

JOURNAL *of the*

MASSACHUSETTS DENTAL SOCIETY

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Remembering
Norman Becker, DDS

Editor and Editor Emeritus

AN APPRECIATION

IWRITE THIS AND FORGO MY PRIVILEGE OF USING THE “EDITORIAL we,” a term generally ascribed by many to be appropriate when used by “sovereigns, editors, pregnant women, and people with tapeworms.”

This quote would have brought a smile to Norman Becker’s face. There has never been a man with a faster smile or kinder heart than Norm. Ironically, although a man who loved and worked with words, he was a very quiet person.

Norman Becker became Associate Editor of the *JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY* in 1975. At the time, he thought himself unqualified, and immersed himself in journalism courses, perhaps not realizing that his intellect, soul, imagination, and common sense more than qualified him for the position.

Norman went on to serve as Editor of the *JOURNAL* from 1980 to 2004. He transformed this publication from a small-format “throwaway” to the current large-format, widely emulated, often imitated, and always educational institution that it has become. Dental journalism became a professional passion of his. Having served as an educator, MDS Trustee, and vibrant member and leader of the North Metropolitan District Dental Society, Norm transformed our *JOURNAL* into a publication that has been bestowed so many prestigious national awards that they are too numerous to list. Typical of his modesty and generosity, he kept none of them, even those that recognized him specifically. He presented all of them to the MDS since he felt that he was merely the conduit for the recognition that he believed was earned by the whole Society. On the 50th anniversary of the *JOURNAL*, he was given the first American Dental Association’s Distinguished Dental Editor Award.

Norm introduced the concept of entire issues dedicated to a particular topic to bring together, within a single publication, a diverse group of expert authors in an area of clinical or ethical importance to more keenly focus the educational value of the *JOURNAL* to all MDS members.

His professional and educational accomplishments are legendary, yet I have never met a more modest, kind, considerate, intuitive, inspirational, generous, unflappable, or simply nice gentleman than Dr. Norman Becker.

Norm was unique in so many ways. He was a passionate Hoosiers fan planted on the coast of Massachusetts. He was a card-carrying, officially certified member of the American Association of Magicians for more than 50 years. He used his sleight of hand to calm nervous patients, amaze family members, and entertain colleagues (and their families). He never left home without at least a couple of props in his pocket. He was dedicated to his family, reveling in each of their many accomplishments, while, of late, simultaneously caring for his infirm wife, Barbara, virtually until the time of his passing.

He inspired countless young people to pursue dentistry as their careers. Their subsequent success contributed to his ever-present smile. A colleague recently confided to me that he grew up in Revere, essentially across the street from where Norm practiced for more than five decades. As a boy, he played stickball in front of the empty lot that was yet to be the site of Dr. Becker’s office. (The back fence was a home run.) When this colleague graduated from dental school, Norm invited him into his office to begin to build a practice. When our friend found a location to establish his own office in a neighboring town, Norm insisted that this newly minted dentist take every patient he had treated, with no restrictions or remuneration, to his own new office. Such acts of kindness and generosity will never be forgotten, and were all so common.



Norman Becker, DDS
1924–2011

Norm’s career began in the days of boiling instruments, sharpening anesthetic needles, and using mortar and pestle to mix amalgam. He ended his career in the age of implants, digital imaging, and digitally scanned impressions. In his own words—written in his last *JOURNAL* editorial (Summer 2004, Vol. 53/No. 2, page 5)—he said, “I have always enjoyed practicing dentistry and cherish the relationships I’ve established with my patients. My profession has [given] me . . . the opportunity to make lifelong friendships with many colleagues. I am eternally grateful for these opportunities and look forward to the future and the changes still to come in dentistry.”

Norm would tell you he was a very lucky man. He practiced for 35 years with his son and best friend, David, as well as several years with his grandson, Todd. His 63-year marriage to Barbara was blessed with five children, eight grandchildren, and four great-grandchildren. He adored them all. He counted world-famous musicians and celebrities as his friends, houseguests, and, when necessary, patients.

He was a Renaissance man who moved effortlessly between the worlds of family, music, dentistry, art, and literature. The joy of whatever was going on around him, no matter where he was, gave a glow to his face.

The Ethics of the Fathers, a book of the Talmud, the seminal work of Jewish knowledge through the centuries, says:

“Honor a man for what he is;
Honor him more for what he does.”

