



Winter 2009 • Volume 6 • Number 4

wisdom

**Conservative Treatment of
the Anterior Worn
Dentition with Adhesive
Composite Resin**

**Nonendodontic
Periapical Pathology**

**What's New
with OSHA**

AIM 14 Critique with Dr. Hillel Ephros - Thur, April 29, 2010
AIM 15 with Dr. Stephen Poss - Fri, April 30; Sat, May 1; Sun, May 2, 2010
AIM 15 Critique with Dr. Stephen Poss - Thurs, October 14, 2010
Locations to be determined.
See inside for details and registration information.

wisdom

Winter 2009 • Volume 6 • Number 4

NJAGD Officers

Jeffrey C. Linfante, DMD, FAGD – President

Haniel C. Rosemond, DDS, MAGD – President-Elect
Public Information Officer

Navin Boggavarapu, DDS, MAGD – Immediate Past President

Mark D. Robinson, DMD, FAGD – 1st Vice President
Asst. Editor, Dental Care Comm. Chair

Evan G. Wasserman, DMD, FAGD – Secretary

Michael Conte, DMD, FAGD – Treasurer
Membership Chair (Student Initiatives)

Manuel A. Cordero, DDS, MAGD – National Trustee, Region 4

Evan Spivack, DDS, FAGD – Editor

Joseph A. Sandberg, DMD, MAGD – Group Benefits Program Chair

Scott M. Dubowsky, DMD, FAGD – Legislative Chair

Shari L. Hyder, DMD, MAGD – Membership Chair, Parliamentarian

Joseph A. Battaglia, DMD, FAGD – Constitution & Bylaws Comm. Chair

Mark P. Cohen, DDS, MAGD – Program Provider Approval Rep

Elizabeth A. Clemente, DDS, FAGD – MasterTrack Program Coordinator

Luciano A. Ghisalberti, DMD, MAGD – Chair of CE

Bruce W. Small, DMD, MAGD – At-large Board Member

George C. McLaughlin, DMD, FAGD – At-large Board Member

Jerry Rosenberg, DMD, FAGD – Board Member

Gerald S. Gildenberg, DDS, MAGD – Board Member

Tomas J. Ballesteros, DMD – Board Member

Brett Druger, DMD – Board Member

Melvin K. Pierson, DDS, FAGD – Webmaster



Felicia Conte – Executive Staff Person

How to Contact us

NJAGD WISDOM

One Dental Plaza, North Brunswick, NJ 08902

Tel: 856-217-1580 or 866-GO-NJAGD Fax: 732-821-1082

In this issue

- 3 President's Message**
- 4 In My Opinion**
- 5 Trustee's Corner**
- 6 Notes from the Regional Director**
- 7 Advocacy on the Statewide Level: the NJDPAC**
Charles Perle, DMD, FAGD
- 8 Conservative Treatment of the Anterior Worn Dentition with Adhesive Composite Resin**
Howard E. Strassler, DMD, FAGM, FAGD
- 10 Nonendodontic Periapical Pathology**
Hillel Ephros, DMD, MD
- 12 Growth Strategies for your Dental Practice: The Impact of "Give Kids a Smile" Program**
Debra Goldsmith, RDH, MS
- 13 What Have You Done for Me Lately? The AGD is Fighting for YOU!**
Joseph Battaglia
- 14 What's New with OSHA**
Alfred L. Frost, MS, DDS
- 16 Is it Time for an Associate?**
Shirley Feuerstein
- 17 News from National: Red Flag Rule Enforcement Delayed Until June 1, 2010**
- 18 Balancing our Lives with Dentistry**
Bill Dennis
- 20 One Dentist's Mid-Life Madness**
Jerry Rosenberg, DMD, FAGD

Wisdom is published by the New Jersey Academy of General Dentistry. The opinions expressed in *Wisdom* do not necessarily represent the opinions of the NJAGD and are not endorsed by the AGD. Advertisements in *Wisdom* do not indicate endorsement of any product or service by the NJAGD or AGD unless specially stated. The NJAGD is an AGD Pace Approved Sponsor for FAGD/MAGD credit.

www.NJAGD.org

President's Message



**Jeffrey C. Linfante,
DMD, FAGD
NJAGD President**

With all the debate on health care in the United States, it is sometimes difficult to know who represents the general dentist in this discussion. For most of us, being busy with family and our practice, we often are not in tune with the political conversation in Washington. So, the question becomes, who best represents the general dentist? The Academy of General Dentistry (AGD) is dedicated to serving our interests. One way is through advocacy. Because of the AGD's efforts, we have representation at both the national and state levels. These actions help protect and advance the general dentist's interests and ultimately help us provide the best care for our patients.

How can we participate in the legislative process? By speaking out to our representatives in Congress and the State House on issues that impact our profession. Many times we feel that there is not a good way to be heard, however there are several ways to communicate. We can send letters or emails, or simply pick up the phone and voice our concerns. One of the best ways to learn more about the issues and to be heard is through the AGD web site, which serves as the eyes, ears, and voice of the general dentist. It alerts you when there is an issue that may require AGD membership participation. Through the AGD Web site, (www.agd.org/issuesadvocacy/) you can learn more about advocacy efforts on legislation and regulation (including state dental boards) in Washington, D.C., and in various states.

On this web page, there are a number of useful tools to help members advocate for their profession, their practice, and for the betterment of public dental health care. An example of one issue is providing real, workable solutions to solve the access to oral health care challenge; the AGD has developed and adopted an official policy on access to care. You can find a complete description in the AGD white paper

titled, *Increasing Access to and Utilization of Oral Health Care Services*.

In addition to the information provided, there is the opportunity to communicate with lawmakers, through the use of the legislative Action Center AGD capwiz. Capwiz is designed to help members deliver on-time, on-target, and on-point messages to legislators, regulators, and the media. These messages are specific to an issue of concern, providing members an easy way to get their message out.

Lastly, I would encourage all members to register for the the Action E-List. By doing so, you will receive an alert when your involvement can make a critical difference.

As American citizens, we have the right to voice our opinion and take part in the legislative process. As a member of the dental profession we have the responsibility. Together our voices are strong and can make a difference, enabling us to provide the best care for our patients.

Stay informed and become an advocate.

Dr. Linfante received his B.A. in Biochemistry from Rutgers University - Cook College, in New Brunswick, New Jersey. He then received his D.M.D. from the University of Medicine and Dentistry – New Jersey Dental School (UMDNJ-NJDS) in 1990. After dental school, he completed a one-year General Practice Residency at John F. Kennedy Hospital in Edison, New Jersey. Since 1991, he has maintained a private practice in Spring Lake Heights, New Jersey. Dr. Linfante joined the faculty of UMDNJ-NJDS in 1996 as an Assistant Professor in the Department of General and Hospital Dentistry. Currently, he holds an appointment in the Department of Restorative Dentistry and serves as the Director of Pre-doctoral Admissions and Student Recruitment.

In My Opinion

Meeting Challenges in the Brave New World of 2010



Evan Spivack, DDS, FAGD
NJAGD Editor

When you were fifteen years old, how did your mind's eye picture the year 2010? In all likelihood, your vision was straight out of a science fiction story—moving sidewalks, flying cars, weekend trips to the moon. The social fabric of life in 2010 probably looked quite attractive as well: nations living together in peace, poverty erased, mankind's focus on leisure and the arts instead of daily drudgery.

The reality of 2010 is far different—and in many ways, far more similar to years past—than we ever imagined it. Technology, while it continues to advance by leaps and bounds, often creates as many problems as it solves. Our expectations exceed the pace of growth despite the speed at which new and improved products are brought to market, often leading to frustrations and stresses that were not faced by generations past. On the social front, our world has not done away with crime, violence, hate or oppression. Too many people still live in poverty and teeter on the brink of survival, both domestically and abroad. We have much to be grateful for as this new decade opens, but we must also understand that we have responsibilities to meet as well.

As dentists, we must be cognizant of the changes that have occurred within our profession and of those in society that affect us and the patients we care for. While many of these changes have been for the better, others have been more insidious. Invariably, change presents us with challenges that must be faced if we are to grow and thrive in now and in the decades to come.

For the most part, new technology has been a great boon to our profession. Dentists are able to offer patients restorative choices that look and function better than anything that could be offered just a few years earlier. Composites and ceramics have vastly improved. Dental implants have become ubiquitous. Imaging technologies offer diagnostic capabilities that can be life-saving and can dramatically improve chances for treatment success. All of these gifts of modern-day dentistry, however, are useless unless we have the education and training that allows us to prescribe and use these modalities

appropriately. More than ever, we are challenged to be life-long learners and keep our knowledge and skills current. We are also being challenged by the rapid introduction of materials into the dental market; we must use discretion in selecting the ones that are tested and will be best suited to their purpose.

Thanks to advances in communication and information technology, we can more easily let our patients—and our prospective patients—know what we can offer them. The web and associated technologies, along with traditional media and other advertising venues, have made dentistry familiar and accessible to a wider range of patients than ever before. But while the dental message is being spread, it is not always spread in the right way. The AGD has stepped up to challenge mall-based bleaching operations and to assure that general dentists have the right to display and advertise their credentials. The Academy is also using the web to reach out to patients to inform them about dentistry and answer their questions.

Perhaps the most significant changes related to dental practice have occurred in the governmental realm. With health care reform being fast-tracked through Washington, the greatest of these challenges to dentistry may be on our doorstep. Several states have already approved plans for mid-level providers, a move aggressively opposed by the Academy. The mid-level provider plan will work against the best interests of the patient population we strive to care for; it is the duty of all dentists and dental organizations to fight against it. Similarly, dentistry must stand strong against those who would ban amalgam, thus limiting the rights of dentists to choose appropriate treatments for their patients.

In this all-important field of advocacy on behalf of general dentists and the patients we care for, we must support the AGD in meeting the challenges that the present day brings. From insurance issues to fluoridation to the right to practice our profession as we wish, there are more than enough challenges to face. It is important that each of us, in whatever way we best can, step up to meet them.

Trustee's Corner

A Message from our National Trustee...



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

Each new year presents us with unique challenges. Our most recent bout in the public arena has been with the ADA's approach to the issue of access to care. The AGD's White Paper on this matter has been available to all the organizations concerned with access issues and it has been at the forefront of the Academy's opposition to the mid-level provider model.

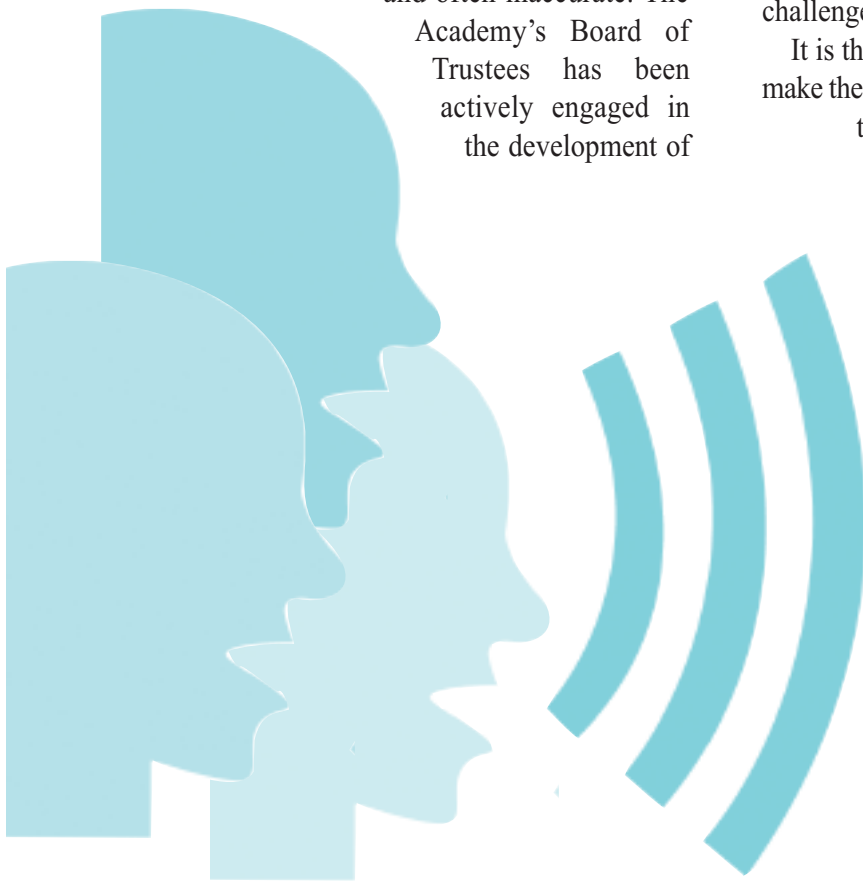
Various groups are working to develop new models for providing dental care to the underserved population. Many of these models presuppose a shortage in the number of dentists available to provide care. While there is no doubt that a segment of the population that needs care faces obstacles in obtaining it, much of the data being presented to support such models is questionable and often inaccurate. The Academy's Board of Trustees has been actively engaged in the development of

an organized and educated fight against the mid-level provider model and other plans that threaten the continued existence of general dentistry as a viable profession.

