news affecting dentists and dentistry or short case reports. We welcome your photos of AGD related events as well as any other articles or photos you may wish to share.

Please send submissions for consideration via e-mail to Editor Dr. Evan Spivack at spivacev@umdnj.edu, or by post to:



NJAGD Wisdom
Attn: Managing Editor
One Dental Plaza
North Brunswick, NJ 08902

Thank you for helping to spread your wisdom through *Wisdom!*



Orthotropics: The Science of Guiding a Child's Growing Face

Instructor: John Mew, BDS, Orthodontist; Date: June 24 & 25, 2005

Place: 737 Holly Lane, Westampton, NJ 08060 (just off Exit 5 of NJ Turnpike)



Age 6, mouth breather



Age 9, untreated



Before Treatment



After Treatment with Bio-Bloc

FACES is sponsoring an exciting and very relevant lecture by the internationally renowned British orthodontist, Dr. John Mew. His studies show that malocclusion and bad jaw alignment are due to adverse myofunctional habits and mouth breathing. The end result is dental malocclusion and unattractive facial features. Dr. Mew will discuss ways to encourage correct facial growth in children. Research has shown that almost all children have the unique potential to grow normally and to develop attractive facial features. His two-day presentation will discuss his BioBloc treatment technique and how he often do not use braces in children and no retainers due to stability of his treatment. Course participants will be given a course manual. You will learn:

1. *The aetiology of malocclusion*
2. *Oral posture—What part does it play in the direction of facial growth*
3. *Faces—What makes them attractive and can orthodontics change them*
4. *TMD—Possible causes and cures*
5. *Diagnosis of growth anomalies in young children*
6. *The cure of malocclusion by forward maxillary growth*
7. *The BioBloc technique*

Dr. John Mew graduated in dentistry at University College London in 1953, and he trained in orthognathic surgery. Seeking alternatives to facial surgery he moved to the specialty of orthodontics in 1965. Since then he has been developing non-surgical methods of correcting unattractive vertical growth in children's faces, using "orthotropics" to encourage horizontal growth. He has written a textbook and published many articles around the world on this subject. Over the past twenty years he has spent much of his time lecturing internationally on his techniques. Currently, he is clinical director of the London School of Facial Orthotropics. He is visiting professor to the University of Medicine and Pharmacy, Timisoara, Romania and honorary lecturer to the Royal Dental College, Aarhus, Denmark. To learn more about Dr. Mew's diagnosis and treatment philosophy, check his website www.Orthotropics.com.

Registration: 8:00 am; Lecture: 8:30 am to 5:00 pm. Questions contact 609-261-1199; email: facialbeauty@aol.com

Registration (limited seating)

Name _____ Phone _____ Email _____

Address _____

Registrations:	<u>Before/on June 10</u>	<u>After June 10</u>	<u>Total</u>
AGD and IAO Member	\$ 895	\$1195	\$ _____
Other Dentist	\$ 995	\$1295	\$ _____
		Total = \$	_____

Check method of payment: Check Visa MasterCard Discover Amex

Credit Card #: _____ Expiration Date _____

Signature: _____

Return completed form with payment made to Jefferson Dental Center:

Jefferson Dental Center
737 Holly Lane
Mount Holly, NJ 08060

Telephone: 609-261-1199 **Fax:** 609-261-2378 **Email:** facialbeauty@aol.com

**Offering 14 C.E. Credit Hours
Through AGD PACE Program**

**Nearest Airport: Philadelphia
Int. Airport** (Course location and
hotel approx. 40 minutes away)

Hotel Information:

Hampton Inn Tel: 609-702-9888

Rates start at \$129/night

Best Western Tel: 609-261-3800

Rates start at \$119/night

(Both hotels located just off of exit 5 of
the NJ Turnpike. Course location only 1
mile from hotel)

Course director: Yosh Jefferson, DMD
(AGD credits offered. AGD and NJAGD
are not responsible for course content.)