Dr. Norman Becker will be remembered as a good and righteous man who served his family, his country, and his profession with honor, pride, and love. He, as his heritage taught him, said little but did much. Each of us is a better person for his having shared part of all that he was with all of us. May his life and his memory serve as guides for us, as we try to follow the examples he set. ■

Arthur
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WAYS TO TRIM COLLEGE COSTS

HERE'S A NEW TWIST ON AN OLD SAYING. THERE ARE THREE things in life that are certain: death, taxes, and college costs that go up every year, even during a recession. How can students and parents avoid the “extreme borrowing” phenomenon that can lead to years of burdensome loan payments? They can start by looking for ways to trim college costs so they won't have to borrow and/or pay as much in the first place. Here are some ideas.

Pick a College with a Lower Sticker Price

Pricey private colleges often like to point out that the majority of their students don't pay the full “sticker price.” The problem is, however, that you never quite know how much exactly their students are paying. Every student's aid package is different, and the presence of merit aid awards makes the picture even murkier. Private colleges with the biggest endowments can afford to be the most generous (replacing loans with grants in aid packages, for example, or guaranteeing merit aid for all four years), but not every private college can do this. Even if a college takes \$15,000 or \$20,000 off its sticker price, that may still leave \$30,000 or more to pay each year.

In the past few years, enrollment at public colleges has soared due to their lower sticker prices—public colleges are typically half the cost of private colleges, and for in-state residents the savings can be even greater. Education experts often debate the benefits of spending more money to attend a well-known, more prestigious private college versus a public college. But it's generally agreed that motivated, bright students can succeed anywhere, and that after a certain period of time, job experience matters more than where you went to college.

Tweak the Typical Four-Year Experience

If your child doesn't mind forgoing the typical four-year college experience, here are some ways to trim costs:

- Attend a community college for one or two years, then transfer to a four-year institution.
- Take Advanced Placement (AP) high school courses to earn college credit and reduce the time in college.
- Look at colleges that offer three-year accelerated degree programs.
- Consider living at home and commuting to school to save on room-and-board costs.
- Research online education options. (One website to start with is www.distance-education.org.)

Consider Taking a Year Off

The number of students taking time off between high school and college is growing in a measurable way. This period, commonly referred to as a “gap year,” is typically spent volunteering, traveling, working, and/or interning. Among the main benefits of a gap year are the increased maturity and focus that come from engaging in new experiences. These traits can help students get their money's worth in college by sharpening study habits and career goals.

Another benefit is the potential to earn money to pay for college. For example, working full-time for 42 weeks (10 months) at the federal minimum wage of \$7.25 per hour equals about \$12,180 before taxes. Or, for the volunteer-minded, the AmeriCorps Program provides a modest living allowance and a stipend; in 2010, it offered \$5,350 in exchange for service work (future stipends will be tied to the maximum federal Pell Grant). And more than 80 colleges now offer matching grants to students who earn an AmeriCorps stipend. (See www.americorps.gov for more information.)



Research Scholarships

After your child fills out the federal government's financial aid application (FAFSA) and the college's financial aid application (the standard PROFILE application or the college's own form), he or she should set aside as much time as possible to research and apply for scholarships. With online searches, students can easily input their talents and background, and get a filtered list of relevant scholarships (try www.fastweb.com or www.collegeboard.com). Also, don't forget to check with your employer and the local chamber of commerce for scholarships.

Budget Well During College

Encourage your child to look for deals on mandatory items like books, supplies, and other personal dorm room items. For discretionary items, establish guidelines for a reasonable amount of monthly spending money, but build in some flexibility. If you do co-sign a credit card application with your child (a co-signer is now required in most cases for applicants under 21), make sure your child doesn't succumb to the temptation of easy money. According to a study last year by Sallie Mae, the average college student has \$3,200 in credit card debt. Discuss your expectations of credit card usage and make sure your child understands how interest accumulates on unpaid monthly balances. ■



GEORGE GONSER

Mr. Gonser is CEO of MDSIS-Spring Insurance Group.

THE FUTURE OF THE INSURANCE BROKER/ADVISOR

ON MANY OCCASIONS OVER the years, I've been in the company of one of my dental professional friends when they are asked, "Doc, my tooth hurts, can you take a look?" To their credit, they always acquiesce. Most consider it part of their oath for being a dentist. Believe it or not, I, too, get asked about my profession many times. And one could say that the pain people are feeling from their health insurance costs equals or exceeds tooth pain. Recently, I was the chauffeur for my son and his date to the prom. After a quick "Hello, Mr. Gonser," my son's date proceeded to ask me: "As an insurance consultant and broker, what are your thoughts on the national health care reform law and the role of the broker?" Aside from the brownie points she had just earned, she got me thinking about the number of questions that I have fielded about the Patient Protection and Affordable Care Act (PPACA). So, as we close in on the anniversary of the law's passing, I thought it would be beneficial to discuss the role of the broker in the health care reform law, now and in the future.