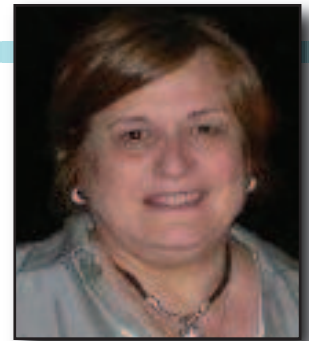
Many dentists are unaware of the potential impact of the mid-level provider plan on their practices and on the patients they care for. They are similarly unaware that the American Dental Association (ADA)—which supposedly represents their interests—is among the groups working towards the development of these critically flawed plans. Yet despite the organizational direction, there are many hard-working and dedicated members in the ADA who are fighting this push. I must commend ADA president Dr. Ron Tankersley for supporting our position in spite of pre-existing systems that challenge issues on which we share common ground.

It is the responsibility of the AGD to educate dentists and make the public aware of the impending crisis. We must stand together as an organization, using the same passion we share for education to educate others about the mid-level provider issue and other areas in which the academy advocates on behalf of us all.

In this new year, we must be ready for new challenges. Let us continue our journey together, providing the best dentistry the world has to offer.



Notes from the Regional Director



**By Elizabeth A. Clemente,
DDS, FAGD
Regional Director, AGD
Region IV (New Jersey)**

The Academy of General Dentistry is an organization that not only exists to serve its members, but takes direction from them as well. Every year, the House of Delegates convenes at the annual session to help set the course for the challenges ahead. Each region, made up of one or more states, sends delegates to the House. As Regional Director (RD), I serve as the liaison between AGD National and our region, New Jersey (Region 4). The RDs are charged with keeping our membership informed about programs and the AGD in Chicago abreast of member concerns. To this end, I would like to discuss what I feel, as a member, is one of the most exciting programs offered in New Jersey. AIM, Advancing Into Mastership, is our Master Track program. We have designed this program to provide members with all the participation credits needed for Mastership in four years. The schedule revolves on a four-year cycle, so members may join at any time during the cycle.

The AIM program allows our participants to broaden their scope of practice with hands-on experience in all areas of general dentistry. Every member is taught to do case presentations, is given lectures on photography and gains experience in the use of PowerPoint to enhance their presentation skills. As a result, several have gone on to lecture themselves. One major advantage of this program that is not advertised or promoted is mentorship and collegiality. Every six months AIM participants come together to share their successes and to seek advice for the treatment of difficult and even failed cases through their presentations. It is through the ensuing discussions and the support and advice of other participants that true enrichment occurs. Many instructors comment that they learn as much as they teach when presenting for AIM. This support extends beyond the lecture and classroom right to the heart of our practices. Many a participant has been known to call a college or the instructor when in the middle of a new or difficult procedure to seek advice. In fact, many, including myself, have done new procedures with another more experienced AIM participant in attendance to assist if needed.

AIM participants are an unusual breed in the world of continuing dental education. They are the ones who still want to stretch their minds and expand their skills. They are present for the full eight hours,



completely engaged while at the same time having fun. So much so that we continue into the evening one of the four days and have dinner together. At the same time, we are a very diverse group with some members close to retirement and others only just a few years into the practice of our wonderful profession.

On this page are a few photos taken at our last AIM session in October, oral surgery presented by Dr. Hillel Ephros, whose article appears elsewhere in this issue. We are practicing injection techniques, extractions, suturing and frenectomies on pig jaws.

Dentists, who have traditionally practiced a “solo” profession, have much to share and an immeasurable amount to gain from the exchange of ideas with each other. I encourage each you to try it. You will find the experience refreshing. The food isn’t too bad either!!

Dr. Elizabeth Clemente is a graduate of the Case Western Reserve University School of Dentistry, and upon graduation completed a GPR in New Jersey. Her professional experiences have included eighteen years of private practice in this state, as well as four years serving as residency program director at the University of Alabama, Birmingham.

Dr. Clemente presently serves as chair of the department of dentistry and is GPR director at Morristown Memorial Hospital. She has been active in the Academy of General Dentistry both on the state and national level, and currently serves as Regional Director for AGD region IV (New Jersey).

Advocacy on the Statewide Level: the NJDPAC

By Charles Perle, DMD, FAGD

Editor's note: Dr. Charles Perle is a long-time, active member of both the Academy of General Dentistry and the American Dental Association, and has been an ardent supporter of the NJDPAC. Elsewhere in this issue the reader will find information on the AGD's new advocacy program, which is active on the national level; we strongly urge all Academy members to support it. The NJDPAC is active on the statewide level, and works in New Jersey on behalf of issues important to dentistry and the patients we serve. We present this article in the spirit of cooperation between our two organizations at a time when dentistry's attention to political issues has become critical.

"If once the people become inattentive to the public affairs, you and I, and Congress and Assemblies, Judges and Governors, shall all become wolves. It seems to be the law of our general nature, in spite of individual exceptions." – Thomas Jefferson

Jefferson's quote is more relevant today than perhaps ever before. Government intrusion is on the rise. The wolves are feasting on the apathy of the electorate and the laziness of business to protect its interests.

In today's world, less than half of eligible voters actually vote. Generally, fewer people are joining professional organizations than at any other time in the preceding decade. And, as a result Jefferson's poignant commentary is ringing true. So, what does this have to do with dentistry?

Dentistry is experiencing more government intervention than ever before. Mounting fees, menacing mandates, exorbitant taxes, and insipid labor laws that were nonexistent ten years ago are now pervasive throughout dentistry. Largely, these business-related issues are making it more difficult to practice the way in which we choose. However, dentists are faring much better than virtually every other healthcare profession because of our professional organization, our unity and our vocal political action.

Organizations like the NJAGD, the NJDA and others work together to ensure that our profession's voice is strong with our political decision-makers. On the statewide level, our most powerful advocacy tool is the New Jersey Dental Political Action Committee (NJDPAC).

Political Action Committees, like NJDPAC, very simply raise funds from individuals and contribute in meaningful ways to political candidates who support its goals and objectives. Sadly, fewer than twenty percent of NJAGD members contributed to the NJDPAC in 2009. Imagine how loud dentistry's voice could be if 25 percent, 50 percent or 75 percent of NJAGD members gave just \$150 to NJDPAC.

In these tough economic times, it is easy to find reasons not to contribute. But, based on Jefferson's notion of government and the American people and today's political reality, it is precisely the wrong financial decision for your practice and your profession.

Benjamin Franklin's immortalized quip, "We must all hang together, or assuredly we shall all hang separately" may have never had more relevance to healthcare than it does today. "Health Care Reform" is winding its way through Washington. The AMA, which is in disarray, has lost control of the issue and lost the voice of its members. Conversely, organized dentistry remains focused, unified and committed to the profession. As a result, dentistry is faring better than medicine in the national healthcare debate.

Organized dentistry and its political action are always there for you. The question is, are you there for them? There is a better than 80 percent chance you haven't.

Think of your contribution to NJDPAC as an investment in protecting your profession, your practice and your family's long-term financial security against the whims of government. In this regard, NJDPAC stands on the point of that spear.

Only you can maintain NJDPAC's strong and forceful voice among the political decision makers.

NJDPAC is the state's largest healthcare PAC largely because those few dentists who do contribute understand its critical importance and give significantly. They understand that contributing to politicians who are interested in listening to what

organized dentistry has to say helps us present our agenda and relay our positions on a variety of issues. NJDPAC gives us an opportunity to build first-name relationships with key decision-makers.

Now, you might say that 'I am a democrat and I don't want to give to republicans' or vice versa. Well, the reality is both parties wax and wane in power of the political process in this state. NJDPAC's job is to insulate as best it can from the changing of the political tide. Fortunately,

NJDPAC's position is clear. It doesn't support one part or the other; it supports a profession, our profession. Are you supporting it?

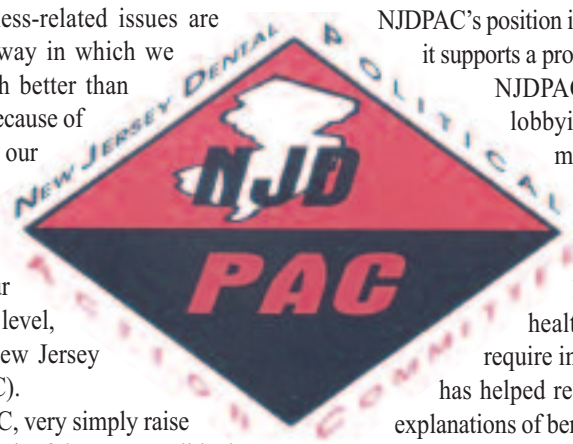
NJDPAC, coupled with an aggressive grassroots lobbying strategy, routinely delivers dentistry's message. A message that has helped stopped the infringement in the use of amalgam.

It has helped stop forced charity care by dentists as a condition of re-licensure. It

has helped stop professional services taxes on healthcare, including dentistry. It has helped require insurers to disclose their dental consultants. It

has helped require that non-participating dentists receive explanations of benefits from insurers. It has helped improve the PIP climate for dentistry. Whatever the issue, NJDPAC's mission is clear 'ensure that dentistry's voice is heard.' But, it can't exist without your financial support.

Only you can maintain NJDPAC's strong and forceful voice among the political decision makers. Contribute today and help yourself and help your profession. Simply fill out the NJDPAC form and fax it back. Want to learn more? Call Jim Schulz, Executive Director of NJDPAC at (732) 821-9400 or email him at jschulz@njda.org.



Conservative Treatment of the Anterior Worn Dentition with Adhesive Composite Resin



Howard E. Strassler,
DMD, FADM, FAGD

As our patients are getting older and keeping their teeth longer, the wear of the incisal edges of anterior teeth has become more pervasive. Some have viewed tooth attrition as reaching epidemic proportions. In most cases attrition of the mandibular incisors is seen as loss of the enamel incisal edge leaving the dentin exposed. This is readily visible by the patient especially when the dentin picks up stain. In the case of the maxillary incisors the wear may not be readily apparent to the patient because it is on the lingual surfaces of the teeth but may be evident due to chipping of the incisal edges and an increase in incisal translucency where the underlying enamel has worn thin.

