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# wisdom

**My Patient Needs Surgical Periodontal  
Pocket Therapy — What Do I Do Now?**

**The Intra-Orally  
Assembled Implant  
Verification Jig**

**Dementia and Oral Health:  
Background and Approaches  
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# President's message



*Joseph Sandberg,  
DMD, MAGD  
NJAGD President*

## News You Can Use

The Academy of General Dentistry has been working closely with the individual State Boards of Dentistry to accept the AGD CE Transcript as proof of meeting CE requirements to maintain licensure. I am happy to announce that in NJ, as well as most other states, the AGD CE transcript is now accepted as proof of CE attendance for license renewals. It is important to check your CE transcript at [www.agd.org](http://www.agd.org) regularly to be certain that all of your approved courses are reflected accurately. Furthermore, it is still recommended that you keep a record of those courses you have attended with the actual certificates or proof of attendance for 7 years.

It is important to realize that in order for the State Board to fully accept the AGD transcript as proof of attendance at courses, the AGD must maintain actual documentation of course attendance. Self-reported CE is not considered verified and therefore not eligible for acceptance by many licensing boards. Based on this information, the AGD will be discontinuing online submission of CE by members, effective Jan. 1, 2008. In addition, in 2005, the AGD mandated that all PACE providers submit CE information on behalf of members who attend one of their courses.

In other news, I recently sent a letter to all NJAGD dentists regarding the passage of the Amalgam Recycling regulation. This regulation requires that most dental facilities (with some exceptions) implement Best Management Practices for amalgam handling within one year (Oct 1, 2008) and to install an amalgam separator within two years (Oct 1, 2009).

In anticipation of this regulation, NJAGD has developed an exclusive program for its members with Dental Recycling North America, Inc (DRNA), the nationally endorsed waste management vendor of the AGD. We have arranged for a special promotion only available to NJAGD members... for a limited time NJAGD members who purchase the DRNA amalgam separator equipment can receive a special discount on a 3 year maintenance service. This offer expires Feb 29, 2008.

Lastly, in this new year I ask you to reflect and consider expanding your professional horizons and reach by joining us at the NJAGD not strictly as members but as leaders. We are in need of doctors who are passionate about general dentistry to become active in the NJAGD to keep our organization strong and growing. Please visit our website at [www.njagd.org](http://www.njagd.org) to see when our Board meetings are scheduled. Call or e-mail me with any questions you may have ([josephsandberg@agd.org](mailto:josephsandberg@agd.org)). One of you reading this appeal, may be a future President of the NJAGD.

The entire NJAGD Board and myself wish a rewarding and fulfilling new year!





*Evan Spivack,  
DDS, FAGD  
NJAGD Editor*

# Stop Me If You've Heard This One Before...

**H**ere's a classic. The patient comes in for her denture adjustment... without the dentures. "But doctor", she says, "I couldn't wear them, they were hurting me!"

How about this one? "The crown was loose over the weekend, so I just put it back with Crazy Glue..."

Surely you know this one, said in all sincerity: "But doc, there's no way I can pay off those bridges after getting that big screen TV... do you know what those things cost!?"

And one of my favorites: "I know those are big cavities, but I figured that since they were baby teeth, they would just fall out!"

The comedic potential of these stories aside, the fact that we have all heard these same lines and more indicates the existence of a more serious problem. Specifically, how well do we communicate with our patients?

Communication between dentist and patient takes many forms, and occurs continuously throughout the patient's interaction with the dental practice. From the very beginning, everyone will benefit from the patient being given a good introduction to the practice, emphasizing philosophy of care, experience and roles of the various team members, and office policy guidelines. This communication can be initiated by the front desk staff and complemented by brochures and the office website.

Lines of communication must remain open from the initial examination through all phases of diagnosis. Too often, patients are unaware of all that goes into radiographic interpretation, oral cancer screening and thorough medical history reviews, and they undervalue these services. It is our responsibility to educate our patients, and help them understand the true value of what they are getting.

Examination appointments are also a good time to educate patients about oral hygiene, restorative and esthetic issues and other dental and oral health matters such as diet and smoking cessation. These are valuable opportunities to reinforce relationships with our patients and let them know what we can offer.

In developing and implementing the treatment plan, true consent can only be obtained if the patient understands the nature of the problem, its causes, potential concerns and options available to resolve it. In many cases, patients will be more accepting of proposed treatment if they understand the thought process behind the plan, have the opportunity to ask questions and feel included in the process.

Continuing education is a continuous stream: education of the dentist, and education of the patient by the dentist. The opportunities to communicate with our patients and educate them should never be overlooked.

## The Future Leaders Conference and more



*Manuel Cordero,  
DDS, MAGD  
National Trustee Region 4*

This past year the Academy of General Dentistry has handled multiple issues involving general dentists and the way we practice. We were on top of the periodontal referral guideline issues as well as the oral sedation rules of engagement. In both cases, the Academy was instrumental in the responsible handling of issues that had potential to be detrimental and limiting to the general dentist. The AGD, which has always been associated with the pursuit of excellence via life long learning, can no longer stand on the sidelines watching how the world of dentistry evolves without our input and concern.

Dr. Michael Silverman, the president of DOCS, clearly stated the reality of who we are and what we can accomplish: "The Academy of General Dentistry... played a major role in preventing the one community of interest from reversing the good work of the guidelines — a community that has historically always gotten its way in the ADA. The AGD is now a powerful advocate for the rights of the general dentists and clearly made a stand for the rights of the dental community to provide safe sedation."

Our lead organization has always been the American Dental Association, and there is none as effective and responsible in matters affecting our profession and those we serve. However, with the influx of opinions and agendas by its specialist members, the ADA has developed a somewhat limited scope on issues of concern to the general dentist. While in the past the ADA addressed the basic issues concerning our profession, other issues have taken prominence in our ever-evolving and competitive field. The cost of providing services continues to rise at ever-increasing rates, but the ability to pay for services provided by the general dentist has not kept pace. Issues such as this, and others, are not new. They truly need and deserve our attention and resolve. For this reason, the AGD is taking a stronger approach to serving its members by preparing leaders who will be effective within their constituents and their communities.

This past November saw the Academy's first Futures Leaders Conference. New Jersey was well represented by Regional Director Dr. Elizabeth Clemente and Public Information Officer Dr. Haniel Rosemond. This conference was designed to focus on those members who will take active roles in our organization in the coming years.

At the conference, experienced Academy members interacted with newer members demonstrating leadership potential and interest in service. Workshops were designed to help them develop the tools needed to become more effective in their components, on the national level and in the communities that they serve. Groups were formed to facilitate participation in the conference as well as to open doors of communication and cooperation within the organization. In encouraging interaction between members of diverse backgrounds and regions, new ideas were brought to light and our eyes opened to the wealth of knowledge that our membership embodies. The unique approach brought to this meeting by Jeff Cufade made this an unforgettable and meaningful experience. Known as an architect of ideas, Jeff certainly built many during this conference.

I would like to take this opportunity to invite our members to join us in leadership roles. Our Board meetings are open, and we welcome — and need — your participation. Help us to help you and our profession by working with us at the New Jersey Academy of General Dentistry.





# My Patient Needs Surgical Periodontal Pocket Therapy

## *What Do I Do Now?*

### Introduction

Treatment of chronic periodontitis begins with initial or Phase I therapy.<sup>1</sup> Phase I therapy may include oral hygiene instructions, periodontal scaling, and occlusal adjustment. These treatment modalities are used initially to:

- 1 help the practitioner assess patient compliance with plaque control instructions and procedures; and
- 2 help assess the clinical changes in the gingival/attachment apparatus, i.e., assess the reaction of the tissue to the reduction or elimination of those factors contributing to the inflammatory/destructive nature of the disease. Many cases of slight or moderate chronic periodontitis will respond favorably to Phase I therapy, thereby eliminating the need for surgical intervention.