It has been said that where there is complexity, there is opportunity. Well, we are in as complex an insurance world as we have ever seen. State and national health care reform laws have changed the way insurance business is being conducted right now and in the future. So where is the opportunity? To me, as a broker/consultant for 20-plus years, opportunity is all around us. I have prided myself on being a proactive professional who provides educational and informative service. How will that change? In an increasingly complex world, it is important now more than ever to stay the course on the level, type, and quality of services that we can offer. However, how I provide products and services to clients and prospects, and the way brokers are compensated, is changing.

If you go back 30 or 40 years, commission percentages were commonly in the 15 to 30 percent range or higher. However, premiums were much lower then. As premiums have escalated to unprecedented levels, the spotlight has been on administrative costs and, as part of that, commissions paid to brokers. Typically, for companies that have five or more employees enrolled in a



health plan, the commissions paid to brokers are in the 2 to 3 percent of gross premiums. For January 1, 2011, many of the carriers are setting a flat-rate commission structure on a per-insured basis. For groups under five in size, the commissions have been at a flat rate set in 1998. For example, on a flat-rate commission structure, if you have two individual plans and one family plan, you would be paid the flat rate multiplied by three subscribers.

Carriers are feeling the pressure of keeping their administrative costs low. Since commissions are, for the most part, being lumped into the administration bucket of the premium dollar, they have slashed commissions to be more competitive in the industry and also to adhere to the state and federal mandates on minimum loss ratio regulations. While Massachusetts carriers typically see 88 to 92 cents of every premium dollar going toward claims—which is far above the national average and higher than what is required by the PPACA—pressures are mounting to keep the costs down for the consumer. Carrier rate caps and brokerage commission cuts have been implemented to aid in that effort. I would expect more commission structures to be on a flat-rate or fee-based structure, depending on the size of the company in the future.

Therefore, insurance brokers are being asked to do more while making less. This also comes at a time when companies and individuals need the help of brokers more than ever. Incorporating tiered networks, a multitude of deductible plans, expanded plan designs, cost pressures, and integration of employee benefits into the goals and objectives of a company is extremely complex. So utilizing a knowledgeable insurance broker is key to navigating the health care reform waters.

The challenges of the health care reform law and employee benefits are not a catastrophic end to the insurance broker. Quite the contrary. The best, brightest, and most responsive brokers will continue to evolve now and in the future. So, the next time you run into me at an event such as the MDS Annual Session, a supermarket, or a Little League field, don't be afraid to ask me any questions about health care reform that you may have. It is not a pain at all. ■



RACHEL ZIPPWALD

Ms. Zippwald is a vice president and SBA business development officer for California Bank & Trust.

SEVEN TIPS FOR LANDING AN SBA LOAN

SMALL BUSINESSES SEEKING FINANCING are in for a bit of good luck these days in the form of small business administration (SBA) loans. There are, however, a few caveats. While SBA loans are available, it may take a bit more work to obtain one, and banks are requiring more information than they have in the past. Here are a few tips to facilitate getting your SBA loan approved.



1. Provide details on exactly how much financing you need and how you will use it. Banks like specifics, so be prepared to provide a precise dollar amount and give details of how you will use the funds. For example, if you're seeking \$125,000 to expand your business, explain to your lender how you will use the funds, such as that you need \$75,000 for working capital to support three months of expenses, and another \$50,000 for seven networked computers and a server. Banks are impressed with research, so provide a written quote for the equipment. If you're planning to consolidate debts and refinance for a longer term, provide copies of your promissory notes and state how much you think you can save with the refinance. Detailed loan amounts with copies of bids, promissory notes, or proposals can help strengthen your loan package because your lender can understand the facts backing up the request.

2. Provide information about company management. When banks lend money, they like to understand who runs the company and to be familiar with their backgrounds. This is a key factor in presenting your loan for approval. Help your lender by providing a resume for each owner or key employee and describe their functions and responsibilities. If certain key positions have not yet been filled, include a thorough job description of the type of person you are seeking. This will confirm for the lender that you have analyzed your needs and have determined the requirements of the position.

3. Be prepared to offer collateral. The SBA requires collateral to fully secure your loan, to the extent that it is available. If you own a home, you will likely be asked to pledge it. The SBA may also request a lien on your business assets and may require life insurance on sole owners of a business. Most loans made by banks are secured loans and, therefore, approval may be contingent on a guarantor who is willing to offer collateral.

4. Detail your credit history and credit score. Your credit score is an integral part of the loan process because it illustrates the ways in which you handle your other obligations. Your bank will eventually run its own credit report, but if you can provide information prior to it doing so, you can discuss any issues ahead of time. If you don't know your credit score, take the time to research it on the Internet, where low-cost reports are available. If you've had problems such as identity theft, bankruptcy, or divorce, you'll want to discuss it with your lender

up front and provide proof that issues have been resolved or discharged.