Tooth attrition has been classified by Pinborg as either physiologic (the gradual and regular loss of tooth structure as a result of natural mastication), pathologic (wear confined to a single tooth or groups of teeth caused by abnormal function or position of teeth), or intensified attrition (wear that is more extensive than would normally be expected).¹ One study reported that of 520 older adults, 84.2% had enamel attrition, 72.9% dentin attrition and 4.2% had severe attrition.²

In most clinical cases, tooth wear is not a single cause-and-effect condition. The wear may be caused by a combination of factors including attrition, abrasion, and erosion.³ The conditions of tooth wear can be classified based upon fundamental wear mechanisms.⁴ These mechanisms are surface-to-surface wear, slurry wear (early stage), and corrosive wear (erosion). Surface-to-surface wear for teeth can be either enamel-to-enamel in contact movements with subsequent microfractures of the enamel structure, or the harder substance, enamel, plowing up the opposing softer dentin substrate. This mechanism of enamel wear is usually due to tooth grinding or bruxism. Slurry wear can be characterized as an abrasive slurry between two moving tooth surfaces that is also referred to as “three-body wear” because there are three surfaces in function—the tooth structure on either side and the food substrate. Corrosive wear, also referred to as erosion, is a non-microbial acid induced tooth loss. Clinically, the diagnosis



Figure 1



Figure 2



Figure 3

of these conditions can be made by the appearance of the tooth surfaces in different occlusal positions. Surface-to-surface wear can be seen where the teeth interdigitate. Where slurry wear has occurred, the teeth do not fit together in all aspects of the tooth loss. This concept has been frequently referred to as erosion.⁵ The cupping of dentin on incisal edges and the flattening of posterior cusp tips with the exposing dentin, the Class VI lesion, can be attributed to this type of wear. Corrosive wear from acids can be caused by ingesting acidic foods and beverages or by stomach acid attacking the teeth as a result of bulimia or stomach acid

reflux. In actuality, the diagnosis of tooth wear is multifactorial in most cases.

How does one treat the anterior worn dentition when dentin is exposed and is continuing to wear and the amount of enamel loss just barely exposes dentin? In some cases the patient notices and asks about the discoloration of the incisal edges of their mandibular teeth due to exposed dentin; other times, the patient notices a bluish translucency at the incisal edges on the facial surfaces of the maxillary incisors caused by the worn dentin on the lingual surfaces of these teeth leaving only enamel that is translucent. In some cases the incisal edges can be restored to the existing vertical dimension with direct composite resin.^{6,7} This article will describe a conservative treatment of the worn anterior dentition using direct bonded, wear resistant composite resin.

CASE REPORT: MANDIBULAR INCISAL WEAR

A 53 year-old man presented to the dental school clinic requesting treatment for all his dental needs. As part of the treatment review, the patient asked if anything could be done for his lower front teeth that were chipping and discolored on the incisal edges due to exposed dentin (Figure 1). It was noted during the examination that the maxillary incisors and canines had some wear but did not require any intervention at that time since the enamel was still intact. After restorative treatment the plan was to provide the patient with a hard acrylic occlusal nightguard to control the patient's parafunctional habit of bruxing. The diagnosis of anterior tooth wear through the enamel into the dentin with a cupped out appearance indicative of a combined surface-to-surface and slurry tooth wear pattern was made. The restorative treatment plan for these teeth was the placement of direct bonded composite resin to restore the worn incisal edges and cusp tips of teeth #22-27. In the past, the use of composite resin to restore worn anterior teeth was not successful because the practitioner did minor tooth preparation (a bevel) on the facial and lingual surfaces to retain the restoration and an adhesive composite resin was placed in a thickness of only tenths of a millimeter. Within a short period of time, the restoration would be dislodged in function.⁷ Success with these restorations depends on a fundamental approach to tooth preparation to guarantee durability of the restoration.⁶

In most cases the teeth to be restored do not need to be anesthetized. The exposed dentin is sclerotic and has little if any sensation. Use of the dental dam for tooth isolation allows the teeth to be prepared and restored with greater efficiency and with a controlled field for the adhesive procedure. Because of the tooth wear, the proximal contacts are usually broader and there is little if any incisal embrasure. It may be necessary to recreate the incisal embrasures using a narrow diameter needle-shaped finishing bur (ET3 fine, Brasseler USA, Savannah, GA). If this is not done at the start, it will be difficult to place the rubber dam.

TOOTH PREPARATION

Before preparing into the dentin, the enamel surface was finished and polished using an abrasive disk system (Soflex, 3M-ESPE, Minneapolis, MN) from medium grit to fine. A final polish of the enamel was accomplished using an intraoral rubber abrasive enamel-ceramic polishing point (Dialite,



Figure 4



Figure 5



Figure 6



Figure 7

Brasseler USA, Savannah, GA). The finishing and polishing of the enamel surface removes any irregularities of the enamel and loose enamel rods that can fracture after the completion of the restoration.

Using a small pear-shaped 330 bur, a preparation was made into the dentin to a depth of 1.0 mm (Figure 2). For smaller lesions, a 329 bur can be used because it has a length of 1.0 mm which is the preparation depth desired. A periodontal probe can also be used to verify the pulpal depth of 1.0 mm of the tooth preparation of all enamel walls (Figure 3). Past clinical experiences and clinical evaluations over the last ten years has shown that this depth into the dentin allows for adequate composite resin thickness to provide longevity to the restoration in function. The preparation removes only dentin leaving a shell of enamel.

RESTORATION PLACEMENT

After tooth preparation, the teeth were etched for fifteen seconds with a 32% phosphoric acid etchant (Uni-Etch, Bisco, Schaumburg, IL) (Figure 4) and then rinsed with an air-water spray for ten seconds. The tooth was lightly dried, leaving a moist dentin surface. A single component, fifth generation adhesive (SeptoBond, Septodont, Lancaster, PA) was applied to the tooth preparation with a disposable brush (BendaBrush, Centrix, Shelton, CT) (Figure 5). In this author's experience, self-etch adhesives can be used successfully for these types of preparations. The adhesive was gently air dried, keeping the air syringe four to six inches from the surface of the tooth so that the adhesive was not thinned before light curing. The adhesive was light-cured for twenty seconds. A dimer acid chemistry low-shrink, wear-resistant nanohybrid composite resin (N'Durance, Septodont, Lancaster, PA) was placed into the incisal preparations. The composite resin was shaped to the tooth surfaces using a plastic filling instrument so that there was little excess that needs to be finished (Figure 6). The composite resin was then light-cured for twenty seconds for each tooth.

FINISHING AND POLISHING

The composite resin placement as described leaves very little excess. In most cases, use of an abrasive-backed disk is not necessary. The finishing can be accomplished using a coarse grit thin disk (XT pop-on disk, 3M, St. Paul, MN) or aluminum oxide impregnated silicone disk (Enhance, Dentsply/Caulk, Milford, DE) (Figure 7). The final polish was done using a super-fine Soflex disk (3M, St. Paul, MN). The rubber dam was removed and all occlusal movements were checked using a very thin, two-sided occlusal film (AccuFilm II, Parkell, Farmingdale, NY). It should be noted that the



Figure 8



Figure 9A



Figure 9B

composite resin restores function in areas that the wear had removed needed function. In this case note the facial surfaces of the mandibular right and left canines have been restored to function in lateral excursions to protect the dentition with canine disclusion. A hard, acrylic, maxillary occlusal nightguard was fabricated to protect the dentition from parafunctional wear. The restored incisal edges have not only made the teeth more wear resistant but also have created a more esthetic result (Figure 8). For this patient, the maxillary anterior teeth were restored using the same technique (Figure 9).

CONCLUSION

In the past, practitioners would watch and reevaluate worn incisal edges of anterior teeth as they continued to wear. Intervention would occur when the crown height was significantly reduced and the only choice to restore these teeth was full coverage porcelain-metal crowns. With the conservative technique described, a wear-resistant composite resin to maintain the occlusion on these anterior tooth surfaces can be placed to defer the need for more extensive crown and bridge procedures in the future.

Howard E. Strassler, DMD, FADM, FAGD, is professor and director of operative dentistry at the University of Maryland Dental School in the Departments of Endodontics, Prosthodontics, and Operative Dentistry. He has lectured nationally and internationally on techniques and a selection of dental materials in clinical use and aesthetic restorative dentistry. He is a fellow in the Academy of Dental Materials and the Academy of General Dentistry, a member of the American Dental Association, the Academy of Operative Dentistry, and the International Association of Dental Research. He is on the editorial board of numerous publications. He is a consultant and clinical evaluator to more than 15 dental manufacturers. Dr. Strassler has a general practice in Baltimore, Maryland, that is limited to restorative dentistry and aesthetics.

REFERENCES

- 1 Pindborg JJ. Pathology of the Dental Hard Tissues. Philadelphia. W.B. Saunders Co. pp. 294-300, 1970.
- 2 Hand JS, Beck JD, Turner KA. The prevalence of occlusal attrition and considerations for treatment in a noninstitutionalized older populations. *Special Care in Dentistry*, 7:202-206, 1987.
- 3 Schneider PE, Peterson J. Oral habits: considerations in management. *Pediatric Clinic North Am* 29:523-546, 1982.
- 4 Kaidonis JA, Richards LC, Townsend GC. Abrasion: an evolutionary and clinical view. *Aust Prosthodont J*. 6:9-16, 1992.
- 5 Xhonga FA, Wolcott RB, Sognnages RF. Dental erosion. II. Clinical measurements of dental erosion progress. *J Am Dent Assoc* 84:577-582, 1972.
- 6 Strassler HE, Kihn PW, Yoon R. Conservative treatment of the worn dentition with adhesive composite resin. *Contemp Esthet Restor Pract* 1(4):42-52, 1999
- 7 Christensen G. A new technique for restoration of worn anterior teeth- 1995. *J Am Dent Assoc* 126:1543-1545, 1995.

LEGEND FOR FIGURES:

- Figure 1 Preoperative view of worn mandibular anterior teeth
 Figure 2 The teeth were prepared to a pulpal depth of 1.0 mm as evidenced by the cutting length of the #330 bur.
 Figure 3 Verifying the depth of the preparation at 1.0 mm with a periodontal probe.
 Figure 4 The preparations were etched with a 32% phosphoric acid gel for 15 seconds.
 Figure 5 A 5th generation adhesive was applied to the etched tooth preparations.
 Figure 6 Care was taken to shape the low shrink nanohybrid composite resin with a plastic filling instrument to minimize excess.
 Figure 7 Initial finishing was done with an Enhance polishing disk.
 Figure 8 The completed restorations are both functional and esthetic.
 Figure 9
 A Preoperative view of maxillary wear
 B Teeth restored with N'Durance nanohybrid composite resin.

Nonendodontic Periapical Pathology

The routine use of dental radiography extends the diagnostic abilities of the dentist beyond the visible oral cavity. Radiographic evaluation has long been a routine element of oral diagnosis and is critical in determining the integrity of teeth, bones and their attachment. An important area of focus is the periapical region where radiographic changes reflect a spectrum of conditions, some of which may be present without producing symptoms. Most of the radiographic abnormalities in this area are produced by loss of mineralized material around the apex and are seen as areas of relative radiolucency. These lesions are typically consequences of pulpal disease and the history and clinical findings are generally consistent with the radiographic picture. The discussion that follows focuses on other entities that may produce radiographic changes in the periapical region. While less common than pulpoperiapical lesions, they may be far more destructive and must be considered, particularly when the history and clinical findings are inconsistent with the radiographic picture.

PULPOPERIAPICAL RADIOLUCENCIES

There is considerable variability among the radiographic appearances produced by pulpal disease. Definitive diagnosis requires microscopic examination of tissue, however, some associations have been noted. Periapical granulomas (PAG) are the most common pulpoperiapical lesions and are generally well-circumscribed, rounded radiolucencies under 2.5 cm in diameter, often with hyperostotic borders. Radicular cysts, the majority of which are related to the lateral incisors, cannot be differentiated from PAG by radiographic characteristics alone, but size over 1.5 cm increases the likelihood that an area of periapical radiolucency is a radicular cyst.¹ Dentoalveolar abscesses may produce similar radiographic changes but the history and physical findings are more significant diagnostic elements. Long-term, stable radiolucencies may remain after treatment/resolution of pulpoperiapical lesions, and are reflective of incomplete bony fill and are often referred to as periapical scars.