The decision to surgically treat the patient is based on the patient's response to the effects of Phase I treatment. A final decision on the need for periodontal surgery should be made only after reviewing the data recorded during a thorough reevaluation examination.<sup>2</sup> When surgical pocket therapy is decided upon, all periodontal surgical modalities accomplish the following:

- 1 increase the access for root exposure to aid in the removal of root deposits;
- 2 resect the soft tissue pocket wall to eliminate or reduce pocket depth; and,
- 3 expose the area to perform regenerative treatments.<sup>1</sup> **Since all periodontal surgical modalities improve the prognosis of those teeth that are treated, the surgeon needs to make another decision. Which surgical treatment modality should be employed for my patient?**

This paper is designed to help the practitioner make a decision based on the three most common resective/subtractive surgical modalities for use in the posterior segments of both the maxilla and mandible. The three modalities reviewed are:

- 1 osseous surgery;
- 2 modified Widman surgery; and,
- 3 flap curettage.

This paper is not intended to address treatment of anterior segments of the maxilla and mandible or treatment by regenerative therapy.

### Osseous Surgery

The resective/subtractive osseous surgical modality, i.e., osteoplasty/ostectomy is best applied to patients with the following parameters:

- 1 posterior segments with early to moderate horizontal bone loss 2-3mm apical to the crestal bone;
- 2 teeth with moderate-length root trunks (referring to multi-rooted teeth); and
- 3 bony defects with 1 or 2 walls.<sup>3,4</sup> The osseous surgical technique utilizes a mucoperiosteal flap which is elevated apical to the mucogingival junction allowing surgical access to the bony wall(s) of the periodontal defects. When osseous recontouring is combined with an apically positioned gingival flap, it provides the periodontal surgeon the most predictable pocket reduction technique.<sup>5,6,7</sup> The combination of osteoplasty/ostectomy and flap placement at the alveolar crest reduces or eliminates the pocket depth.

Osteoplasty/ostectomy is designed to restore the form of the preexisting, "healthy" alveolar bone to the level present at the time of surgery or slightly more apical to this level. If discrepancies exist between the shape of the bone and the overlying gingiva, these discrepancies predispose patients to recurrence of pockets post-surgically.<sup>8,9</sup> The use of resective osteoplasty/ostectomy eliminates these discrepancies and creates a bone form that the gingiva is able to follow.<sup>8</sup> This newly created bone form, now referred to as "physiologic form with positive architecture", helps prevent the recurrence of pockets.<sup>10</sup> When the osseous surgery modality was tested in longitudinal studies compared to other surgical modalities<sup>11</sup>, it produced sites where probe depths were significantly reduced and maintained their stability. The teeth were also retained long-term with stable pocket depths.<sup>6,12,13</sup>

If the surgeon's goals are:

- 1 reduction/elimination of pockets (without undo reduction of supporting bone);
- 2 prevention of recurrent pockets; and,
- 3 promotion of patient centered (better access for plaque removal) periodontal maintenance, the use of the osseous surgery modality would be the treatment of choice to achieve those goals.



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## Modified Widman Surgery

In cases of early to moderate bone loss, the Modified Widman Surgical technique<sup>14</sup> is used primarily to expose root surfaces for meticulous instrumentation. It is also used for the removal of the soft tissue pocket lining.<sup>14</sup> In this technique, the mucoperiosteal flap is purposely **not** elevated beyond the mucogingival junction (undisplaced flap). The flap is replaced intentionally helping to approximate the interdental papillae. When the facial and lingual papillae are sutured together, primary closure completely covers the interproximal bone with gingiva. The modified Widman technique does not intentionally reduce or eliminate pocket depth. Limited reduction of pocket depth occurs by tissue shrinkage during the ensuing healing process and by the formation of a long junctional epithelial attachment to the root surface.<sup>14</sup>

In 1974, Ramfjord and Nissle<sup>14</sup> modified the 1965 technique by Morris<sup>15</sup> and outlined the technique in detail. It should be noted that limited osteoplasty was used to help adapt the gingiva to the necks of the teeth and was used to help coapt the facial and lingual papillae for complete closure when sutured over the interproximal bone.<sup>14</sup>

It is important for the surgeon to note that the modified Widman technique maintains similar probe depths after a seven year period compared to the osseous surgical technique<sup>14</sup>; however, more attachment is retained compared to the osseous surgical technique because **no** attempt is made during modified Widman surgery to achieve ideal/positive anatomical bony architecture.<sup>14</sup> This technique, because of very limited pocket depth reduction, requires meticulous, frequent professional maintenance.

## Flap Curettage

### (flap access for debridement of roots and bone lesions)

This type of flap is used in cases of moderate to advanced bone loss when the osseous topography has a vertical component or when the bony topography is not conducive to pocket reduction/elimination via osteoplasty/osteotomy. Osseous recontouring is not an option, in most advanced cases of chronic periodontitis, because ideal physiologic/positive architecture cannot be created without removing an excessive amount of bone supporting the teeth. Pocket reduction/elimination, therefore, is not possible without severely jeopardizing the prognosis for those teeth included in that surgical site.

This surgical technique incorporates a mucoperiosteal flap which is technically a replaced flap. The internal bevel incision is made apical to the crestal bone.<sup>1</sup> Unlike the Modified Widman procedure, this flap is elevated beyond the mucogingival junction in order to gain access to both the root surfaces and to the surrounding bony defects. Preservation of the entire soft tissue flap, minus the portion of the soft tissue wall removed during the initial incision, leaves the surgeon the option to perform regenerative procedures, **limited** osseous recontouring, and/or strategic extractions during the operation. This technique is quite versatile. It is a valuable tool when treating advanced disease or moderate disease with pockets not amenable to either of the previously described techniques.

## Conclusion — What should you do?

All surgical pocket therapy used to treat early or chronic periodontitis improves the prognosis for the teeth incorporated in the surgical site; therefore, which surgical approach or technique will give your patient the best prognosis for long-term retention of

his/her teeth? Your decision will be based on the parameters of what you term “a successful end result”. If you want maximum pocket reduction/elimination as your end result, then osseous surgery would be your choice. If you want maximum retention of the attachment around the teeth with minimal pocket reduction, then modified Widman surgery would be your choice. If you are treating advanced chronic periodontal disease with:

- 1 bone lesions not amenable to osteoplasty/osteotomy;
- 2 bone lesions that need to be accessed by a flap elevated beyond the mucogingival junction; or
- 3 bone lesions amenable to regenerative procedures — then flap curettage/access for debridement and/or regeneration would be your choice. The decision is now yours to make!

## About the Author

*Dr. Steven Cooper obtained his degree in dentistry from State University in Iowa and his Certificate and M.S. in Periodontology from The University of Iowa. He is currently an Assistant Professor at The University of Iowa, College of Dentistry where he has been awarded several honors such as Clinical Instructor of the Year and most recently, Instructional Improvement Award.*

*Dr. Cooper is the accomplished author of numerous publications including journal articles and abstracts in the field of laser treatment, gingival inflammation and video assisted clinical instruction in dentistry. His teaching and clinical research has resulted in invitations to lecture and present his work to a variety of dental audiences. Dr. Cooper is a member of the American Dental Association, Academy of Periodontology, Omicron Kappa Upsilon and the International College of Dentists.*

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# Background and Approaches to Treatment



Evan Spivack,  
DDS, FAGD

**D**r. Alois Alzheimer first described the disease that would come to bear his name in 1906, when average life expectancy was fifty years and only approximately four percent of the United States population was over the age of 65. That number has risen dramatically, and it is estimated that by the year 2030, the percentage of Americans over age 65 may exceed twenty percent. What was once considered a rare disease is now commonly diagnosed, and is among the leading causes of death in the elderly. Dentistry will be taking on an ever-increasing role in the care of this population, and every dentist should feel comfortable providing care to this large and complex patient population.

While the aging population is faced with numerous physical and dental concerns, perhaps no single issue looms as large for the aging individual, their family members and society as a whole as does dementia. This article will outline the various forms of dementia, the disease process, and treatment considerations for the dentist caring for the aging patient with dementia.