5. Provide complete copies of tax returns, financial statements, and bank statements. While it can be time-consuming to gather these documents, your bank will want to know everything about you and your business if they are to become, in essence, your financial partner. One way to streamline the process is to scan your financial documents and provide them to your lender in the form of a disk or a flash drive. Your lender may even be willing to accept your documents via email.

6. Explain how you'll achieve your projections. Now is the time to brag about you and your business and to sell your lender on your vision and forecasted success. If customers have expressed a desire to do business with you, give your lender a copy of their correspondence. Prove to the lender that a market for your service exists and demonstrate the validity of your sales and expense figures. If the loan for which you are applying is intended for a new piece of equipment that will allow you to reduce your staff needs, describe how this will occur and show the math.

7. Expect questions and be patient. Your lender needs to connect with your story and business, and will appreciate your assistance in doing so. Take the time to thoroughly explain the nature of your business, your vision, and your background. Your banker will likely be presenting your loan approval to other parties, so he or she will need your help in making your case. The process may be time-consuming, so it helps to be patient. Feel free to request an estimated time frame for approval and respect that the projected date may slip a bit. It's best not to call or email your lender frequently—remember that in lending, no news is often good news. ■

Dr. Norman Becker— A Personal Tribute



SCOTT G. DAVIS

Mr. Davis is chief communications officer at the Massachusetts Dental Society.

It was my first day on the staff of the Massachusetts Dental Society in 1998 when a colleague gave me a brief verbal introduction to Dr. Norman Becker.

“He’s been the editor of the *JOURNAL* practically forever,” she explained. “Norm’s great. Everybody knows him.”

“Hmm,” I thought to myself. “Kind of like Norm on *Cheers*, a person whose name everyone knows.”

“And,” she concluded, “he even does magic tricks.”

A dentist who’s also a magician? Now, I’ve heard of some dentists who figuratively performed magic in their offices. But as a hobby? This must be someone really special.

I never knew just how special until I got to know him.

It was actually several weeks after that when I met Dr. Norman Becker for the first time. Although I don’t remember exactly when and where that first introduction was, what I won’t forget was the twinkle in Norm’s eyes as he talked about dentistry and especially

the *JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY*, a publication he had been associated with for nearly half his life.

Dr. Norman Becker didn’t actually start the *JOURNAL* when it was founded in 1951. But being involved with the publication for 36 years—first as Assistant Editor, then Editor, and finally Editor Emeritus—makes it seem as though he did.

It was then *JOURNAL* Editor Dr. Lou Soldan who asked Norm to become Assistant Editor in 1975. As Norm related in the 50th anniversary issue of the *JOURNAL* that was published in 2001, “I was flattered but intimidated. Even . . . when I was asked to become Editor after Dr. Soldan’s retirement, I hesitated—I was afraid I would not be good enough. . . . However, with the encouragement and advice of many friends within organized dentistry, I made the *JOURNAL* my passion. With the guidance of my good friend, Dr. Herb Schilder, this passion became an important part of my professional life.”



Dr. Norman Becker (left) demonstrates his magic talents with assistance from his son, Dr. David Becker.



Dr. Norman Becker (right) receives the 1991 Golden Pencil Award for the *JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY*.

For Norm, it was also a labor of love.

First as Assistant Editor and later as Editor, beginning in 1980, Norm was a hands-on volunteer, identifying subjects for stories and contributors to write them, editing the articles, and writing the editorials. Eventually, the position of Assistant Editor would be assumed by his son Dr. David Becker, with whom he shared a dental practice along with Dr. Charles Silvius, current President-Elect of the MDS.

But there's little doubt that it was Norm Becker who helped elevate the position of dental editor to what it is today. He raised the bar for others to try to reach.

In recognition of his many contributions to the profession, the ADA's Council on Communications presented him with its first Distinguished Dental Editor Award in 2001. He was among three dental editors recognized for bringing exceptional credit to their Society, dental journalism, the dental profession, and organized dentistry.

He has also been a Past President of the American Association of Dental Editors (AADE), an organization that has recognized the JOURNAL with numerous awards through the years.

It was in 2004 when the reins for the publication were officially passed on to David, who also serves as MDS Trustee of the North Metropolitan District Dental Society, with Norm becoming Editor Emeritus. But Norm continued to contribute to the publication through the Book Reviews column in each issue. And, of course, he still was involved in his dental practices in Revere and Boston with David, Dr. Silvius, and most recently with Norm's grandson, Dr. Todd Belfbecker, who joined the practice after graduating from Tufts University School of Dental Medicine.