NONENDODONTIC PERIAPICAL PATHOLOGY

Little has been written about the prevalence of nonendodontic processes in the periapical region. A number of case reports have been published, but only one retrospective study was found in a recent review of the literature.² The authors looked at records of more than 4,000 specimens submitted to their oral pathology service over a period of thirty years. These submissions, representing 13% of the total volume of the lab, were logged in with a clinical diagnosis of pulpal necrosis. Upon microscopic examination, 0.65% of these were signed out with a different histopathologic diagnosis unrelated to pulpoperiapical disease.

These diagnoses included cysts and tumors including lesions known to be destructive and for which aggressive treatment has been recommended.^{2,3} In the absence of conflicting data, and with no way to establish a definitive diagnosis for lesions that are discarded or left in situ, it seems reasonable to accept Ortega's numbers as an estimate of the extent of this problem and to assume that between one half and one percent of periapical lesions may be nonendodontic. This raises the question of just how far clinicians should go toward the ideal, i.e., submitting for histopathologic evaluation every shred of tissue removed from their patients. Impractical and unnecessary as it may seem, failure to do so could result in missed diagnoses and, in some settings, may be

a regulatory issue. Any discussion of how clinicians evaluate and manage potentially pathologic tissues should begin with the concept of differential diagnosis.

DIFFERENTIAL DIAGNOSIS

The process differential diagnosis is the key to developing an appropriate diagnostic and therapeutic plan. Database acquisition always begins with a good history and continues with a thorough clinical examination. Radiography and other modalities such as vitality testing help to drive us further down the right paths of the diagnostic algorithm. In the diagnosis of peripaical pathology, radiographic coverage must extend well beyond the visible lesion and should include a panoramic film to screen for changes outside the field of coverage provided by plain dental radiographs. (fig 1) Vitality testing helps to exclude pulpal disease and may alert the clinician to periapical processes that require more extensive evaluation. In fact, any inconsistency among the history, clinical findings and radiographic appearance should be viewed as a red flag. After building a database using the available, pertinent tools, the differential diagnosis is honed by thinking categorically and by organizing possibilities in order of likelihood. It may be helpful to conceive of this in stages:

1. Which types/groups of pathologic entities fit the history and physical findings?

Beyond the patient's complaints, consider age, gender and race as well as maxilla vs. mandible and other contextual factors.

2. Looking at the radiograph using a "low power" type of approach, what is evident?

Note the shape, size, location and radiographic nature of the lesion (purely lucent, mixed, opaque) as well as the presence or absence of any other lesions.

3. Switch to a "higher power" view of the radiographs; what details may be of significance?

Look at the periphery of the lesion and focus on relationships between the lesion and other structures including the bone around it, tooth roots, canals and foramina.

The product of this process should be a list, sometimes very short, often a bit longer, of reasonable possibilities in order of their likelihood. If the list includes one or more entities that are destructive and require aggressive treatment, or are manifestations of a systemic process, or for any other reason demand a histopathologic diagnosis, a specimen must be generated and submitted for microscopic examination. In other cases, many dentists use clinical judgment and abide by applicable regulations and empirically select a treatment plan. At the very least, such an approach mandates an appropriate period of post-treatment observation.

LESIONS THAT MAY MIMIC PULPOPERIAPICAL PATHOLOGY

A number of case reports as well as Ortega's study suggest that nonendodontic periapical lesions may fall into several categories: anatomical variants, cysts and cyst-like lesions, benign neoplasms, malignancies (primary or metastatic to the jaws) and osteomyelitis. Some examples are presented below.^{1,2,4-10}

Anatomic variants occasionally produce radiographic images that suggest the presence of pathology. A few of these may occur at the



Hillel Ephros,
DMD, MD

apices of teeth including anterior lingual bone cavities, mental foramina, nutrient canals, marrow spaces, nasal fossae, maxillary sinuses and the incisive foramen. Misdiagnosis and inappropriate treatment are less likely after engaging in the differential diagnosis process described above. Imaging the area in question using more than one technique and/or angulation may be helpful to rule in or out an anatomic variant.

Cysts and cyst-like lesions are not uncommon in the jaws and may intrude upon the periapical region(s) of one or more teeth. In this group is the idiopathic bone cavity (IBC), formerly known as the traumatic bone cyst. The new nomenclature is reflective of the lesion's lack of a cystic lining and its questionable and highly variable association with trauma.



Figure 1

IBC is typically discovered as an incidental radiographic finding in patients under 25 years of age. The body of the mandible is the most common site with the radiolucency usually noted above the inferior alveolar canal in association with vital teeth whose roots remain intact with a normal lamina dura. A presumptive diagnosis is made when the lesion is opened for biopsy after vitality testing and negative needle aspiration. The absence of either a solid tumor mass or a fluid-filled epithelial sac strongly suggests IBC. Curettage of the bony wall should produce a specimen that will be consistent with IBC. For IBC, biopsy is not only a diagnostic procedure but is often therapeutic as well with good bone fill demonstrated over time on follow-up radiographs.^{1,3}

Benign tumors are an eclectic group of lesions with a wide range of behaviors. On the aggressive end of the spectrum are ameloblastoma, odontogenic myxoma and calcifying, epithelial odontogenic tumor (Pindborg). Far less troubling lesions include the adenomatoid odontogenic tumor (AOT) and the ameloblastic fibroma.

The panoramic radiograph in figure 2 illustrates the danger of making assumptions about radiolucencies in the periapical region. The innocuous-looking lesion adjacent to the root of the endodontically treated premolar is an odontogenic myxoma.

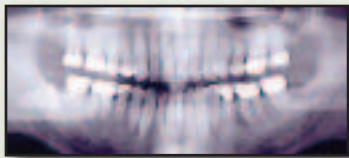


Figure 2

Myxomas are not as common, nor quite as aggressive as ameloblastomas, but they are

destructive and are generally treated by resection with a margin of unaffected bone. These are mesenchymal lesions seen most commonly in individuals under the age of 50 with females affected slightly more than males and with the mandible involved more often than the maxilla. Due to painless growth, diagnosis of a myxoma is often delayed until it is found incidentally on a radiograph or the patient develops signs or symptoms such as facial asymmetry, tooth mobility or, rarely, sensory deficit.^{1,3}

The central giant cell lesion (CGCL) is similar to the aneurysmal bone cyst (ABC) which is not a true cyst. It is identical to the giant cell tumors found elsewhere in the skeleton which are the most common



Figure 3

neoplasms of long bones. CGCL of the jaws is more likely to occur in individuals under 30 years of age, has a greater affinity for females, and preferentially affects the mandible,

often involving the parasymphiseal region and crossing the midline. If found early, or if imaging is inadequate, the CGCL may mimic pulpoperiapical disease. More often, its painless and relatively rapid growth results in its detection in more advanced stages when it may appear as a multilocular radiolucency with marked thinning of cortical bone, scalloped borders and resorption of involved tooth roots. These lesions may be related to hyperparathyroidism and this should be ruled out as part of the diagnostic work-up. Curettage is commonly employed but the recurrence rate is high. Intralesional steroid injections have also been used in the management of CGCL.^{1,3}

MALIGNANCY

Cases of primary malignancy of bone involving the periapical area have been reported, but such situations are rare. However, the jaws are targets for metastatic lesions from a number of internal malignancies. In fact, in up to 30% of these cases, the jaw lesion is the first sign of the disease. The mandible is affected more often with the molar region the preferred site of involvement. Symptoms may develop rapidly and may include pain, sensory deficit and swelling. In women, the breast, female genital organs and adrenals are the most likely sites of the primary tumor, while among men, lung and prostate cancers are most often responsible. Kidney, colon, thyroid, liver and bone are potential primary sites of jaw metastases for both genders.¹¹ In addition to metastatic lesions from remote primary cancers, the jaws may be involved in hematologic malignancies such as multiple myeloma and lymphoma.^{1,3}

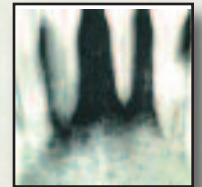


Figure 4

SUMMARY

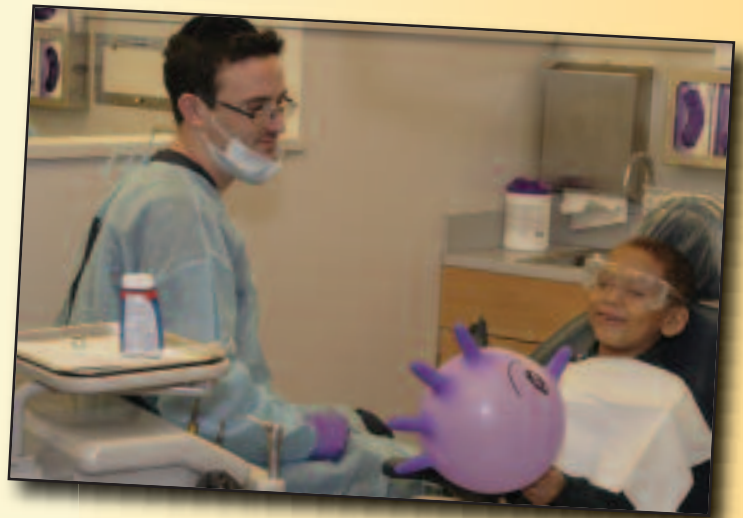
When faced with a radiographic abnormality near the apex of a tooth, we must not allow ourselves to assume that the image is a reflection of pulpal necrosis. With adequate imaging well beyond the lesion and a thorough history and clinical examination, the clinician should be able to develop a differential diagnosis. For most periapical radiolucencies, this is a straightforward process. In some cases, particularly those in which the history, the clinical exam and the image are not congruent, the differential diagnosis must include other entities, some of which have the potential to cause harm. In these situations, it is incumbent upon the clinician to pursue a diagnosis and ensure that the patient receives appropriate treatment. Even if the patient is referred to one or more specialists, it is the general dentist who is that patient's advocate. Ultimately, the generalist must be satisfied that everything possible has been done to provide his/her patient with the correct diagnosis and adequate treatment.

REFERENCES

- Wood NK and Goaz PW. Differential Diagnosis of Oral and Maxillofacial Lesions, Mosby, St. Louis, 1997.
- Ortega A et al. Nonodontogenic periapical lesions: a retrospective study in Chile. *Int Endod J* 40:386-90, 2007.
- Marx RE and Stern D. Oral and Maxillofacial Pathology, Quintessence, Chicago, 2003.
- Favia G et al. Central (intraosseous) adenoid cystic carcinoma of the mandible: report of a case with periapical involvement. *Journal of Endodontics* 26:760-3, 2000.
- Morse DR, Bhamhani SM. A dentist's dilemma: nonsurgical endodontic therapy or periapical surgery for teeth with apparent pulpal pathosis and an associated periapical lesion. *Oral Surg Oral Med Oral Pathol* 70:333-40, 1990.
- Philipsen HP et al. Adenomatoid odontogenic tumor mimicking a periapical (radicular) cyst: a case report. *Oral Surg Oral Med Oral Pathol* 94:246-8, 2002.
- Weine FS, Silverglade LB. Residual cysts masquerading as periapical lesions: three case reports. *JADA* 106:833-6, 1983.
- Ribera MJ. Osteoblastoma in the anterior maxilla mimicking periapical pathosis or odontogenic origin. *Journal of Endodontics* 22:142-4, 1996.
- Nixdorf DR et al. Clinical presentation and differential diagnosis of nasolabial cyst. *L Can Dent Assoc* 69:146-9, 2003.
- Filho HN et al. Periapical radiolucency mimicking an odontogenic cyst. *Int Endo J* 37:337-44, 2004.
- Hirschberg A et al. Metastatic tumors to the jawbones: analysis of 390 cases. *J Oral Pathol Med* 23:337-41, 1994.

Growth Strategies for your Dental Practice: The Impact of “Give Kids a Smile” Program

Debra Goldsmith, RDH, MS
Asst. Prof., Dept. of Community Health,
UMDNJ-New Jersey Dental School



There is no doubt that the challenging economic climate for small business is difficult, and dental practices are no exception! How do you stay above water when the economy is wreaking havoc on your patients? How do you address growth strategies in a market that isn't growing? One strategy that is working is volunteer, community-based marketing. It is a strategy that we don't hear enough about, yet it is used by many professionals in one capacity or another. At UMDNJ-New Jersey Dental School (NJDS) the students, faculty and community volunteers have demonstrated how one of their volunteer programs can impact on growing dental practices. This program has addressed a growing need while providing dental care to kids whose families can't afford to pay for it.