## DEMENTIA

Dementia is defined as a permanent or progressive decline in several dimensions of intellectual function that interferes substantially with activities of daily living (ADLs). In determining care plans for the dental patient with dementia, certain aspects of this definition take on heightened importance. The dentist must recognize the progressive nature of the disease process, and plan ahead for inevitable decline. Additionally, recognizing that dementia impacts on ADLs — including oral hygiene — is critical to ongoing oral maintenance.

The hallmark of dementia is memory loss. Although a degree of memory loss is considered normal as part of the aging process, significant functional changes can signal the onset of dementia and indicate a need for medical evaluation. Some of the functional changes that may serve as warning indicators are listed in Table 1.

Although senile dementia of Alzheimer's type (SDAT, commonly referred to as Alzheimer's disease) is by far the most commonly encountered form of dementia, accounting for nearly seventy percent of all cases, several other conditions may lead to similar-appearing patient decline. The dentist should be familiar

*Table 1 —*  
Selected warning signs of dementia

- Increasing forgetfulness and difficulty with recall
- Difficulty in performing familiar tasks
- Disorientation to time and place
- Dramatic changes in mood, behavior and personality
- Increasing errors in judgment

with these disease entities, as management considerations may vary due to the cause of dementia. Additionally, the dentist may play a role in appropriate patient referral and even in helping to determine a correct diagnosis.

### Depression

Persons with depressive disorders often exhibit decreased communication skills and poor memory, which can be misinterpreted as Alzheimer's disease.

### Drug toxicity

In some instances, patients exhibit signs and symptoms easily mistaken for Alzheimer's dementia due to overdosing of prescription medications or adverse effects of such drugs taken in combination. This form of dementia is often reversible once the offending medication is discontinued.

### Metabolic disorders

A variety of metabolic disorders can produce symptoms closely mimicking SDAT. One more commonly encountered disorder, associated with alcoholism, is Wernicke-Korsakoff syndrome, caused by a thiamine (vitamin B<sub>1</sub>) deficiency.

### CNS infections

Although not commonly encountered in routine dental practice, patients may present with neurological infections mimicking SDAT. Creutzfeldt-Jakob disease, and its variant caused by eating meat of cattle with "mad cow disease" is among the more prevalent.

## ALZHEIMER'S-TYPE DEMENTIA

Senile dementia of Alzheimer's type (SDAT) is the most prevalent form of dementia. Table 2 outlines key demographic features of Alzheimer's disease. Autopsy studies have demonstrated large plaques of beta amyloid and tangles of tau proteins in the brains of those with SDAT, but current research has not completely explained the role of these findings in causing neuronal death.

Although numerous theories have been advanced as to the cause of this disorder, none of these have been conclusively determined to be the cause of this brain cell failure. The theory that aluminum plays a key role in disease progression (widely espoused in the 1970s and 1980s) has never been confirmed, researchers believe that SDAT has both genetic and environmental cause. To date, one gene has been identified as increasing the risk of SDAT, and another gene, present in a handful of extended families worldwide, has been definitively linked to the disease.

Despite the lack of an identifiable cause, a number of risk factors have been identified that predispose towards development of SDAT.

These risk factors include:

- Advanced age (nearly fifty percent of those over age 85)
- First-degree relative with SDAT (two to three times more likely)
- Head trauma
- Risk factors for vascular disease (hypertension, hypercholesterolemia, diabetes)
- Down syndrome (almost 100% in those over age fifty)

Although definitive diagnosis of SDAT can only be done postmortem through brain biopsy, a presumptive diagnosis can be made through other methods. Common screening procedures begin with a through a review of symptoms and medical/family history. Cognitive function tests are used, including the MMSE (mini-mental state examination). Physical examination, neurological evaluation and diagnostic tests (including blood and urine testing) are used to rule out other causes of dementia. Functional imaging studies may be ordered, including fMRI and PET scans; structural imaging studies using MRI and CT scans may also be used.

There has been no effective treatment for Alzheimer's-type dementia found to date. Research looking towards aspirin and other nonsteroidal anti-inflammatory agents (NSAIDS), as well as prednisone, has found no significant benefit to these drugs in the use of SDAT; herbal supplements have similarly not been proven to be effective.

Several medications are commonly prescribed that have been found to temporarily delay the worsening of dementia symptoms for between six and twelve months; these drugs are listed in Table 3. Other drugs are commonly used to help manage the behavioral aspects of dementia; many of these are noted in Table 4. Tegretol and Depakote, although most commonly use as antiseizure medications, are increasingly being prescribed to this population to assist in mood stabilization.

The course of disease progression in SDAT may be described as three stages. Although the length of time in each stage may vary, patients exhibit similar routes of deterioration (Figure 1). In stage one, which may last from two to four years, the patient exhibits memory losses and all-around decrease in capabilities. Patients in the second stage of dementia continue to decline, but at a slower pace; this plateau period may last from months to several years. The third stage of SDAT is the terminal phase of disease; generally, decline is rapid with death as an endpoint.

## Table 2 — Demographic features of Alzheimer's disease

- Affects 5.1 million people in U.S.
- Over 150,000 New Jersey residents
- Affects 13% of persons age 65 and older
- Affects 42% of persons age 85 and older
- 411,000 new cases diagnosed in 2000
- Fifth leading cause of death in those age 65 and older

Source: Alzheimer's disease facts and figures 2007  
(Alzheimer's Association)

## THE DENTAL PATIENT WITH DEMENTIA

In caring for the person with dementia, it is critical that the dentist identify the primary caregivers that interact with the patient. As the patient declines, the caregiver(s) will take on increasingly greater roles in all aspects of their lives, particularly in the activities of daily living (ADLs), including oral hygiene. The caregiver may be a family member, a close friend, or a health care worker. It is important that the dentist recognize that the caregiver may or may not be the legal guardian, or have power of attorney for the patient.

The dentist must also determine the patient's ability to make decisions relating to dental treatment. Although still their own guardians, many of these patients will not have sufficient decision-making capacity. The dentist should elicit the input of caregivers and close family members where possible when formulating care plans.

Treatment planning decisions for the person with dementia are made more complicated due to the lack of input from the patient. The dentist must develop a treatment plan based on principles of the dentist's best judgment in determining the patient's needs and most appropriate care as well as the concept of "substituted judgment". This concept requires the dentist to determine, as best as possible, what decisions the patient would make if he or she were able to do so. Factors to consider include the patient's dental history, current dental findings and discussions with family members and caregivers.

Initial assessment of the patient with dementia, as for all patients, begins with a thorough review of the medical history. The person giving the history should be able to provide thorough,



Figure 1

accurate and current information on all diagnoses, medications and hospitalizations. In addition, the dentist should obtain a list of all of the patient's medical care providers, with telephone numbers should the need for consultation arise. The social history should focus on the patient's ability to perform ADLs, daily routine and habits.

A thorough dental history, aside from the physical examination, is critical in helping to determine the direction of the care plan. In addition to obtaining an accurate treatment history, the dentist should elicit a sense of the patient's (and the caregivers') attitudes towards dental care. Current oral hygiene practices, as well as an assessment of the caregiver's skills and motivation, should be examined and appreciated.

The oral examination for the patient with dementia should include an evaluation of all hard and soft tissues as well as existing dental prostheses. Increased attention should be focused on those forms of oral pathology more commonly seen in this patient population, including xerostomia, candidiasis, root caries, and oral cancer.

### STAGING DENTAL CARE

In determining the care plan for the patient with dementia, the dentist must consider the patient's current status and must also attempt to determine, as realistically as possible, the future course of the disease. The patient's current stage of dementia is a useful tool in formulating an appropriate oral care program.

In the earliest stages of dementia, the dentist must look to aggressively treat all existing dental and oral pathology, working to achieve good overall oral health. Any treatment should take into account the reality of future cognitive and functional decline that the patient will experience. It will seldom be appropriate to observe developing carious lesions or defer extractions or root canal procedures if the need for such seems near. Despite this, there will often be little need for modification in the way in which treatment is provided to the patient with early-stage dementia, as most patients will be able to routinely present for treatment visits and tolerate chairside procedures.