In addition to the JOURNAL and his dental practice, Norm served as Chair of the Massachusetts Chapter of the Pierre Fauchard Academy and for many years hosted the organization's annual breakfast at the Yankee Dental Congress (YDC). He also facilitated activities for the Fauchard Foundation.



Dr. Norman Becker working his magic with children at the Yankee Dental Congress 32 in 2007.

But unlike other organizations that donate money for worthy causes, when it came to the Fauchard Foundation, it was Norm who would be the one to call *me* asking if the MDS had a project that needed funding and suggesting that I send the proposal to him.

That was typical of Norm. Or to paraphrase MDS Historian Dr. Charles Millstein, "Norm was never the 'norm.'"

But Norman Becker's many contributions were certainly not limited to the JOURNAL or to organized dentistry, for that matter. Even into his eighties, he would volunteer his time on the MDS Foundation Mobile Access to Care (MAC) Van and was recruited on several occasions to perform magic for children at events the Society sponsored. One of the last times he did that was for a group of children invited to YDC in 2007 to celebrate the official launch of the MAC Van. But if you looked carefully at the adults in the crowd, who were mostly dentists, they seemed to be just as fascinated by Norm and his magic act as the children were.

Norm was also one of just two non-musicians (his former dental practice partner being the other) inducted into the Overseas Press Club Jazz Hall of Fame for his many contributions associated with the relationship between the playing of musical instruments and the mouth.

In more recent years, my face-to-face interaction with Norm was limited primarily to seeing him at the MDS Annual Session,



Three generations of Drs. Becker at the MDS Annual Session (from left): David Becker, Todd Belfbecker, and Norman Becker



Dr. Norman Becker and his wife, Barbara, at the Yankee Dental Congress



Drs. Anthony Minichiello (left) and Norman Becker (right) with jazz great Buck Clayton

where he was a delegate from the North Metropolitan District. There, he would sit proudly right next to his son and grandson.

And, of course, I would always see him at the Yankee Dental Congress.

Each year at Yankee, I would look forward to Norm coming into the Press Office, sometimes with his wife, Barbara, who would often remark that she couldn't keep up with him. But even if you couldn't always keep up with Norm, it was always good to catch up with him.

At least one day at every Yankee, he would sit down in the Press Office and tell me about something that captured his attention and interest, doing it with the youthful enthusiasm of a first-year dental student who had just completed his first clinical procedure. He would then regale me with stories from the past, but would always give me good ideas for possible JOURNAL articles for the future. Norm had this unique way of always using history to look ahead.

Because of his illness, he was unable to come to Yankee this past January. It was the first year that he didn't stop by to visit me in the YDC Press Office.

It just wasn't the same.

Fortunately though, part of that void was filled one day with a visit by other members of the Becker family—grandson Todd and his wife, Emily, with their newborn, Maya, Norm's great-granddaughter. They stopped by on Maya's inaugural tour of YDC, where she experienced the sights and sounds of her first Yankee from the comforts of a stroller. Maya even had a guest badge, so she was an official attendee.

Although Norm couldn't be at Yankee himself, it was almost as though he had spiritually passed the torch to yet another generation of Beckers.

Norman Becker, DDS, died on February 23, 2011. He was 86.



Photo by Susan Jacobs



The magician may be gone . . . but definitely not the magic he left behind.

As a dentist and active member of organized dentistry, there is little doubt that he left an indelible legacy to the Massachusetts Dental Society, one that will certainly continue to live on in this publication that he loved so much. It will also remain alive through the many contributions that are being made to the MDS by his family—

son David and his wife, Jackie Belf-Becker (who has served on many YDC committees through the years), and grandson Todd, who is Chair of the MDS Council on Access, Prevention, and Interprofessional Relations. Todd, by the way, will take over writing the Book Reviews column from his grandfather.

And someday, maybe Maya will become part of dentistry, perhaps even having her name on the JOURNAL masthead.

As author Norman Vincent Peale once wrote, "There is a real magic in enthusiasm. It spells the difference between mediocrity and accomplishment."

Dr. Norman Becker was indeed the epitome of both enthusiasm and accomplishment. The magician may be gone . . . but definitely not the magic he left behind. ■



Dr. Norman Becker (far right) at the Forsyth Dental Infirmary for Children, where he worked from 1947 to 1951

The Art of Case Presentation

ROGER P. LEVIN, DDS

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Introduction

When dentists complete dental school, they often breathe a sigh of relief, glad to have survived the rigors of study and gained their clinical skills. However, most new dentists do not realize that another complex skill must still be learned to succeed in dentistry—the art of case presentation.