The “Give Kids a Smile” program (GKAS) is the largest nationally recognized volunteer program of its kind, providing dental services to thousands of underserved children. The GKAS program is designed to assist qualified children twelve years and under with dental care and preventive education. It is a community-based program supported by dental faculty, students and community volunteers. In 2008, GKAS provided dental assistance to over 5000 underserved children in over 2000 communities nationwide.



ADA, American Dental Association®

Since the inception of the 'Give Kids a Smile' program in 2003, our dental school has provided volunteer dental health care and education to thousands of underserved and uninsured children throughout the State of New Jersey. The total number of children treated has more than doubled since 2003. This year NJDS, through the efforts of over 400 volunteers, provided dental services for over 1,000 children. The volunteers included dental hygiene students, pediatric residents, dental students, faculty, staff, and volunteer dentists. The increase in children participating in this one-day event is due in part to the excellent marketing campaign provided by the New Jersey Dental Association. This marketing effort creates public awareness for access to dental care, and provides advertising for each dental site involved.

We are encouraging all of you to consider participating in GKAS day on February 5, during Dental Health month. There is no better way to promote yourself and your business than by showing the community that you care about them.

While helping kids is enough of a reason to participate in the GKAS program, there is an ancillary benefit to dental practices. Community-based programs such as GKAS allow your dental practice to reap the benefit of passive marketing to the community without infringing on your patients' sensitivity to the financial challenges they are facing. Studies have found that most people appreciate and are more apt to do business with organizations that volunteer their time and services to children in need.

If your dental practice gets involved in the program, not only will you be providing a great service for children and families in your community, but you stand the chance of building more credibility for you and your dental practice. It is a soft approach to marketing, yet can have the same or better impact on reaching your customer base. People prefer to do business with professionals who give back to their communities, and the GKAS program is a great vehicle for doing that.

Another advantage of community-based volunteer programs is that they allow participants, particularly dental students, a broad range of experiences not typically encountered in the normal dental academic settings. These programs increase community awareness, empathy for patients, communication skills with diverse groups of patients, and provide wide exposure to unusual dental cases.

It is interesting to note that for some children GKAS was their first dental visit. Without our assistance, these children may have never seen a dentist until it was too late to treat what may have been a very minor problem. Several parents of the children we treated commented on how they had recently lost their job, and how much they appreciated our dental school helping their child. Many of our own students remarked how rewarding it was for them to participate in such an important program. Most said they felt it was their professional responsibility, and that they would likely continue the program after graduation.

One of our faculty members treated 50 children in a private Clifton, NJ, office on GKAS day. Three dental hygienists and four dental assistants from that office volunteered their time. Since that day, four families whose children participated in the program have joined the office as new patients. It was a win-win for the kids, their families and the practice.

For more information on GKAS as well as other ways to volunteer your services, please contact Eric Elmore at (732) 821-9400-or e-mail him at eelmore@njda.org. Eric can answer your questions and provide specifics on how to organize a successful volunteer program.

Debra Goldsmith, Assistant Professor in the Dept. of Community Health, New Jersey Dental School-UMDNJ, is licensed in dental hygiene, and later received her MS in Health Science from UMDNJ. Her responsibilities include both lecturing and clinical teaching to freshman and sophomore dental students in diverse areas including prophylaxis, caries risk assessment, chemotherapeutic intervention, patient management, tobacco cessation counseling, nutritional counseling and mouth guards. Ms. Goldsmith also serves as course director for preventive dentistry for junior and senior predoctoral students, is director of the dental school's outreach programs and is responsible for establishing community partnerships and new community events.

WHAT HAVE YOU DONE FOR ME LATELY?

The AGD is Fighting for YOU!

“What have you done for me lately?” An interesting question, and one posed over and over by dentists throughout the United States. Quietly, the Academy of General Dentistry is becoming the recognized voice of the general dentist. While maintaining its well-established credibility founded in a commitment to continuing dental education and life-long learning to better serve and protect the public its members serve, the AGD now occupies a unique position in dentistry. The Academy is the only professional dental organization committed to protecting the interests of general dentists and their patients when advocating to state dental boards, state and federal legislators, the American Dental Association and the myriad of health organizations comprising the varied communities of interest within the medical and dental professions.

The AGD provides comment on legislation and regulations state by state and communicates issues of interest to state AGD legislative chairpersons and presidents for these leaders to decide if the constituent membership needs to be alerted to a given issue(s) and/or take action. Additionally, the AGD is represented by a Washington, D.C. lobbying firm, which serves as the AGD’s voice in the nation’s capital. Check the website at www.agd.org/issuesadvocacy/hotissues/activity for further information.

So: What’s been done for you lately? Here is only a sample of how the AGD advocates on your behalf:

Supporting access to care through the dental team concept

Together, the dental profession must address access to care in a way that best utilizes the proven concept of the traditional dental team and the clinical judgment and diagnosis of a licensed dentist. The AGD is deeply concerned with the issue of access to care and recognizes what is necessary to solve it. The establishment of an unlicensed, nondentist dental practitioner to provide irreversible dental procedures puts patients at risk, fragments the profession and diverts funds from the appropriate solutions to access to care. The solutions to access to care that are identified in the AGD’s *White Paper on Increasing Access to and Utilization of Oral Health Care Services* should not only serve as the blueprint for dental health care initiatives within the health care legislation now being considered on the federal level but also to address each state’s and community’s unique access to care issue.

The AGD will continue to oppose the implementation of an independent or unsupervised nondentist dental practitioners in the states. For a copy of the “White Paper”, contact the AGD Government Relations Department at advocacy@agd.org or 888.AGD.DENT (888.243.3368), ext. 4307.

Analyzing your dental benefits participation contracts

Do you understand the terms of your HMO or PPO contract? Does the contract require you to refund claims payments to the insurer? Who decides if the services you render to your patients are necessary—you or the insurance company? Understanding dental benefits contracts *before you sign them* is critical to timely and secure reimbursements.

While the ultimate decision to sign a contract is yours, the AGD can supply you with the services of a licensed, on-staff attorney who can review your contract and explain its terms to you. Best of all, the AGD’s contract analysis service is free to AGD members. (The same service is available to nonmembers for a reasonable fee.)

If you have a contract that you would like to discuss with an AGD expert, please contact the AGD’s Director of Dental Practice Advocacy at benefitsadvocate@agd.org. You may also visit *The Fine Print*, the AGD’s dental benefits self-help center, by logging on to the AGD Web site (www.agd.org) and clicking on the “Practice Management” tab.

Challenging corporate restrictions to the practice of dentistry

In 2009, more than 1,500 members used AGD Action Alerts to voice their concerns to Align Technology on the Invisalign® proficiency requirements. In addition to AGD Action Alerts, the AGD responded by engaging in substantial negotiations with Align Technology, notifying the American Association of Dental Boards (AADB), and investigating noncompliance with the law as well as with the PACE guidelines; these investigations are ongoing. While the AGD is pleased that Align Technology has instituted a six-month grace period on its requirements, the underlying concerns remain. The AGD understands the importance of this matter to the practice of dentistry and will continue in its efforts to advocate on your behalf in this matter and on other corporate restrictions against the practice of dentistry. See www.agd.org/issuesadvocacy/hotissues/invisalign.

Defining educational objectives for dental implant therapy

General dentists with sufficient education and experience have safely practiced dental implant therapy for decades. However, debate surfaced in 2008 regarding the adequacy of education provided in this field. In 2009, the AGD responded with the *Educational Objectives for the Provision of Dental Implant Therapy by Dentists*. The AGD will continue to assure the availability of continuing education for general dentists to attain the appropriate education and training to provide dental implant therapy.

Advocating for general dentistry on the Code on Dental Procedures and Nomenclature

Contact the AGD’s Code Subcommittee if you have comments on or requests to change the Code on Dental Procedures and Nomenclature (the “Code”). The AGD will review each submission carefully. E-mail benefitsadvocate@agd.org for more information.

Now—what you can do to advocate on behalf of general dentistry:

- Recruit your colleagues to become members in the AGD
- Contribute to the AGD Advocacy Fund (www.agd.org/membership/renewal)
- Respond to AGD Action Alerts and Capwiz requests – supply AGD and NJAGD with your email address.
- Engage your ADA delegates and reinforce AGD’s commitment to protect the profession and the patients its members serve.
- Answer the “Call for Volunteers” on the AGD website (www.agd.org/governance/cfv/home.asp)
- Support NJDA PAC and engage your NJDA leaders and reinforce NJAGD’s commitment to protect the profession and the patients its members serve
- Contact the NJAGD and get involved – it’s your profession! So what’s done for you isn’t done to you.

(This article contains information supplied by the AGD Dental Practice Council and the AGD Legislation and Governmental Affairs Council)

Dr. Joseph Battaglia is a Past President of NJAGD, and is currently the Chair of Constitution and Bylaws and Chair of AGD Council on Dental Practice.

What's New with OSHA



**Alfred L. Frost, III,
MS, DDS**

The OSHS Act was established in 1970 to ensure that employers furnish their employees both employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm. Since 1970 there have been no significant changes to what OSHA expects of employers. OSHA regulations are, however, frequently reviewed, refined and interpreted by both an OSHA review commission and by court precedent.

OSHA has the ability under its "General Duty Clause" to cite dentists for violations in which the workplace is not maintained free of hazards to which an employee is exposed and for which a specific regulation or Standard does not exist. In recent years a very significant increase in musculo-skeletal and repetitive motion injuries have been seen in the workplace. As a result, OSHA is now looking at adding a Standard dealing specifically with ergonomics.

A comprehensive review of OSHA is beyond the scope of this article and is usually presented as either a half or full day seminar. We will instead, spend the first portion of this article reviewing the main areas where dentists get into trouble and with which you should already be somewhat familiar. The second portion will be a more detailed look at ergonomics as this is the new "hot button" issue and one with which you may not be well acquainted.

Historically approximately 70% of the citations issued to dentists deal with violations of the Blood-Borne Pathogens (BBP) Standard; 20% deal with violations of the Hazard Communications Standard (Haz Com); while the remaining 10% is inclusive of violations in such areas as gas storage, machine guarding, electrical, etc. Throughout these primary categories citations are most commonly issued in four areas:

- Training of staff in BBP
- Training of staff in Haz Com
- Existence of required written programs
- Record keeping

The BBP Standard is designed to protect employees against exposure to pathologic micro-organisms in blood or saliva which can cause disease in humans including HBV, HCV and HIV among others.

A written Exposure Control Plan (ECP) is required to address the topics of Hazard Determination, BBP and Personal Protective Equipment (PPE) as concerns the elimination or minimization of employee exposures to blood or Other Potentially Infectious Materials (OPIM). The ECP must contain:

- An Exposure Determination
- A discussion of how you will use Engineering Controls (EC) and Work Practice Controls (WPC)
- A discussion of PPE and how you will train your staff in its use
- The exposure determination must list tasks and jobs whose performance exposes staff members to blood or OPIM.

In the EC and WPC discussion you must address in detail how you will:

- Use EC and WPC
- Ensure staff usage of PPE
- Provide training and what you will cover during that training, as regards BBP
- Communicate hazards to employees
- Provide medical surveillance and post-exposure follow-ups
- Provide Hepatitis B vaccinations
- Evaluate exposure incidents and what you will do if an exposure occurs

- Use labels and signs
- Handle record keeping

The training of staff with respect to PPE must be conducted live with a person qualified to present the material, demonstrate PPE usage and answer all questions regarding PPE and BBP in general. OSHA frowns on the use of a CD or video tape as a sole training tool.