In the second stage of dementia, the patient is in the protracted middle phase of the disease and, although the rate of decline slows, there is continued loss of independence and function. The caregiver(s) will take on increasingly more responsibility for routine care, and will be more involved in the decision-making process. He or she will also be the person best able to provide regular medical history updates as the patient's condition deteriorates. Treatment planning during this stage is geared primarily towards maintenance of the existing dentition and prostheses. Whenever possible, teeth

### Table 3 — Medications used in the treatment of SDAT

#### Cholinesterase inhibitors

- Donepezil (Aricept)
- Rivastigmine (Exelon)
- Galantamine (Razadyne)

#### Glutamate regulator

- Memantine (Namenda)

### Table 4 — Medications used for behavioral symptoms

#### Antidepressants

- Citalopram (Celexa)
- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Trazodone (Desyrel)

#### Anxiolytics

- Lorazepam (Ativan)
- Oxazepam (Serax)

#### Antipsychotics

- Aripiprazole (Abilify)
- Clozapine (Clozaril)
- Haloperidol (Haldol)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Ziprasidone (Geodon)

should be restored rather than extracted and existing dentures should be repaired as needed rather than having new prostheses fabricated. As function decreases, patients will require more frequent recall/maintenance visits. Patients will often be able to sit for care, but lengthy appointments should be avoided due to decreased attention spans and physical tolerance.

The third, or terminal stage of the dementia process is characterized by sudden onset and rapid decline in all parameters. The caregiver is now completely responsible for the patient's maintenance and wellbeing, and must be educated in appropriate oral hygiene techniques. Recall visits should be scheduled on a regular and frequent basis, with every effort made to maintain the existing dentition. Pathology must be aggressively eliminated, as oral conditions may worsen quickly and become more difficult to manage. With patient deterioration, the focus of care will often shift towards elimination of sources of pain and infection.

### CONCLUSIONS

The number of patients with dementia is increasing dramatically. The need for dental care by this population is unquestioned and, in many cases, remains unmet. Patients with dementia will present challenges to the dentist in terms of their cognitive and functional limitations, and their complex medical comorbidities often require modifications in treatment planning. This article discusses the demographics and features of dementia, and discusses treatment approaches to this significant population.

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Alzheimer's Association: [www.alz.org](http://www.alz.org)

### About the author

The career of Evan Spivack, DDS, FAGD has centered around the care of patients with complex medical conditions in office, hospital, institutional and clinical settings. He is currently director of the Special Care Treatment Center at the New Jersey Dental School-UMDNJ, which provides care to persons with developmental, medical and psychological disabilities.

# CE Exercise Questions

The NJAGD invites you to test your knowledge of the preceding article,  
“Dementia and Oral Health: Background and Approaches to Treatment”

by Evan Spivak, DDS, FAGD.

Reading the article and successfully answering 7 of the following  
10 questions will qualify for 1 CE credit from the NJAGD.



- 1** By the year 2030, it is estimated that the percentage of Americans over age 65 will exceed:
  - a. 4%
  - b. 10%
  - c. 20%
  - d. 25%
- 2** Alzheimer’s disease accounts for approximately what percent of dementia cases?
  - a. 10%
  - b. 25%
  - c. 50%
  - d. 70%
- 3** Wernicke-Korsakoff syndrome is associated with alcoholism. Dementia due to drug toxicity is often reversible.
  - a. both statements are TRUE
  - b. both statements are FALSE
  - c. first statement is TRUE, second statement is FALSE
  - d. first statement is FALSE, second statement is TRUE
- 4** Risk factors predisposing towards Alzheimer’s-type dementia include:
  - a. advanced age (over age 85)
  - b. head trauma
  - c. risk factors for cardiovascular disease
  - d. both A and C
  - e. all of the above
- 5** Exposure to aluminum is considered the most likely cause of SDAT. Definitive diagnosis of SDAT is only possible with postmortem brain biopsy.
  - a. both statements are TRUE
  - b. both statements are FALSE
  - c. first statement is TRUE, second statement is FALSE
  - d. first statement is FALSE, second statement is TRUE
- 6** The concept of “substituted judgment” requires the dentist to make decisions based on an assessment of the patient’s:
  - a. previous dental treatment
  - b. current oral/dental findings
  - c. financial resources
  - d. both A and B
  - e. all of the above
- 7** Approximately what percentage of Americans over age 65 are affected by Alzheimer’s disease?
  - a. 5%
  - b. 13%
  - c. 20%
  - d. 25%
  - e. 30%
- 8** Warning signs of dementia include:
  - a. increased forgetfulness
  - b. dramatic changes in behavior and personality
  - c. disorientation to time and place
  - d. both A and B
  - e. all of the above
- 9** Oral pathological conditions often associated with the aging patient with dementia include:
  - a. oral cancer
  - b. hypersalivation
  - c. occlusal (pit and fissure) caries
  - d. both A and C
  - d. all of the above
- 10** The focus of oral and dental care for the patient with SDAT shifts primarily towards elimination of sources of pain and infection during which stage of the disease?
  - a. stage one
  - b. early stage two
  - c. late stage two
  - d. stage three

Indicate your answer by circling the correct response and then tear-out or photocopy this form and return to:

NJAGD Wisdom CE Exercise  
1 Dental Plaza, P.O. Box 6020  
North Brunswick NJ 08902  
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# The Intra-Orally Assembled Implant Verification Jig



John DiPonziano,  
DDS, MAGD, FICOI

The usual method for checking the accuracy of a master cast for a multi-unit implant prosthesis is with the use of a “verification jig.” This laboratory-fabricated device is made from acrylic and is constructed on the master cast that contains the implant replicas. The typical verification jig is delivered to the dentist as a one-piece unit that is screwed onto the implant fixtures in the mouth and checked for a passive fit. A passive fit is defined as no space between the interface of the jig and the implant fixtures — therefore “verifying” that the master cast is correct.

A major drawback to this design is that any fixture that is subgingival is not visible when the jig is screwed on. This gingival obstruction prevents the practitioner from truly evaluating the fit of the jig on all of the fixtures. Even gently screwing down the jig — one implant at a time — does not ensure that the clinician will be able to evaluate a passive fit due to the inherent flexibility of the acrylic.

A better alternative is to have the jig fabricated as individual units that are each screwed onto their respective fixtures in the mouth (Figure 1). These individual units are then luted together with either auto-cured methyl methacrylate (Duralay or GC Pattern Resin), or light cured urethane methacrylate (Triad gel), and the whole assembly is removed as one unit from the mouth (Figure 2).

There are two significant advantages to this technique: One is that the intra-orally assembled jig is transferred to the master cast to check for the passive fit. This allows an unobstructed view of each interface between the jig and the implant replica (Figure 3 and 4). The second advantage is that since the jig is an accurate representation of each fixture position relative to each other in the mouth, the master cast can be corrected by altering the position of the ill-fitting implant replicas. This alteration of the master cast is only possible if two or more interfaces between the jig and the implants fit totally passively. This allows the inaccurately positioned replicas in the master cast to be cut out of the cast and repositioned using the jig attached to the passively fitting replicas as a guide (Figures 5 through 10). [If the jig does not fit passively on at least two fixtures, a new impression must be made and a new master cast constructed.]

The intra-orally assembled verification jig helps ensure the construction of an accurate implant master cast. This enables the laboratory to produce a prosthesis with greater precision and consequently leads to less time-consuming chair-side appointments for the dentist (Figure 11).



Fig. 1: Individual jig units screwed down to implant fixtures.



Fig. 2: Jig units luted together with resin.



Fig. 3: One-piece jig checked on the master cast.



Fig. 4: Close up showing position 5 and 6 are not a passive fit.



Fig. 5: Cutting out ill-fitting replica from master cast with round bur.



Fig. 6: Master cast with all ill-fitting replicas removed.



Fig. 7: 1, 5 and 6 positions removed from master cast and placed on jig.



Fig. 8: Master cast with gingival simulation material placed back on cast.



Fig. 9: Corrected master cast.



Fig. 10: Used to backfill areas where ill-fitting replicas were replaced.



Fig. 11: Final hader bar.