For many dentists, case presentation skills do not come naturally. True to their dental school training, dentists tend to focus on the technical features of cases. Patients, on the other hand, are far more concerned with lifestyle benefits. Therein lies the problem. When a presentation is heavily geared toward clinical aspects of treatment, patients will often lose interest. An uninterested patient is an unmotivated patient—and that's fatal to case presentation.

Practices need guidelines that must be maintained during case presentations. These guidelines can often help increase case acceptance to unprecedented levels.

Establish Your Case Presentation Game Plan

The following guidelines will help practices achieve more successful case presentations:

- **Start on time.** When consultations do not start on time, patients become concerned about running late, especially if they have another meeting or need to pick up their children. Starting case presentations on time not only shows respect for patients, but keeps them from feeling rushed. Hurrying through case presentations is viewed negatively and decreases the level of case acceptance. If you conduct a “spontaneous” unscheduled case presentation, keep in mind that the patient may not have the extra time to adequately digest what you have to say. In that case, try to *end* on time.
- **Allow no interruptions.** Stick to this rule except in the case of true emergencies. Momentum builds as the case presentation progresses. Any interruption will cause that momentum to grind to a halt. If patient motivation has been built, it will be lost if interruptions occur.



Clinical details do not typically win over patients—benefits do.

Patients will always want to know what the procedure will do for them.

- **Be prepared for questions and objections.** If a patient is going to spend time and money on recommended treatment, he or she will understandably want to know more about it. Questions and objections should be anticipated, calmly answered, and thoroughly explained to help the patient become comfortable. This isn't too difficult a task, as many patients will have similar questions.
- **Use powerful scripting.** A weak or inarticulate response to a patient's question will often derail a case presentation. Effective scripts allow both the dentist and the team to provide consistent and effective answers to the most common inquiries.
- **Educate the patient.** A patient may know little or nothing about the proposed treatment. Anxiety is usually about the unknown. Offer a clear, concise explanation of what is involved.
- **Emphasize benefits.** Clinical details do not typically win over patients—benefits do. Patients will always want to know what the procedure will do for them. Remember that saying "yes" to treatment is largely an emotional decision, particularly in elective treatment cases.
- **Use targeted support materials.** Educational materials, such as brochures and before-and-after photo albums, should be available to reinforce services discussed with the dental hygienist and/or the doctor. In addition to being educational, this material should "speak" to the target audience in mind. For example, a cosmetic brochure should prominently feature beautiful smiles on attractive people.
- **Present financial options.** Many cases are lost during the discussion of fees and payment methods. Offices that understand how to guide patients through several financial options, such as outside financing, have a much higher case acceptance rate than others.
- **Always follow up.** Any patient who has been presented a case and does not schedule for treatment should receive a follow-up phone call from the front desk staff the next morning. Many patients are extremely interested in having treatment and just need a slight prompt to schedule. By having a front desk staff member call the next morning, you have a much greater opportunity of getting patients to follow through with treatment. This phone call should be scripted to ensure effective communication.
- **Reschedule when necessary at no charge.** It is always best to meet with patients when they are already in the office during an exam. However, if the doctor does not have time to fully discuss a potential case at that time, the patient should be rescheduled for a consultation at no charge. The patient should have a 20- or 30-minute uninterrupted appointment to meet with the doctor and discuss the potential case. If these appointments are handled correctly, most patients will accept treatment, and practice production will increase.

The Goal—Trust

All of the preceding guidelines must serve one goal—gaining patient trust. Without trust, case acceptance is unlikely. Many dentists believe that all of their patients have high levels of trust for the doctor and the practice. Unfortunately, that trust is conditional. Patients may find it easy to be confident in the restoration of a broken or decayed tooth, but that confidence does not necessarily extend to a larger case or elective treatment.

Keep in mind that patients have a specific vision of dentists. Many patients think of dentists as taking care of basic dental needs. They often do not realize their dentist is fully capable of providing more complex or more comprehensive treatment, as well. Since elective procedures still constitute only a small percentage of practice production, patients

continue to view dentistry mainly as a need-based activity. Consequently, dentists must develop different styles of case presentation for elective treatment.

One recommendation is to schedule consultations during specific times of the day. View scheduling as a system where consultations are placed in the mid-afternoon, after most of the high-level treatment has already been completed for the day. This allows the doctor to focus completely on the patient in an atmosphere relaxed enough to spend the necessary time for presenting the case, answering questions, and working through objections.

Conclusion

Effective case presentation is critical to practice success. Even if all other systems are in place and operating efficiently, failure to master case presentation skills will hinder practice growth.