Employees need to demonstrate their understanding of the topic and this can only be accomplished in a live format. Training of staff regarding PPE must include:

- When it is required
- What PPE is needed for each specific task/job
- How to properly don, doff, adjust and wear the PPE
- A discussion of the limitations of PPE
- A discussion of the care, maintenance, useful life and proper disposal of the PPE

Now, let's briefly turn our attention to Hazard Communications. The employer must take steps to decrease exposures, substitute less hazardous materials (where possible) and establish proper work practices. A written Haz Com program is mandatory and must address three principle topics:

Labels and warnings: Here you must identify the chemicals, their manufacturer names and contact information and any hazard warnings associated with them.

Material Safety Data Sheets (MSDS): These must be present in the workplace and available so that staff members can read them at any time.

Employee information and training: You must provide information and training on hazardous chemicals in the workplace and on protective measures to be taken to prevent exposures.

In addition to being mandatory, written programs which are well executed and define the protocols to be followed in your office are a great way of showing OSHA that you are doing all you can to ensure employee safety. Along with the BBP ECP and the Haz Com programs already discussed, other written programs must be in place and updated as needed. The most significant of these is the Emergency Action Plan (EAP). There are instances where this does not have to be written but I strongly suggest you write it. It is easy enough to do and gives you an additional layer of protection in the event of an incident.

You must determine what "expected" emergencies are relevant to your practice and have a separate plan to deal with each. In lieu of this you may simply maintain a single master plan with contingencies for each emergency. Examples of emergencies might include: fire, medical emergencies, extended power loss, workplace violence, robbery, etc. In the case of fire, for example, your plan might state how you will report the fire, how evacuation is to occur, how staff will be accounted for after the evacuation, etc.

Please note that I always suggest a written EAP as some of the components to be addressed in it, specifically fire prevention and the use of portable fire extinguishers, are always required to be in writing. Lack of properly composed, updated and maintained written programs can lead to significant fines.

Before moving on to the new area of ergonomics I'd like to touch briefly on record keeping. The following is a list of records which must be maintained and the duration of time for which each must be maintained.

Exposure Records: maintain for duration of employment plus 30 years.

Employee Medical Records: maintain for duration of employment plus 30 years. If an employee works less than 1 year, you may give them the records at termination and then be exempt from the 30 year maintenance requirement.

Training Records: maintain for at least 3 years from the last training or update.

Sharps Log: maintain for 5 years from the end of the year that it covers.

MSDS: maintain for as long as the chemical is in use plus 30 years.

As I mentioned at the outset OSHA is now seriously scrutinizing musculo-skeletal and repetitive motion injuries occurring in the workplace. These injuries may range from carpal tunnel syndrome or DeQuervain's tenosynovitis (repetitive motion injuries) in both clinical and clerical staff to neck and back pain or eye injuries in clerical staff working at stations with computer monitors. You should always analyze the various jobs and work tasks and correct deficiencies when noticed. Instruct employees to tell you when they find something physically uncomfortable in their work environment. Look for:

Awkward postures such as leaning forward to view a computer screen, raising elbows overhead to perform tasks, etc.

Prolonged repetitive motion such as keyboard use or certain hygiene procedures.

Contact stress such as repeated contact with the hard edges of a desk, etc.

By way of example: What you should look for at a computer work station:

- The top of the monitor should be at or just below eye level
- Head and neck should be in vertical alignment with torso
- Shoulders should be relaxed
- Elbows should be close to the body and supported
- Lower back should be supported
- Wrist and hands should be in line with the forearms
- Work surface should have adequate room for keyboard and mouse
- Feet should be flat on the floor
- Complaints of eye fatigue, irritation, blurred vision, headaches, etc.

Correct these deficiencies by:

- Training staff in techniques for proper posture
- Using a rest bar during keyboarding
- Using padding on sharp/firm desk edges
- Using padded arm rests
- Using chairs which provide good lumbar support
- Adjusting monitor light intensity
- Adjusting room lighting, etc.

While far from exhaustive the above should serve as an outline for you to review what you currently are (or are not) doing in your own office. With OSHA a small pro-active effort can prevent serious problems later. Check out your practice and correct deficiencies. If you need any help, give me a call.

For more information regarding **OSHA compliance** or **Dental Waste Management** contact **DRNA at 1-800-360-1001 Ext. 15** or on the web at **www.DRNA.com**

Dr. Alfred Frost holds a B.A. in biology from Canisius College in Buffalo, N.Y., an M.S. in epidemiology (magna cum laude) from the Roswell Park Cancer Institute, Buffalo, N.Y. and a D.D.S. (with Thesis Honors) from the SUNY at Buffalo School of Dentistry. He has completed fellowship research work at the Roswell Park Cancer Institute, residency training programs at the Eastman Dental Center (a division of the University of Rochester School of Medicine and Dentistry) and at the Genesee Hospital in Rochester, New York. Dr. Frost operated a large dental group practice and served as the managing partner for over fifteen years. In addition to his clinical, research and business backgrounds, Dr. Frost is OSHA trained and certified. He currently holds the position of Vice President for Clinical and Scientific Affairs for DRNA, Inc. and lectures and consults with dentists in the areas of Hazardous Waste Management, EPA, OSHA, HIPPA, Infection Control and other regulatory management issues.

IMPLANTS

- 3i • Bicon • Astra Tech
- Lifecore • Nobel Biocare
- Straumann • Zimmer

**Cut Your Costs Without
Cutting Your Quality!**

Get Your
Continuing
Ed. Credits
with Us!



Academy
of General Dentistry

FREE
Diagnosis
Estimates
Pick-Up &
Delivery



**ASTETO
DENT LABS**

Building Your Practice One Tooth At A Time!

1-800-447-7750
www.asteto.com

Is it Time for an Associate?

“Is it time for an associate?” This may be the most frequently asked question that consultants encounter. Dentistry must be the most associate-active of all health-care professions. Dentists seem to always be considering bringing an associate into the practice. Unfortunately, however, very few dentists bring in an associate at the right time or for the right reason. In fact, many dentists go through numerous associates without ever knowing the real reason the relationship did not work out as planned.

There is a right time and a right situation to consider an associate. But first, let’s discuss the wrong reasons that we encounter time and again.

The most common reason that dentists bring in an associate is because they are just not busy enough. As strange as this may sound it is true! As the dentist begins to examine the problem, he realizes that he is no longer getting as many new patients as he once did. Further examination reveals that his overall patient base is getting older and older each year and these patients need less dental work—the dentist has already done the bulk of the work. He also soon realizes that the lack of new patients is a direct result of not getting the younger patients he once was getting.

The established dentist decides that if he brings in a younger associate dentist then the younger patients will start coming back into the practice. This is really a logical thought: a patient base often does grow older as the dentist grows older. The bulk of most dentists’ patients are within ten years on either side of the dentist’s age. It is logical that that “lost generation” may indeed come back into the practice if a younger dentist is available. After all, the new dentist is also from that same generation.

But the question is whether this is really a valid reason for an established practice to bring in an associate? The answer is that it is not—and in fact, this associateship arrangement is almost always doomed to fail. The problem is that the patients are coming to the practice to see the younger associate and if the associate leaves the practice more than likely the patients will follow the associate. Statistically, in over 90% of the cases we have encountered since 1988, associates will eventually leave the practice to set up their own practice or get involved in another associateship!

Why? Because sooner or later the associate will discover that he is building a practice within a practice and that he really does not need the host dentist like he or she once thought. These young dentists begin to wonder why they should allow a host dentist to earn 50% or 60% of their collected production when they could enjoy 100%

Another common reason that dentists hire associates is to fully utilize their facility. The established dentist in this situation may only be working 4 days a week and never in the evenings or weekends. The established dentist figures that a hungry associate will be agreeable to working Fridays, Saturdays and some

evenings. The facility would then be fully utilized. Good idea?

It will work for a while but not in the long run. Again, the associate eventually discovers that he or she is building a practice within a practice and will leave to set up his or her own practice. When associates leave, they often takes some staff and patients with them. This scenario happens frequently and may be very costly to the established dentist. For example, we know of an associate who married the host’s hygienist and took the front office person to his new practice. The result was that the host dentist lost more than \$150,000 in annual gross practice revenues in addition to what the associate had been producing. It was financially devastating.

A third reason for hiring an associate is due to the host dentist anticipating selling his practice; he wants to see if the new doctor will be able to handle the transition. This is a valid reason to bring in an associate, but unfortunately, it is rarely structured properly. This is typically a totally ambiguous relationship of “let’s see how we like each other and then if everything works out OK you can buy me out”. There is hardly ever a contract and if there is a contract it is typically inadequate with little to no protection for either the established dentist or the associate. The host dentist is tired and wants to slow down, but since there is no commitment by either party, he does not usually slow down at all during this ambiguous “look see” period. The established dentist will rarely refer patients to the associate so the associate is frequently not very busy. Even if the intention was to see if the associate can handle the practice, the associate hardly ever gets a chance to prove he or she can. These relationships begin on a lack of trust by both parties and generally end ugly.

There are only TWO valid scenarios for bringing an associate into your practice.

First scenario: you need an associate because you are entirely too busy! You have more patients than you can handle. You are booked so far out that you are losing patients because they can’t get into the practice in a reasonable amount of time. You need another pair of doctor hands just to keep up with your work load! In this scenario the associate will be busy right away!

Or

Second scenario: you are ready to start slowing down and phasing out toward retirement. Perhaps you are tired or perhaps you have accomplished your financial goals. Whatever the reason, you need another pair of doctor’s hands to handle the patients you are ready (right now) to pass on to the associate. In this scenario the associate will be busy right away!

There is only ONE right way to bring an associate into your practice – a fully committed equity associateship arrangement.



Shirley Feuerstein

In the equity associate structure, the established dentist and the associate are both contractually committed to the eventual transfer of practice ownership. The equity associateship arrangement can be structured as either a Deferred PreSale (seller will remain with the practice as the buyer's associate after the sale), or a Deferred Sale (seller will leave the practice after the sale), or a Deferred Co-Ownership Program (host and associate eventually become equal co-owners in the practice).

Regardless of the desired structure, the plan must have a clearly defined method of allowing "sweat equity" credit to the associate for what he or she contributes in practice growth over and above what the practice was producing when the associate entered the practice. There must be a comprehensive contract protecting the interests of both the established dentist and the new associate. The exact deferral period (time lag to the buy-in or buy-out date) must

be clearly defined in the contract (however, it is not unusual for the host and associate to accelerate the buy-in or buy-out date in these transactions). The exact formula and terms for determining the buy-in or buy-out price are pre-determined and defined in the contract. The contract clearly defines the working relationship of the parties after the buy-in or buy-out, etc., etc.

Get the point? There is nothing left to the imagination in these critical relationships. Everything is clearly defined and pre-determined by contract. The success rate of various deferred transition programs is virtually 100% as opposed to the 90% to 95% failure rate of standard associateship arrangements.

An associateship definitely has its place in the dental community, but only if the relationship is structured properly. Don't become a statistic...and please, please don't jeopardize your largest asset.



SAVE THE DATE
AGD ANNUAL MEETING & EXHIBITS
NEW ORLEANS • JULY 6 - 11, 2010
Registration has begun,
visit www.agd.org to register today

NEWS FROM NATIONAL:

Red Flags Rule Enforcement Delayed Until June 1, 2010

The Federal Trade Commission (FTC) has delayed enforcement of the Red Flags Rule once again—this time from November 1, 2009, to June 1, 2010. The rule will require every creditor to have a written policy in place to identify and deal with the possibility of identity theft. According to the FTC's Bureau of Consumer Protection, a dental office is considered a "creditor" because it accepts payment at a later date. Many in the health care sector were taken by surprise to learn from FTC-issued guidance that the rule was intended to go beyond financial institutions to include health care providers. It is the position of the AGD that dental offices should not be included in this rule.