Shirley Feuerstein

# Leveraging Your Value

**O**ccasionally we have the privilege of evaluating that very rare practice that has successfully mastered the combination of both delivering extremely high-quality dentistry and also receiving the well-deserved high compensation for such services rendered. Many practitioners offer exceptional services, but few have figured out how to convince patients to have the services performed or how to get fairly compensated for such services when they are delivered. Those practitioners that know the secret are astounding in their ability to produce exceptional financial results on a relatively limited patient base. Some time ago we had such a rare privilege.

The practice had merely 1900 active patients (all fee-for-service) and was producing \$1,200,000 annually. Just in case you thought this was a misprint, I will state this once again. This practice produces an average \$1.2 million dollars each year working with just 1900 active patients! That is an average of over \$630 annual production per patient per year!

We were brought in to evaluate this practice because this 46-year-old dentist was interested in an associate. He was ready to share his secrets and become a mentor. The thought was that he would cultivate his “heir apparent” while also teaching a younger doctor how to achieve such fantastic results. Seems like a logical plan... read on!

During the course of our consultation, we discovered that this would not be the first associate that had been in this practice. In fact, it would be the third. The first was a recent graduate and just could not get accustomed to the fast paced operations of the practice. He left after only 3 months. The second had been out of school a couple of years and had already developed some speed and practical experience. This associate was a great addition to the practice. Unfortunately, the Host and the associate did not have a formal succession plan in place and the associate abruptly left to establish his own practice not far away after 3 years with the Host. He did hurt the practice some and became a competitor, but unlike many Hosts that experience such a loss, this Host quickly recovered. Further consultation revealed that the Host was indeed interested in being a mentor. He also wanted an associate to create another passive income source (hygiene is also a passive income source). We investigated the possibility of selling his practice under the Pre-Sale

Program (seller remains as the associate for the buyer for as long as he desires) but he was really not ready to relinquish ownership yet. He said he wanted another associate, but this time with a formal contract. He would even consider provisions for a long-term transition of practice ownership. We proceeded with our analysis and transition plan formulation on this basis.

Our analysis revealed that this practice was simply outstanding. In hundreds of practice valuations since 1988, we had only encountered a small handful of practices quite like this one. The practice produced at a per-patient rate that was 50% greater than the per-patient production goal that other practices were just trying to achieve... not actual production but the production goal! The fees were on the high side (as they should have been for the area) and the procedure mix was tilted in favor of high-dollar procedures. Even the hygiene department was quite efficient with more than 60% of the total active patients in active recall (more patients could have been in the recall program but frankly this doctor did not have the time or desire to check more hygiene patients). As you might expect, the experienced staff was phenomenally trained and quite competent. It was obvious that this doctor had an extraordinary talent and should indeed be a mentor for some lucky dentist... but should this extraordinary doctor be limiting his mentorship ability only to young dentists?

Now our story takes a rather sharp turn! We presented our practice analysis and showed Dr. A (we will call him Dr. A from now on) the best plan to bring in his next young associate. The plan made perfect sense and he was ready to proceed. But then we threw him a curve. We consulted him on the concept of **leveraging his value... not the value of his practice but rather leveraging his value as an extraordinary practitioner!**

We explained that the majority of other practitioners did not have his unique insight and extraordinary talent to lift a practice to such lofty financial heights. We were able to get him to realize that his talent was distinctive and quite valuable to his colleagues.

We further explained that there were a number of practitioners in his area that were interested in getting out from under the responsibility of practice management and ownership — some are good at it and some are not — some enjoy it and some don't! Such practice owners desire to sell their practices utilizing the Pre-Sale Program and remain with the practice as a full-time associate for

the purchaser for many years. Sellers such as these had reached a point in their life where managing a practice was a stressful burden and they simply wanted the opportunity to treat patients and go home without concerns or worries.

Gross income per patient in the \$200 to \$250 range is quite standard in the majority of dental practices. The owner/practitioners of such practices just do not possess either the special ability or the energy required to take a practice to such high levels as Dr. A has already accomplished. Acquiring and merging one of these practices into his own practice is simply the most profitable move that a doctor of Dr. A's caliber could ever make!

Take a typical scenario. The practice has 2,200 active patients and grosses \$475,000 per year. That is an average of \$215 per active patient (remember Dr. A averages \$630 per patient). This practice is just 3 miles from Dr. A's office. The practice's fees are in the same ballpark as Dr. A's fees. The hygiene department is well developed with about 30% of the total practice collections from hygiene. The seller has a great reputation in the area and is the type individual that anyone would be proud to work with. The only glaring difference in the two practices is that the seller is either not presenting and/or not having optimum treatment accepted by his patients. He does some large cases but only on a small percentage of his vast patient base. The seller sincerely wants to learn how to improve his practice production and has even attended various practice management seminars through the years. But, like many dentists, each time he returns from such a self-help seminar he simply slips back into his usual routine with little or no improvement in his practice production. The seller is 52 years old.

Dr. A can purchase this practice for \$330,000 and the entire transaction will be financed — no out of pocket costs to Dr. A whatsoever. The seller would like to continue working full-time for a minimum of 8 years and plans to continue to treat 100% of the patients he is currently treating. The acquisition and merger of this practice into Dr. A's location is projected to result in a net positive cash flow to Dr. A of more than \$65,000 per year after all practice expenses (including any additional staff requirements), after all annual production commissions to the seller and after all annual debt service payments on the acquisition loan. This increased cash flow of \$65,000 also assumes absolutely no improvement in the production capabilities of the acquired practice.

Now the true magic starts. Remember that Dr. A is a very talented dentist and is also looking for an associate that he can

teach. Dr. A's value is being able to increase the production of a practice. The seller desires to learn to be more productive and recognizes that his personal income (commissions as Dr. A's associate) can substantially increase if he can just learn to produce at a mere fraction of the pace of Dr. A's production per patient.

So let's look at the possibilities. Let's say that Dr. A is able to teach the seller to improve his average production from the \$215 he currently does to \$400 per patient (still some \$239 per patient less than Dr. A is currently producing). That is an annual production increase of \$405,000 (\$475,000 to \$880,000). You can clearly see the financial boost the seller will experience (almost doubles his personal income), but what is Dr. A's gain?

If the seller receives a 40% commission (a standard in the Pre-Sale Program) and Dr. A's production related expenses average about 18% of production (typical production expense ratio in most practices), Dr. A will profit by 42% of the increase in the seller's total production. This equates to an additional \$170,100 over and above the \$65,000 net cash flow Dr. A achieves by simply acquiring and merging the practice. In summary, Dr. A will have his associate; will be the mentor he wants to be; and will significantly leverage his personal value into an additional annual take home cash flow of \$235,100 as a result of acquiring and improving the seller's practice. Nearly \$1 million dollars more income each year and Dr. A does not treat a single one of the seller's patients!

So which associate is really best for Dr. A... a young associate who brings enthusiasm and a desire to learn OR a seller who brings enthusiasm and a desire to learn PLUS an additional 2,200 active patients into Dr. A's practice? There is time to bring the "heir apparent" in later on in your career. Don't use your unique talents to create potential competitors... leverage your value to increase your personal net worth and practice value.

It may be time for you to investigate which "associate" is best for you and how you can leverage your value into new financial heights that you never dreamed existed!

### About the author

Shirley Feuerstein, a transition consultant for PARAGON, INC., has vast experience with practice sales, mergers, presales, progressive ownership programs, partnerships and practice valuations. Ms. Feuerstein has over 30 years experience in the dental profession and understands the goals of dentists and can provide information about the transition process. She can be reached at her office (908) 222-0199 or cell (908) 868-9330 or email [shirley@paragon.us.com](mailto:shirley@paragon.us.com).

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# Reward Your Patients, Enhance Care, And Increase Your Profits?



Gary D. Serota



William Dennis

**C**ertainly, optimal patient care includes supporting healthy behaviors. Patients have come to welcome (and often require) all forms of encouragement. With this support, they often become engaged in their own care, loyal to you, and even willing to refer family and friends — knowing their recommendation will be appreciated. Everyone understands this, yet few practices fully implement an effective level of support to generate real success with their internal service and marketing efforts.