By following guidelines for case presentation, such as focusing on education, emphasizing benefits, presenting financial options, and always following up, dentists are far more likely to gain the trust of their patients, which can lead to greater practice success. ■

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Dr. Perlman is global clinical director of Special Olympics, Special Smiles, and clinical professor of pediatric dentistry at the Boston University Henry M. Goldman School of Dental Medicine.

Introduction

“Starting on Jan. 1, (2011), our 79-million-strong baby boomer generation will be turning 65 at the rate of one elderly every eight seconds.”¹

By 2030, one in five residents of this country will be 65 years of age or more, and in six states, one in four residents will reach this milestone: Florida (the highest, at 27 percent), Maine, Montana, New Mexico, North Dakota, and Wyoming.² These predictions regarding the aging “baby boomer” population have appeared repeatedly in the media as government agencies have sought to prepare for the eventual massive consequences for the health and services industries, national and individual family economics, and the need for a seemingly endless array of private and public programs.

“Elderly to double to 14 percent of global population by 2040.”³

“[U.S.] Census Bureau reports world’s older population projected to triple by 2050.”⁴

Unfortunately, using all-inclusive “mega numbers and proportions” in the listing of the prospects for 20 percent of the population makes these estimates become “just numbers” and not actual people. We need to personalize these numbers if we are to bring increased attention to the health and social needs of these individuals. The use of available Census Bureau data at the state and county levels provides an increased meaningful picture at a more local level during the period when the 65-and-older population of Massachusetts will increase from 13.7 percent to 20.9 percent of the state’s population (growing from an estimated 908,000 seniors in 2010 to nearly 1.5 million seniors in 2030, an increase of 63.7 percent).^{2,5}

(Author’s Note: Specific information from the 2010 Census on senior residents at the state and county levels may not be available for a period of time.)

Numbers and Percentages

In 2008, there were more than 870,000 residents aged 65 and over in Massachusetts (13.4 percent of the state population, compared to 12.8 percent nationally), including 10,000 or more elderly in 12 of the state's 14 counties. (Note: Detailed demographic data regarding the senior population are not available from the Census Bureau at the county level.) While there were lesser numbers of elderly in counties with smaller total population, numerically there were more than:

- 50,000 elderly in Barnstable County
- 60,000 elderly in Hampden and Plymouth Counties
- 70,000 elderly in Bristol and Suffolk Counties
- 90,000 elderly in Norfolk and Worcester Counties
- 100,000 elderly in Essex County
- 191,000 in Middlesex County

Proportionally, older residents ranged from:

- 24 percent in Barnstable County
- 20 percent in Hampden County
- 18 percent in Berkshire County
- 10 percent in Nantucket and Suffolk Counties, and
- 12–15 percent in the remaining nine counties (see Table 1)

Comparing the 2000 and 2008 Census estimates, the number of individuals in Massachusetts aged 65 years and older increased by 1.1 percent, compared to 10.8 percent nationally. However, while the number of elderly aged 65–84 years in Massachusetts actually decreased, there was a 21 percent increase in the number who were 85 years and older. (See Table 2.) The increasing number of those considered “very” elderly in the state and throughout the nation portends the potential for even greater increased supportive services and financial expenditures.

Minority Populations

The U.S. Census Bureau only reports the minority population proportions at county and age levels for the 10-year decennial census. Estimates for the number of elderly minority in 2008 for each county were developed by assuming that the proportion of minority elderly in each county was comparable to the reported proportion of minorities in the total county population.

Table 1. U.S. and Massachusetts Counties 65-Years-and-Older Population by Selected Characteristics: 2000, 2008, 2009⁶⁻⁸

| | Number (in thousands) | Percent of total population (2008) | Percent in poverty (2000) |
|----------------------|--------------------------|--|---------------------------------|
| United States | 38,870 | 12.8% | 14.0%* |
| Massachusetts | 871 | 13.4% | 11.0%* |
| Counties: | | | |
| Barnstable | 53 | 24.0% | 5.0% |
| Berkshire | 27 | 18.2% | 7.2% |
| Bristol | 75 | 13.7% | 12.0% |
| Dukes | 2 | 15.2% | 5.3% |
| Essex | 101 | 13.7% | 8.9% |
| Franklin | 10 | 14.3% | 8.8% |
| Hampden | 64 | 19.9% | 9.6% |
| Hampshire | 19 | 12.5% | 6.7% |
| Middlesex | 191 | 12.9% | 7.1% |
| Nantucket | 1 | 10.3% | 7.1% |
| Norfolk | 92 | 13.9% | 5.7% |
| Plymouth | 63 | 12.7% | 7.9% |
| Suffolk | 78 | 10.7% | 17.0% |
| Worcester | 97 | 12.3% | 9.5% |