Meanwhile, the House of Representatives resoundingly passed H.R. 3763, a bill exempting small businesses owners,

including private practicing dentists, from compliance with the Red Flags Rule. H.R. 3763 now goes to the Senate and you can help to convince your senator that this bill needs to be voted on and passed. **Make your voice heard by participating in an e-mail campaign to lawmakers about H.R. 3763.** Visit www.capwiz.com/agd/home and click "Take Action." From this site, you can send your senator a pre-written letter or e-mail requesting his or her support of H.R. 3763.

From taking action on state and federal issues to third-party payer assistance and patient outreach, the AGD is continuously working to strengthen the voice of general dentistry, and it couldn't do it without its members' support. Stay up-to-date on current legislation and learn about the AGD's latest advocacy efforts at www.agd.org/advocacy.

Balancing our Lives with Dentistry



Bill Dennis

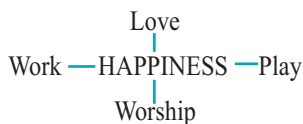
High level performance requires internal as well as an external balance. Tangents unrelated to what is most essential in our lives or work seem more costly. Moving away from what is most important in life can be costly. Whether one scrambles to find enough patients for a few days a week or leads a large practice, the challenge is more real these days. One may ask “do I work to live or live to work?”

This short article will briefly outline a map for looking at the major centers of our lives as they relate to each other. It will allow us to stand back and view ourselves while also giving us some helpful information.

Dentistry, perhaps the most “impossible” of the professions, requires skill in the arts, sciences, business, psychology, and entrepreneurship as well as major auxiliary functions. Physicians seldom have “timed” surgery. Family physicians refer to specialists more and more these days. Other surgeons generally have untimed surgery; if and when they perform surgery. Psychiatrists respond most often with a prescription. Psychotherapists listen carefully and respond with questions but they rarely deal with more than one person at a time. Attorneys have staff to multitask and never use their hands or backs and rarely use their legs, unless they are litigating.

So, on all levels with a dizzying array of roles and functions, dentists multitask minute to minute, hour to hour and day to day; year in and year out. Everything and everyone is taken care of promptly and with attention to all the specifics, with everything from occlusion to shade and material choice. Increasingly complex interpersonal and financial issues with patients, as well as delicate personnel issues converge in the same room in a single conversation.

Indeed, more than ever real balance beckons as a prerequisite for sanity. One way to evaluate ourselves is to see eight broad areas of our lives, often this is illustrated as a circle or eight equal parts (visualize a pie cut in eight equal slices). This might be viewed and considered an amplified version of L. D. Pankey’s model. He used the psychologists’



He then applied it to dentistry and it looks like this:

- A. Know Yourself
 - B. Know Your Patient
 - C. Know your work
 - D. Apply your knowledge
- Rewards: Spiritual, Material

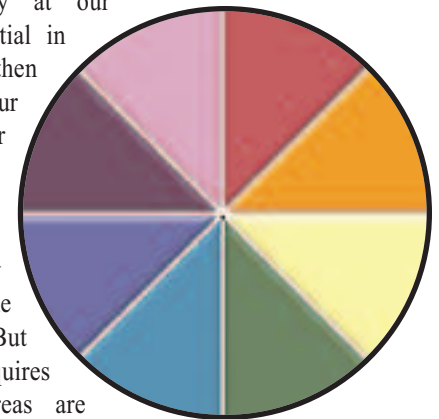
This reference comes from L.D. Pankey’s book on the philosophy of life and the practice of dentistry.

Coaches now use a “wheel of life” which allows us to observe ourselves. It also lets us assess our values and expectations. The easy method for using this map is to grade yourself with a number from one to ten for each of the sections. A grade of “one” is “not at all satisfied” and a grade of “ten” means “completely satisfied.” This is not an exact science but by just spending a few honest minutes reflecting and then assigning a written score will give you a sense of your relative level of

content. Use the same mental criteria for all the sections. I try to go through this exercise twice a year and I keep a record of the results. It is amazing how my numbers change. If you spend more than five minutes on this exercise, you are ruminating.

These areas of a “Modern Balanced Life” include: Spiritual or Inner Wellness; Mind or Mental Wellness; Body or Physical Wellness; Relationships and People; Career and Work; Finances and Money; Home and Living Space; Fun and Recreation.

Looking more closely at our individual wheel is essential in making changes. We are then changing an area based on our own criteria, relative to other areas in our lives. Obviously a wheel out of balance creates a “rocky road”. You certainly may choose to pursue goals in one or more of the areas. But remember, real change requires commitment. These areas are



sometimes considered equal in their importance for sustained stability and performance. So, most often the wheel’s balance relates to our ongoing functionality and growth.

Inner Wellbeing, which is the first area, is a summation of our inner balance and our surplus energies for supporting others. Great lecturers and genuine leaders exude this quality. Whether speaking all day to five hundred clinicians with baffling ease or making a difficult decision and then communicating that to their staff, this inner wellbeing presupposes a commitment to supporting others effortlessly. We all need this quality for a sustained coordination of sophisticated daily activities.

This presence comes from a continuous practice of connecting with ourselves, and all that we value most. It is hard to imagine someone out of balance with any other area possessing this quality in abundance.

Next, in order of essential importance is mental health, which includes clarity, concentration, intuitive and expressive skills as well as all the attributes we associate with good right brain and left brain functions. There is also a tremendous capacity for sustaining work easily. When clear, we are at our best, clinically and business wise. We make extraordinary decisions at the right time and in the right way.

Mental stability presupposes a high level of emotional equilibrium; even during stressful times. Of course, every day is a new challenge. It is easy to misinterpret the signs of health in this area or to deceive ourselves when certain symptoms arise. For instance, anger, expressed or not at home or at the office tells us we usually are not perceiving the situation as though we can do something about it. Or, it means often that we can not let something go that we already know can not be changed. This stability creates a loyal staff and loyal patients; everyone

wants to know and be known by someone who is grounded enough to relate to each person in a way that honors them.

Building healthy relationships often requires an ability to listen carefully enough so that you may remember the conversation and can refer to it as a common experience. This requires forgetting what you want to say as you listen. It means really forgetting about yourself and focusing all attention on who is talking to you. This simple act creates a solid bridge and assists in establishing lasting relationships. One of our most successful clients said to me last week, "you have got to know everything about a patient, every detail that is possible." Internal marketing begins with relationships.

Our financial health includes all debt, savings, money flow and spending habits. It includes all investments and their real value to you at this moment and in the near and distant future. It includes the value of your: practice, team, facility, location, community, clinical skill, reputation, and your brand of dentistry. It is also closely related to physical health.

Our office and home environments provide a mirror and also solid tools for upgrading ourselves. How dated is your reception area? This is where every patient spends their time, as well as those people accompanying patients to their appointments. It is the least expensive place to upgrade your image and your office environment. Eighty percent of offices I visit have beverages in the reception area these days.

This is where customer service begins and where you should hold your weekly team meetings. It is most likely used more than any room in your home or office, and it has the potential to influence your bottom line. The way patients are treated in the waiting room profoundly impacts their experience for their appointment. Patient management in the reception area may be directly related to internal marketing.

A lack of accomplishment in one area, usually, is a reflection of our value of that area. The real stability of your practice is the foundation of the practice. You are the foundation. How you interface with staff, mentors, patients, materials, family, equipment, spouse, associates or practice owners reflect your values. You embody your values day in and day out in your thoughts, language and action. Often we misinterpret behaviors; and often we misinterpret monthly and yearly practice statistics. Your Wheel of Life numbers show your values are by your standards, giving a guide for future effort. Your collection numbers are objective and give the parameters for effort and spending.

Expectation strongly influences our experience. What are your expectations five or ten years from now? The game changes, continuously. Today social media, high tech operatories and a plethora of diagnostic and treatment tools are emerging just as the economy moves into unknown territory. We also know that a slew of new patients and great collection numbers for the previous three months do not mean long term stability. Success is being redefined on the internet dental forums, where occasional tragedies and their causes are reported along with many wonderful triumphs.

As our internal barometer for balance and/or happiness keeps rising; we have the capacity to practice and live at a higher level. Now, many around us may expect more. Emphasizing balance in all areas

is important. Work, relationships, finances, our environments at home and at the office are our mirrors for how we are doing.

This clarity gives us solid ground and we know where we stand.

So, it seems that "the good life" excludes nothing. If insomnia, weight, a troubled son or daughter, or any life issue is not addressed, it expands exponentially into other areas of life. Balancing our expectations with our values helps eliminate surprises. Working on your business and not just in it requires a commitment to invest in yourself. One advantage of investing in yourself is that you have tremendous control over your dividends and if you apply yourself to your investments continuously, the dividends never stop.

An additional advantage for the practitioner who is healthy and balanced is that he/she can offer patients a relationship that includes knowledge and practice in these areas. Health and balance for some practice cultures is the new "Purple Cow;" that unusual quality that is offered as an adjunct but also is integral to the overall philosophy of the practice. As health care becomes more illusive and more of a commodity, more and more people are looking for a place or a community and/or a practice that embodies what is discussed here. All things being equal, this type of practice will provide conversations and even referrals that are not easily available through conventional medicine today.

About the author: Bill Dennis M. Ed. President, Coaching Solutions. Coaching Solutions (coaching-solution.com) offers highly credentialed dental professionals who customize practice management programs for their clients and their practices. Bill Dennis, M. Ed. President; Vice President, Sue Locke M. A.; Sandy Budinsky, Certified Human Resources Consultant; and Laura Russell, RDH, MBA are inductees in the Academy of Dental Management Consultants. Together with other dentists and doctors, Coaching Solutions has created a team who mentor and support our clients to the highest levels of success. Coaching Solutions will bring you the tools you need to create greater financial and practice success. They support dentists wanting to enhance their lives and practices through better leadership, communication, business systems and financial management. E-mail inquiries to: dentalseminar@aol.com.



Just What The Doctor Ordered:
Help with running the office more efficiently so you can build your practice more effectively.

MileStone Bank specializes in a new banking approach distinctively designed for the dental industry.

Call today for a "second opinion" banking analysis.

 **MileStone Bank** Dental Industry Specialist

Ph (866) 672.2655 | Fax (267) 880.0139 | www.milestonebank.com
© 2009 MileStone Bank. Member FDIC Insured.

One Dentist's Mid-Life Madness

After graduating from the University of Pennsylvania in 1983, I was very excited to be going into private practice. There was so much to accomplish during that time, including starting a family with my wife, Vickie. We purchased a home office in Jamesburg, NJ.

During the first few years in practice I met a number of colleagues that suggested I join the ADA and AGD. While I thought it would be a good idea to join, along came soccer coaching, boy scouts, and community involvement as a Board of Education member. At that point I started to feel as though I was being stretched in a number of directions, so I felt these dental organizations could wait until I found some more time. Reluctantly, I dropped out of the AGD.

So away my life went. In between family activities, and the practice steadily growing, I found myself looking to Dawson, Piper, and Christensen for my professional growth. I was beginning to take several implant courses. I also joined some study clubs, took monthly continuing education courses at Jersey Shore Medical Center and read everything I could get my hands on. I met interesting colleagues and was exposed to different ideas. One day I was viewing some videos of this gregarious speaker, Dr. Howard Farran, who highly recommended getting your FAGD/MAGD. My initial thought was that this was for someone younger and not twenty-odd years out of school in the middle of a career, with family and personal activities. Luckily, my second thought was to rejoin the AGD and see what it had to offer. I was excited to get involved again, but was concerned when I noticed they had a formal test for the requirements to achieve Fellowship. Could I pass a test on Pharmacology, Pathology, or Dental Materials? Now, this seems like information that you would be better prepared for fresh out of dental school. I felt that I was a good solid dentist who could make a well-fitting crown, was good at diagnosing periodontal disease, could even get most patients comfortable with a denture, but formal testing? I hadn't taken a test in over twenty years! Nonetheless, I started piling up the credits, as I was still pushing the test to the back of my mind.

In addition to attending courses, I was doing CE from journals, DVD's etc. I remember getting called for jury duty and knowing I would be sitting doing nothing for hours. I brought about twenty saved-up journals, read the articles and took all of the tests that day. As always, I picked up some tips that I could use in my practice.