Rewarding patients in a meaningful way sounds expensive. Is it really possible to affordably reward your patients, enhance their oral health, and increase your referrals and profits?

Loyalty and rewards experts say “yes” ... a 5% increase in retention can substantially increase patients and revenues. Assuming a 10% annual new patient acquisition rate and all other things being equal, a practice retaining 95% of its patients annually will double its size in 14 years, while a practice with 90% retention produces no net growth over the same period — and most dental practices lose 20% or more of their active patients each year. A 10% difference in retention doubles the first practice’s size in just *seven* years.

So investing in your current patients results in better oral health and higher quality patient relationships. Communicating with current patients is so much less expensive than new patient acquisition advertising, no practice can afford to ignore this critical internal channel. This is especially true in New Jersey, where the “culture” values style and appearance and patients have particularly high expectations for professional services like dental care. Yet, times are challenging for dentists and patients alike — from heating oil to gasoline, hotels to restaurants, we pay more for everything, and no one wants to cut back.

Is there a way to reward your patients to say “thank you,” improve their oral health, save them money on the things they really want, and drive more profit to your practice’s bottom line? Yes — invest in a rewards program that energizes your patients’ commitment to your practice... here’s how:

**Set clear, simple objectives:** motivate current patients to be more valuable, rewarding them for adhering to treatment plans, keeping hygiene appointments, returning after a long absence, recommending friends, or just having healthy check-ups; systemize your rewards process to make it fast, easy and automatic; create a patient experience designed to drive quality referrals.

**Avoid the most common mistakes:** don’t discount your fees (this says your services aren’t worth your standard rate, and promoting free or discounted services to new patients can anger your current loyal base); don’t offer more dental care as rewards

(free services undermine your value again, and experience proves what people really want is travel, entertainment and quality goods and services); don’t try it yourself (use professional programs to ensure your office can concentrate on delivering great dental care); communicate frequently and consistently about rewards and how patients earn them; pick a flat rate program that covers the cost of rewards and “points” (otherwise this can get very expensive).

**Include these essential features:** provide automatic rewards (just for being your valued patient), *plus* earned rewards for valuable dental behaviors (keeping scheduled appointments, electing a cosmetic procedure, etc.); deliver instant use of rewards (don’t make patients wait or collect thousands of points before patients can redeem for something valuable); position rewards as a sincere thanks for making your practice possible (everyone likes to be appreciated, and appreciation without tangible value can ring hollow); offer it free (don’t try to cover costs by charging patients for their own rewards — recapture your investment from increased revenues as patients spread the word, come in more frequently, and utilize more of your services); communicate consistently (announcing more rewards every month in a positive, personalized message builds your “brand” and creates a genuine relationship, a far cry from the “benign neglect” of two postcards and two reminder calls per year).

It is now possible to reward patients with an affordable and turnkey loyalty program that enhances patient health and drives more revenue to your practice. Internal marketing featuring patient rewards can be the best use of at least part of your marketing budget, and the best investment you can make in the success and growth of your practice. Yes, you can reward your patients, enhance care, and increase your profits!

## About the author

*Gary Serota is a co-founder of Loyal Patients, Inc.™ (LPI) in Reston, Virginia, provider of Loyal Patient™ Rewards, a unique patient loyalty program completely customized for dentistry and featuring a patent-pending technology. He has spent over 20 years providing unique benefits and rewards programs for small businesses, Fortune 500 clients, and large national associations.*

*Bill Dennis is President of Coaching Solutions, a premier New Jersey based practice management team of professionals who customize solutions to your practice concerns. The faculty includes Dentists, MBAs, Hygienists, Educators, Consultants, Coaches and CPAs all working together to support change exclusively in dental practices. Coaching Solutions is partnering with LPI to introduce the Loyal Patient™ Rewards program to dentists and their patients in New Jersey and other states. Bill Dennis can be reached at 856-786-4814 or via email at bill@coaching-solution.com*



Nathan G.  
Browning

# Why Estate Planning Will Always Be Important

Since Congress passed the Economic Growth and Tax Relief Reconciliation Act of 2001, the federal estate tax has been highly confusing to most people. While that law provided tax relief, it also increased uncertainty over how estates will be taxed in the future.

For example, the law mandated changes in key provisions of the federal estate tax during every year from 2002 through 2009. Then, it provided for a total repeal of the estate tax for one year only, in 2010. Under “sunset” provisions of the 2001 law, virtually all estate tax changes are to be unwound after 2010.

Of course, since 2001 the pressure has intensified on Congress to make further changes that will clarify the long-term future of the estate tax. President George W. Bush has argued for totally repealing the federal estate tax, while other leaders say the tax should touch only mega-wealthy American families.

As these issues are being debated and resolved, it’s important to keep a basic idea in mind: Whatever happens to the federal estate tax, estate planning will always be important and valuable. This article explains the advantages that this planning process can help individuals and families achieve, without regard to estate tax complexity.

## The Limits of a Will

Some people think a will is enough to ensure that their wishes and goals will be honored after they are gone. Writing a will often can be an important part of estate planning, but it is only one step. An “estate” is created at the moment of death as a vehicle for settling affairs of the deceased. After the death of a will’s maker or testator, the document is entered into probate court where its contents become public. So, the first shortcoming of relying on a will is the loss of privacy.

Since assets passing through probate also can be vulnerable to delays, challenges and court costs, wills may not always be the best way to provide for heirs. For example, a common mistake made in writing wills is to specify how assets are to be distributed, but not to give clear instructions for paying the deceased’s debts and estate costs, including any state inheritance taxes due. Even if the will specifies assets to be used in paying debts and costs, it is not always possible for the estate to access cash right away. In some cases, assets of the deceased are frozen and not released by the probate court for some time.

A key goal of sound estate planning is to carry out the deceased’s wishes and pay off obligations through the most effective means possible. Several ways are available to avoid the public disclosures of probate, including passing assets through life insurance, annuities and retirement plans. Trusts can be valuable in providing both privacy and continuing management and distribution of assets.

## Possible Estate Planning Goals

A checklist of common estate planning goals is below. In this case all goals relating to federal estate taxes have been deleted, even though planning for this tax can be a high priority as long as the tax exists.

- ❑ Making sure your surviving spouse has enough money to live comfortably.
- ❑ Protecting a surviving spouse and other heirs from the demands of managing money or operating a business.
- ❑ Making sure that all debts and obligations are paid with funds that are readily available to the estate.
- ❑ Specifying assets to be given to a favorite charity, with optimum income tax benefits.
- ❑ Making sure that any retirement plans left to heirs receive favorable income tax consequences.
- ❑ Disposing of your real estate, collectibles or business property in the most effective manner.
- ❑ Making plans for a “special-needs” child or grandchild; or earmarking funds to be used for the benefit of grandchildren who may one day need money for college, whether they are alive or not yet born.
- ❑ Arranging for a partner or key employee to buy out your business interest, by paying “cash on the barrel” to your heirs.
- ❑ Making gifts to family members or charities during your lifetime in an efficient way.
- ❑ Making sure that a particular financial goal — such as helping children purchase their first home — is completed, whether you live or not.

Are any of these goals among your priorities? If so, it could be wise to take estate planning seriously, even if Congress continues to make changes in the federal estate tax.

In many cases, your estate planning goals can be met through a variety of tools including a professionally prepared will, one or more trusts, lifetime gifts and life insurance. A good time to begin the estate planning process is near the onset of retirement. Qualified professionals can help you integrate your need for income and financial security in retirement with planning designed to meet your estate goals. This often results in the most important benefit of all — increased confidence and quality-of-life for the rest of your life.