Clinical Pearl

Aviva L. Andreen, DDS

Dentists, dental hygienists and dental assistants live in the world of universal precautions, forever on guard against bacterial, viral and fungal threats. Here is a new twist on an old friend in the dental operatory to help protect us from dangerous “sticks.”

Wilmer Palma-Diaz, CDA, of the Special Care Treatment Center of the Pediatric Dentistry Department at UMDNJ has been using a McKesson-type rubber mouth prop wrapped with a 4x4 gauze and/or a 2x2 gauze to protect his finger from contaminated instruments during use. The thickness of the buccal side of the rubber mouth prop protects the hand without the danger of a stick from a sharp instrument. While the finger fits into the lingual side of the mouth prop, the gauze cleans the instrument as it is wiped against the mouth prop.

McKesson props are available in both latex and non-latex

materials. With different sizes of mouth props available, there is a fit for every hand size, male or female, large or small. Wrapped in gauze, the prop can be worn by the assistant, the hygienist, or the dentist. At present, it is not available on the market with a tab to hold the finger. A large gauze can tie the mouth prop in place on the hand, or a piece of surgical tape can be placed under the gauze on the lingual side to hold the finger (on top of the glove, of course). If this catches on, the future may bring a version that will have a loop for a clinician to hold a mirror and wipe contaminated sharp instruments simultaneously.

Is there anything in your day-to-day practice that makes dentistry better, easier or safer? It can be a new technique or an established material...either way, share your knowledge with your colleagues. Submit your “Clinical Pearls” to the editor for consideration spivacev@umdnj.edu. ☺

New Jersey's Dr. Vincent Mayher Runs for National AGD Vice President

Each year, regional delegates of the Academy of General Dentistry (AGD) meet to elect a new vice president. The winner of this election serves one year as vice president and another year as president-elect before assuming the role of Academy president. In July, delegates will have the opportunity to elect Vincent Mayher, DMD, MAGD, as the next vice president.

"I've known Vinny Mayher a long time. He is one of the most honest, caring, and hardworking people I know. The AGD would benefit from his integrity and organizational skills demonstrated by his work on the Legislative Council, Mastertrack program in New Jersey and as AGD Trustee. Some people like to server for themselves — Vinny does it for others!"

— Dr. Bruce Small

Vincent "Vinny" Mayher is currently the trustee of AGD Region 4. He serves as chair of the Academy's Budget and Finance Committee, and as a member of the Academy Foundation's Board of Directors. Over the years, he has served as regional director of Region 4, chair of the Regional Directors, and served six years on the Academy's Council on Legislative and Governmental Affairs.

Dr. Mayher is a past president of the New Jersey Academy of General Dentistry (NJAGD) and co-founder of the NJAGD Master track program. He is the American Dental Association (ADA) Action Team leader for the 1st Congressional District in New Jersey, and currently serves on the New Jersey Dental Political Action Committee's Executive Board. A past president of his ADA component, the Southern Dental Society of New Jersey, Dr. Mayher has been a member of the New

Jersey Dental Association House of Delegates and the AGD House of Delegates for nearly twenty years.

Dr. Mayher practices general dentistry in Haddonfield, New Jersey. Prior to that, he served a tour of duty as a United States Naval Dental Officer.

Dr. Mayher is a fellow of both the American and International Colleges of Dentists. He was a member of the New York City dental ID Team after the September 11th disaster, and serves as a volunteer pilot and spokesperson for Angel Flight East. A Rotary International Paul Harris Fellow and a Lector at St. John Newman Church in Mount Laurel, New Jersey, Dr. Mayher lives in Mount Laurel with his wife of 25 years, Elaine, and their three daughters, Lauren, Kristin, and Megan.

Dr. Mayher has held a number of leadership positions in the Academy on both the local and national levels. Pointing out the expanding role that the Academy is embracing, He promises to foster efforts to provide quality continuing education culminating in Fellowship, Mastership, and beyond, while standing tall as an advocate for the general dentist in the legislative and third-party arenas.

More information on Dr. Mayher's candidacy can be found on his AGD website, <http://www.agd.org/Mayher.asp>.





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