As I approached 400 credits or so, the idea of becoming a Fellow entered my mind. I asked myself, "would this really make a difference to my patients?" Most of them would not notice anything, and some might ask what FAGD was. For the most part, however, they would only get the benefit of my increased knowledge. Something inside me said that I should try to do this for my own professional satisfaction. At that point, I started looking at when and where the AGD Annual Meetings were being held. They were in interesting places but they were during the summer—my sailing season. We own a 31' Hunter Sailboat and not too much comes in the way of our sailing.

Finally, 2008 was winding down, I was at 500 CE hours, and the "dang" test still loomed in front of me. The deadline for taking was the test was December 31st. I had saved up a bunch of AGD journals and ordered a few of the AGD practice test booklets. I made an appointment with a local testing center right before the holidays to take the test and informed my wife, Vickie, I would need to take a few nights a week for several weeks to study. So each night I sat next to a fireplace and pored over textbooks and old tests. The fascinating part of studying was that some of the material started to come back to me from dental school. I also found that much of the subject matter was clinically relevant to my practice. I realized that this was actually making me a better dentist. This was also the time I started remembering my old test-taking skills.

The Friday I was scheduled to take the test it was snowing. Was this the excuse I needed to not have to take the test??? I called up the



**Jerry Rosenberg,
DMD, FAGD**

The Successful Dentist in 2010



Is this you? Your practice may depend upon it.



DENTAL Esthetic Institute

1421 Main Street, Rahway, NJ 07065 • Tel: 888.866.8452

AC Dental is a Certified Dental Laboratory, Dawson trained and one of the professions leading full service laboratories for the past 30 years. Our experience has made us the laboratory of choice when esthetics are the determining factor in the success of a restoration. We are a top 25 implant laboratory and the tri-state areas leading provider of Zirconia All-Ceramic restorations. In this new economic environment technical acumen is not the only determining factor of success. The dentist who is successful today must also be proficient in marketing their practice and the services they provide. This was the motivation for the formation of our marketing department two years ago. Since then we have provided our partner doctors with complimentary customized and proven marketing programs that have helped grow their practice and attract new patients. Any laboratory can fabricate a crown or a bridge at AC Dental we don't want to be viewed as just another vendor but rather your partner helping you grow your practice one smile at a time.

test taking site and they were still open. So out I went into the snow. No one else was at the test center so it was quiet. As I was taking the test it started to feel like dental school again: most of the questions seemed pretty good but every now and then one came up that didn't make any sense. After approximately four hours I finished. The proctor hit a couple of keys on the computer—I passed!

I'll say it again...I passed! IT FELT GOOD THAT I STILL HAD IT. The test was harder than I thought and as usual some questions were just downright weird, but it felt good to complete and pass this test.

In July, 2009, we went to Baltimore to receive my award. I thought we would just be going through the ritual, not a big deal. However, when I went into the auditorium and saw how many other dentists were there receiving their FAGD's and MAGD's, not to mention how many people were there to support them, I was very touched.

As I was sitting in my gown waiting my turn, my wife, Vickie, somehow got a seat in the second row and I was able to see her. I started to think about the journey that we had taken and became emotional. As a middle-aged dentist, I felt something stir in me. It was a combination of coursework, everyday learning in my practice and passing the test. I would highly recommend going for your FAGD no matter what your age. It is a worthwhile journey.

Dr. Rosenberg received his B.A. in Biochemistry from Rutgers University, in New Brunswick, NJ in 1979. He then received his D.M.D. from the University of Pennsylvania School of Dental Medicine in 1983. Since 1986 he has maintained a private practice in Jamesburg, NJ.



PARAGON
DENTAL PRACTICE TRANSITIONS

www.paragon.us.com 866.898.1867

Jason Vives, D.D.S.
has acquired equity in the Orthodontic practice of
Donald Frantz, D.D.S.
Old Bridge, New Jersey

We are proud to have represented both parties in this transaction.

The PARAGON Difference: After thousands of clients and hundreds of transactions over the past two decades, PARAGON consultants know that no two clients and no two transactions are the same. A practice transition is a very personal event that requires very special attention. Nothing is taken for granted. Every single transaction is customized to satisfy our client's specific needs and goals. Each transaction is handled as if it were us who were the clients. This is just one of the many reasons why PARAGON is so unique. Judge for yourself! Call us for a complimentary consultation. No obligation... just a very worthwhile education!

Shirley Feuerstein
908.868.9330 (cell) • 908.222.0199 (office)
shirley@paragon.us.com



Hillel Ephros,
DMD, MD

AIM 14 Critique with Dr. Hillel Ephros

Thursday, April 29, 2010

AIM 15 with Dr. Stephen Poss

Friday, April 30, 2010
Saturday, May 1, 2010
Sunday, May 2, 2010



Dr. Stephen Poss

AIM 15 Critique with Dr. Stephen Poss

Thursday, October 14, 2010

Dr. Stephen Poss lectures internationally on esthetic dentistry and TMD. He is an active consultant to several dental manufacturers and has had numerous articles published in the leading dental journals. Dr. Poss is presently the Clinical Director at The Center for Exceptional Practices in Cleveland, Ohio and maintains an aesthetic-based practice in Brentwood, Tennessee.

Locations to be determined. Visit www.njagd.org for details and registration information.

**NEW JERSEY ACADEMY OF GENERAL
DENTISTRY MEMBER FINANCIAL BENEFITS**

*Members of the NJAGD can now
enjoy these Financial Benefits offered by
Darby Dental Supply.*

- Save an average of 10-17% off current Darby pricing
- Receive a quarterly 2% rebate on all purchases
- The NJAGD receives a 1% quarterly rebate of all members purchases!

TO PARTICIPATE, PLEASE COMPLETE THIS SIMPLE FORM AND FAX TO DARBY TODAY! THERE IS NO OBLIGATION.

YES NO I am currently a Darby customer.
Customer number _____

YES Please enroll me in the Darby Rebate Program

Name _____

Street Address _____

City/State/Zip _____

Phone _____

Fax _____

FAX: 1-800-957-7362

Christina Kenderes
1-800-645-2310 ext. 4093
Christina.Kenderes@darbydentalsupply.com

***DARBY...
IT'S ALL IN THE COMPANY
YOU KEEP!***

www.darbydental.com

Darby Dental Supply, LLC,
300 Jericho Quadrangle, Jericho, NY 11753
Phone: 800.645.2310 / Fax: 800.957.7362

Visit our website at
www.njagd.org
for news and up-to-date information!

BOARD MEETING DATES:

**LOCATION:
NJDA Bldg
One Dental Plaza
North Brunswick, NJ 08902
TIME: 7pm**

January 2010

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

March 2010

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

April 2010

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

**Congratulations to
DR. JOHN NAZZARO
of Matawan, N.J.
the winner of a free Continuing Education
raffle at our October 28, 2009 CE Course.**



2010 GENERAL MEMBERSHIP APPLICATION

For more information:
Call us toll-free: 888.AGD.DENT (888.243.3368)
Or join online: www.agd.org

Code: _____

Referral Information

If you were referred to the AGD by a current member, please note information below:

Member's Name _____

City, State/Province, or Federal Services Branch _____

Member Information

First Name	MI	Last Name	Designation (e.g. DDS, DMD, BDS)	Informal Name (if applicable)
Type of Membership: (Check one) <input type="checkbox"/> Active General Dentist <input type="checkbox"/> Active General Dentist (recent graduate in last four years) <input type="checkbox"/> Associate <input type="checkbox"/> Resident <input type="checkbox"/> Dental Student <input type="checkbox"/> Affiliate				<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of Birth (mm/dd/yyyy) Required for access to the AGD Web site
Do you currently hold a valid U.S./Canadian dental license? <input type="checkbox"/> Yes <input type="checkbox"/> No				
License Number _____ State/Province _____ Date Received (mm/yyyy) _____				
If you are not in general practice, please indicate your specialty: _____				
Current practice environment: (Check one) <input type="checkbox"/> Solo <input type="checkbox"/> Associateship <input type="checkbox"/> Group Practice <input type="checkbox"/> Hospital <input type="checkbox"/> Resident				
<input type="checkbox"/> Faculty: _____ Institution _____ <input type="checkbox"/> Federal Services: _____ Branch _____				
If you are a member of the Canadian Forces Dental Service, please indicate your preferred constituent: <input type="checkbox"/> U.S. Military Counterpart <input type="checkbox"/> Local Canadian Constituent				

Contact Information

Your AGD constituent is determined by your business address, unless one is not available.

PREFERRED METHOD OF CONTACT:

E-mail Mail Phone

PREFERRED BILLING/MAILING ADDRESS:

Business Home

Business Address	City	State/Province	ZIP/Postal Code
_____	_____	_____	_____
Name of Business (if applicable)	Phone	Fax	
_____	_____	_____	
Home Address	City	State/Province	ZIP/Postal Code
_____	_____	_____	_____
Phone	Primary E-mail		Web site Address
_____	_____		_____

Education Information

ARE YOU A GRADUATE OF AN ACCREDITED* U.S./CANADIAN DENTAL SCHOOL? Yes No Currently Enrolled

Dental School	Graduation Date (mm/yyyy)	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
_____	_____	_____	
Are you a graduate of an accredited* U.S. or Canadian post-doctoral program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Enrolled			
TYPE: <input type="checkbox"/> AEGD <input type="checkbox"/> GPR <input type="checkbox"/> Other <small>*See back.</small>			
Post-Doctoral Institution	State/Province	Begin Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
_____	_____	_____	_____

For information on qualifying for the residency dues discount, please refer to the description on the back.

Optional Information

GENDER: Male Female Are you interested in becoming: A Mentor A Mentee

ETHNICITY: American Indian Asian African-American Hispanic Caucasian Other _____

HOW DID YOU HEAR ABOUT US? AGD Member (please indicate information in the Referral Information box) AGD Web site AGD Constituent

Newsletter Advertisement Mailing Dental Meeting Other _____

Dues Information

1 AGD Membership Dues	_____
2 AGD Constituent Dues	+ _____
TOTAL AMOUNT ENCLOSED (Required)	= _____

Payment Information

Promotional Code (if applicable) _____

Check (Enclosed) VISA MasterCard American Express Diners Club Discover

NOTE: Payments for Canadian members can only be accepted via VISA, MasterCard, or check.

Exp. _____ Please print the name as it appears on the card

I hereby certify that all the information I have provided on this application is correct, and by remitting dues to the AGD, I agree to all terms of membership.

Signature _____

Date _____

Return this application with your payment to:
Academy of General Dentistry
211 East Chicago Avenue, Suite 900
Chicago, IL 60611-1999

For credit card payments, fax to 312.335.3443

Dues rates effective until 10/01/10. Contact the AGD or visit www.agd.org for updated rates.

Power UP

your dental practice



Coaching Solutions has the answers for your practice.

- ✓ Customized systems that work for you
- ✓ Turn-key patient rewards programs
- ✓ Fee analysis and team assessments
- ✓ Team hiring and building
- ✓ Dental Office Manual with job descriptions
- ✓ Case presentation skills that always work
- ✓ Projecting a professional image through graphic design
- ✓ Marketing yourself online
- ✓ Free practice assessment
- ✓ In-office assisting program
- ✓ "Scheduling to go"
- ✓ Full hygiene program
- ✓ ON-LINE ACCREDITED, INEXPENSIVE CE



Custom Programs for your Practice

Hygiene should be generating significant money for your practice.

Call today for a complimentary analysis. We can help!

856-786-4814



COACHING SOLUTIONS

Leadership for Success

606 Parry Boulevard
Cinnaminson, NJ 08077

Tel 856-786-4814
Fax 856-786-4815

Contact **Bill Dennis**
President, Coaching Solutions
bill@coaching-solution.com
www.coaching-solution.com

Start building your ideal dental practice today. Call **856-786-4814** or visit **www.Coaching-Solution.com**