## About the Author

*Nathan G. Browning is a Registered Representative and offers securities products and services offered through Park Avenue Securities LLC (PAS), 7 Hanover Square, New York, NY 10004. PAS is a member NASD, SIPC. Material discussed is meant for general illustration and/or informational purposes only and it is not to be construed as tax, legal or investment advice. Although the information has been gathered from sources believed reliable, please note that individual situations can vary, therefore the information should be relied upon when coordinated with individual professional advisor. For questions on this and other financial planning matters, Nathan G. Browning can be contacted at 866-807-8727.*



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# Images in Clinical Practice

*submitted by: Evan Spivack, DDS, FAGD*

## Case presentation

A 26-year-old Caucasian female presented to the New Jersey Dental School-UMDNJ for routine examination and comprehensive care. The patient denied systemic disease, reported taking no chronic medications, and reported no food or drug allergies. Intraoral examination was unremarkable except for a fluctuant, domed lesion in the anterior floor of the mouth. On questioning, the patient reported that this lesion was recurrent and non-painful, although it was "annoying" to her tongue.



## Discussion

This lesion is a ranula. Similar lesions occurring elsewhere (most often on the lower lip) are referred to as mucoceles. Other sites for mucocele formation are the tongue, gingival and buccal mucosa. The name "ranula" derives from the Latin term for frog, as the lesion is said to resemble the amphibian's belly. Ranulas have an incidence of 0.2 cases per 1,000 individuals, whereas mucoceles overall demonstrate an incidence of 2.4 per 1,000. There is no sex- or race-based predilection; however, most mucoceles and ranulas occur in children and young adults.

Ranulas often result from escaped mucous from an injured excretory duct; less commonly, obstruction of the sublingual or submandibular gland may lead to ranula formation. Some case reports have suggested Sjogren syndrome, sarcoidosis and HIV as increasing the risk of ranula development.

Although generally painless, the lesion may enlarge sufficiently to cause difficulty with speech, mastication, respiration and swallowing due to displacement of the tongue.

Ranulas are usually treated with a surgical approach. Marsupialization of the ranula with packing of the pseudocyst is often effective. If the lesion recurs, however, complete excision of the ranula and the involved salivary gland is indicated. Laser ablation and cryosurgery have demonstrated some success, and the use of sclerosing agents is in the experimental stage.

## References:

- Zhao Y, Jia Y, Chen X, et al, Clinical review of 580 ranulas. *Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, & Endodontics.* 98(3):281-287, September 2004.
- McEwen D, Sanchez MM, A Guide to Salivary Gland Disorders. *AORN Journal.* 65(3):554-567, March 1997.

*Do you have any cases of clinical interest that you would like to share with your colleagues? If so, please e-mail the editor, including the image and related clinical information, at spivacev@umdnj.edu*

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Course 8:30 am - 4:30 pm  
For information or  
to register,  
visit the website at  
[www.NJAGD.org](http://www.NJAGD.org)

## AIM Mastership Program

### “Implant Prosthetics & Restoration”



Speaker:  
**Dr. John  
DiPonziano**

Dates: May 16-18, 2008  
(Friday-Sunday)

May 16-17:  
8:30 am - 4:30 pm  
May 18:  
8:30 am - 12:30 pm

Location:  
Jefferson Dental Center,  
Mt. Holly, NJ

CE credit: 52 hours

Visit our website  
[www.NJAGD.org](http://www.NJAGD.org)

| January   | February  | March  | April   | May   | June   |
|---|---|--|---|---|--|
| <p><b>7</b> NJAGD Membership and Board Meeting</p> <hr/> <p><b>25</b> Dr. Donald DeFonce Memorial Lecture</p> <p>Speaker:<br/>Dr. Mark Murphy<br/>"Seven Habits of Highly Effective Dental Teams"</p> | <p><b>2</b> Wisdom Deadline for Spring 2008 Issue</p> | <p><b>7-8</b> Participation Co-Sponsored by NJAGD and the Perio Institute</p> <p>Speaker:<br/>Dr. Steven Cooper<br/>"Perio Surgery Hands On Workshop"</p> <hr/> <p><b>11</b> NJAGD Membership and Board Meeting</p> <hr/> <p><b>12</b> Lecture &amp; Participation</p> <p>Speaker:<br/>Dr. John Burgess<br/>"Restorative Dentistry Update 2008: Improving Your Impression-Making &amp; Provisional Skills"</p> | <p><b>6</b> Wisdom Deadline for Summer 2008 Issue</p> <hr/> <p><b>30</b> NJAGD Membership and Board Meeting</p> | <p><b>15</b> AIM Mastership Program Presentations</p> <p>Moderator:<br/>Dr. John DiPonziano</p> <hr/> <p><b>16-18</b> AIM Mastership Program</p> <p>Speaker:<br/>Dr. John DiPonziano<br/>"Implant Prosthetics &amp; Restoration"</p> <hr/> <p><b>21</b> NJAGD Annual Meeting and Course</p> <p>Lecture &amp; Participation</p> <p>Speaker:<br/>Dr. Dennis Brave<br/>"Real World Endo"</p> | <p><b>4-5</b> NJDA Annual Convention Atlantic City, NJ</p> |

## NJAGD highlights

### AIM Mastership Program "Surgical Implant Placement"

Speaker: Dr. Ira Schecter  
October 12-14, 2007



Join NJAGD for the  
**Dr. Dennis Brave –  
 Real World Endo Course**  
 and 1st Annual General NJAGD  
 Meeting 12:00pm-1:00pm  
 Wednesday, 5/21/08  
 8am Reg, 8:30-4:30

# 2007 NJAGD New Members

| Name                        | City            | Name                                 | City               |
|-----------------------------|-----------------|--------------------------------------|--------------------|
| Helen Ro, DDS               | Haddonfield     | Tuan N. Do, DDS                      | Parsippany         |
| Chad Lazar, DMD             | Mount Laurel    | Danish Qadri                         | Fort Lee           |
| Robert Pitel, DMD           | Swedesboro      | Eric D. Veenstra                     | Haledon            |
| John Jk Choi, DMD           | Edison          | Rana A. Loutfy, DDS                  | Lyndhurst          |
| Jonathan W. Parker, DMD     | Fair Lawn       | John J. Archible, III, DMD           | Bloomfield         |
| Gabriel Ruiz, DMD           | East Brunswick  | Michel F. Massaro, DMD               | Englishtown        |
| Rui S. Seu, DDS             | Roselle Park    | Robert F. Tanne, DMD                 | Atlantic Highlands |
| Sujithra Rajagopalan, DDS   | Edison          | Ali N. Weiselberg, DDS               | Fort Lee           |
| Heather L. Paparone, DMD    | Ventnor City    | Andrew I. Kleiman, DMD               | Clark              |
| Charanpreet Singh, DMD      | Middlesex       | Louis M. Scibelli, DMD               | Whitehouse Station |
| Susie S. Lee, DDS           | Old Bridge      | Andrea C. Sun, DDS                   | Jersey City        |
| Dorothy E. Drain, DDS       | Sicklerville    | Colynda Vu, DMD                      | Mount Laurel       |
| Trisha Charland, DMD        | Jersey City     | Lauren M. Salch, DMD                 | Secaucus           |
| Anthony F. Cannilla, DMD    | Denville        | Nicholas S. St George, DDS           | Jersey City        |
| Deolinda Reverendo, DMD     | Morrisville     | Jocelyn Jeffries, DDS                | Long Branch        |
| Alena Nawrocki, DDS         | Somerset        | Gagandeep S. Riar, DDS               | North Brunswick    |
| Frances J. Glenn, DDS       | Nutley          | Sophia Park, DDS                     | Syosset            |
| Lisa Lynch, DDS             | Midland Park    | Ewa Zoltek, DMD                      | Little Falls       |
| Jeffrey T. Mohn, DDS        | Rochelle Park   | Elizabeth F. Dougherty,<br>DMD, FAGD | Denville           |
| Marc J. Pukenas, DMD        | Ventnor City    | Nirali H. Trivedi, DDS               | Manville           |
| Aarthi C. Fernandez, DDS    | Ridgefield Park | Bindu Sachdeva, DDS                  | Edison             |
| Greg B. Scheier, DDS        | West Orange     | Jennifer C. Kim, DMD                 | Fort Lee           |
| Musa Macapodi, DDS          | Jamesburg       | Elmo R. Randolph, DMD                | Orange             |
| Anna Pawlowska, DDS         | Edison          | Jeffrey M. Finkelstein, DMD          | Livingston         |
| Daniel J. Grasso, DMD, FAGD | Brick           | Noah A. Agard, DDS                   | West Orange        |
| Eunjung Shim, DMD           | Maywood         | Doris E. Collins, DMD                | Brick              |
| William J. DeMarco, DMD     | Tuckerton       | George Athansios, DMD                | Cedar Grove        |
| Erica Brunton, DMD          | Lincoln Park    | Carol E. Bolanos, DMD                | Sewell             |
| Payam Hanian, DMD           | Princeton       | Amitkumar Patel, DDS                 | Marlboro           |
| Ira Adler, DDS, FAGD        | Marlton         | Hsin-chieh Tu, DDS                   | Jersey City        |
| David R. Ray, DMD           | Woodbury        | Ari Frohlich, DMD                    | Teaneck            |
| Joseph S. Jacob, DMD        | Sayreville      | Dayna L. Zoller, DDS                 | Livingston         |
| Haleh Kossari, DMD          | Franklin Lakes  | Michael E. Felber, DDS               | Oradell            |
| Stacey M. Bock, DMD         | Jersey City     | Mary K. Caron, DMD                   | Beachwood          |
| Hameed R. Farrokhrooz, DDS  | Clarksville     | Joseph G. Muscatiello, DMD           | Milltown           |
| Boris Alvarez, DDS          | Verona          |                                      |                    |

# 2007 NJAGD Retired Members



|                              |             |
|------------------------------|-------------|
| Kenneth I. Delman, DMD, FAGD | Asbury Park |
| Allyn N. Holtzin, DDS, FAGD  | Marlton     |
| Niles H. Spier, DDS, FAGD    | Toms River  |
| Joseph S. Trovato, DDS       | Kearny      |



# REGISTRATION FORM



**ONE FORM PER PERSON**  
PLEASE DO NOT ALTER FORM

PLEASE DUPLICATE IF NECESSARY

Please check one:  DDS  DMD  RDA  RDH  Office Staff

Name (please print): \_\_\_\_\_

Primary Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

AGD#: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Payment Information** (A form of payment must accompany the pre-registration form in order to be processed)

Check (payable to NJAGD)  MasterCard  Visa  AMEX TOTAL AMOUNT: \$ \_\_\_\_\_

Credit Card No.: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**Course Fees**

Please check box

- Day/Date: Wednesday, September 19, 2007 / Lecture A  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Marvin Simring  
Course Title: "Occlusal Management"
- Day/Date: Thursday, October 11, 2007 / AIM #9  
Fee: **Fee already paid in April 2007**  
Speaker: Dr. Douglas Damm  
Course Title: AIM Mastership Program (Critique from April 2007)
- Day/Date: Friday—Sunday, October 12—14, 2007 / AIM #10  
Fee: **Mbr. \$1,250.00 (2 ½ days) Non-Mbr. \$1,600.00 Light \$850.00**  
Speaker: Dr. Ira Schechter  
Course Title: AIM Mastership Program "Basic Implant Surgery Workshop"
- Day/Date: Wednesday, October 24, 2007 / Lecture B  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Edward Swift  
Course Title: "Untangling the Confusion of Today's Restorative Materials"
- Day/Date: Friday, November 2, 2007 / Lecture C  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Jim Kohner  
Course Title: "Connective Tissue Grafting Hands On Workshop"
- Day/Date: Friday, January 25, 2008 / Lecture D  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Mark Murphy (DeFonce Lecture)  
Course Title: "Seven Habits of Highly Effective Dental Teams"
- Day/Date: Friday—Saturday / March 7—8, 2008 / Lecture E  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Steven Cooper  
Course Title: "Perio Surgery Hands On Workshop"

Please check box

- Day/Date: Wednesday, March 12, 2008 / Lecture F  
Fee: **PARTICIPATION & LECTURE Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00  
LECTURE ONLY Mbr. \$110.00 Non-Mbr. \$125.00 Guest \$99.00**  
Speaker: Dr. John Burgess  
Course Title: "Restorative Dentistry Update 2008:  
Improving Your Impression-Making Skills & Provisionals"
- Day/Date: Thursday, May 15, 2008 / AIM #10  
Fee: **Fee already paid in October 2007**  
Speaker: Dr. John DiPonziano  
Course Title: AIM Mastership Program
- Day/Date: Friday—Sunday, May 16—18, 2008 / AIM #11  
Fee: **Mbr. \$1,050.00 (2 ½ days) Non-Mbr. \$1,400.00 Light \$475.00**  
Speaker: Dr. John DiPonziano  
Course Title: AIM Mastership Program "Implant Prosthetics & Restoration"
- Day/Date: Wednesday, May 21, 2008 / Lecture G  
Fee: **PARTICIPATION & LECTURE Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00  
LECTURE ONLY Mbr. \$110.00 Non-Mbr. \$125.00 Guest \$99.00**  
Speaker: Dr. Dennis Brave  
Course Title: "Real World Endo"
- Day/Date: Friday, September 19, 2008 / Lecture A  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Dennis Thompson  
Course Title: "Bone Grafting & GTR Hands On Workshop"
- Day/Date: Wednesday, October 15, 2008 / Lecture B  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Joseph Massad  
Course Title: "Advances in Complete Removable Prosthodontics  
Including Enhancements in Implant Dentistry"
- Day/Date: Friday, January 16, 2009 / Lecture D  
Fee: **Mbr. \$195.00 Non-Mbr. \$225.00 Guest \$99.00**  
Speaker: Dr. Robert Fazio (DeFonce Lecture)  
Course Title: "Pharmacology"

Please mail or fax to:

NJAGD  
One Dental Plaza, PO Box 6020, North Brunswick, New Jersey 08902-6020  
Fax: (732) 821-1082

**INCOMPLETE REGISTRATION FORMS WILL NOT BE PROCESSED**  
**CONFIRMATIONS WILL BE MAILED PRIOR TO THE LECTURE**

**Cancellation Policy: All requests for refunds must be in writing. Requests post-marked or faxed after 30 days prior to the course date will not be honored. Please allow up to six (6) weeks after the conclusion of the course for refund processing.**



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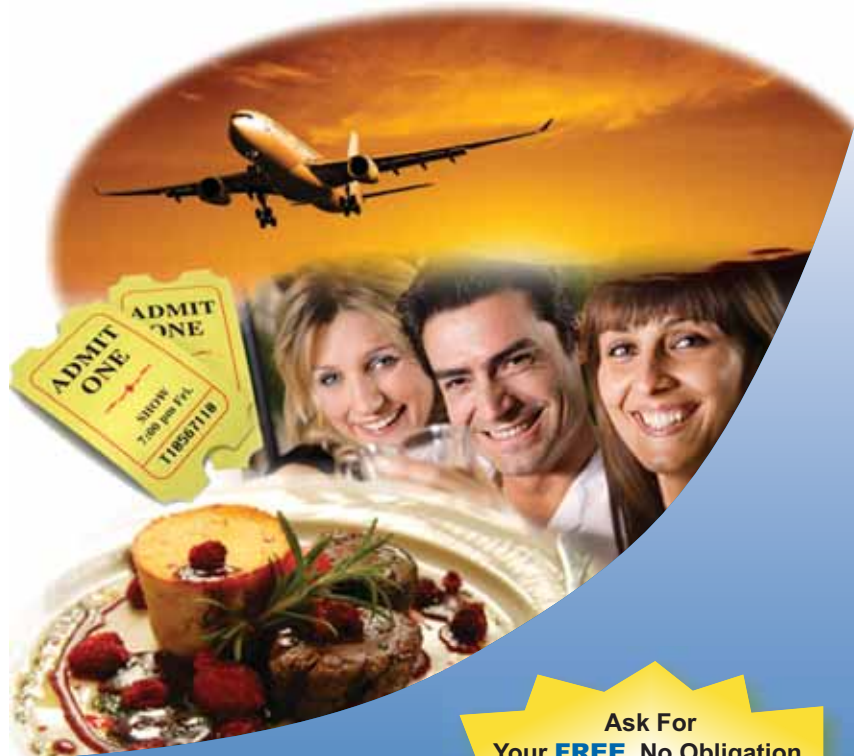
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