Note: Includes only noninstitutionalized individuals

Numbers have been rounded

*2009 data

Table 2. The Change in Number and Proportion of the Elderly Population in the United States and Massachusetts Between 2000 and 2008⁹

| Age | Number (in thousands) | | Change | |
|----------------------|--------------------------|--------|--------|---------|
| | 2000 | 2008 | Number | Percent |
| United States | | | | |
| 65–84 | 30,791 | 33,148 | 2,357 | 7.7% |
| 85-plus | 4,286 | 5,722 | 1,436 | 33.5% |
| 65-plus | 35,077 | 38,870 | 3,793 | 10.8% |
| Massachusetts | | | | |
| 65–84 | 743 | 728 | -15 | -2.0% |
| 85-plus | 118 | 143 | 25 | 21.2% |
| 65-plus | 861 | 871 | 10 | 1.1% |

Note: Numbers have been rounded

Based upon this assumption, in 2008:

- The proportion of the minority elderly population ranged from approximately 5 percent in Barnstable and Franklin Counties to 21 percent in Hampden County and 42 percent in Suffolk County.
- The number of minority elderly ranged as high as 32,000 in Middlesex County and 33,000 in Suffolk County. (See Table 3.)

In 2008, 82.7 percent of the Massachusetts population was reported as white, 6.1 percent as black, 4.8 percent as Asian, and 8.3 percent as Hispanic (may be of any race). These data are for those individuals who reported a single race.¹⁰

Elderly with Disabilities

Nationally, 18.1 million senior residents (52 percent) have a disability. Of this number, 12.9 million (37 percent) have

Table 3. Estimated 65-Years-and-Older Minority Population by Massachusetts Counties: 2008¹⁰

| | Percent of 65-plus population | Number (in thousands) |
|----------------------|-------------------------------|-----------------------|
| Massachusetts | 17.3% | 151 |
| Counties: | | |
| Barnstable | 5.6% | 3 |
| Berkshire | 6.3% | 2 |
| Bristol | 9.8% | 7 |
| Dukes | 9.3% | <1 |
| Essex | 17.8% | 17 |
| Franklin | 5.3% | <1 |
| Hampden | 20.8% | 13 |
| Hampshire | 9.9% | 18 |
| Middlesex | 17.1% | 32 |
| Nantucket | 12.2% | <1 |
| Norfolk | 15.1% | 13 |
| Plymouth | 12.9% | 12 |
| Suffolk | 42.2% | 33 |
| Worcester | 11.0% | 11 |

Note: Numbers have been rounded

Table 4. Massachusetts 65-Years-and-Older Residents with a Disability by County: 2008¹¹

| | Percent of 65-plus population | Number (in thousands) |
|----------------------|-------------------------------|-----------------------|
| Massachusetts | 34.7% | 282 |
| Counties: | | |
| Barnstable | 28.4% | 28 |
| Berkshire | 36.0% | 8 |
| Bristol | 38.8% | 27 |
| Dukes | NA* | NA |
| Essex | 33.1% | 31 |
| Franklin | 36.6% | 4 |
| Hampden | 41.8% | 25 |
| Hampshire | 30.2% | 6 |
| Middlesex | 33.2% | 60 |
| Nantucket | NA | NA |
| Norfolk | 30.6% | 27 |
| Plymouth | 30.1% | 17 |
| Suffolk | 42.8% | 31 |
| Worcester | 36.0% | 32 |

Note: Includes only noninstitutionalized individuals

Numbers have been rounded

* In an effort to protect privacy, the Census Bureau does not report numbers below a set threshold

a severe disability, and 5.5 million (15.6 percent) need assistance with daily living. Senior females (56.5 percent) were more likely to be disabled than senior men (45.4 percent), related, to a degree, to

the longer life span of females. Among the noninstitutionalized population, 14.2 million seniors (38 percent) have a disability.⁶

In Massachusetts, more than one-

third of the elderly (34.7 percent) have a disability (282,000 individuals). The proportion of elderly with a disability ranges from 28 percent in Barnstable County to approximately 42 percent in Hampden and Suffolk Counties. Numerically, the number of elderly with a disability ranges as high as 60,000 in Middlesex County. (See Table 4.)

Poverty

In 2009, 14 percent of the U.S. elderly population and 11 percent of the Massachusetts elderly population lived in poverty. (Note: The U.S. Census Bureau reports county-level poverty data for senior residents for the 10-year decennial census.) In 2000, in the Massachusetts counties, the proportion of elderly in poverty ranged as high as 12 percent in Bristol County and 17 percent in Suffolk County. (See Table 1.)

Health Concerns

“... [M]ore than 10,000 people per day, or more than four million per year, for the next 19 years fac[e] an increased risk of Alzheimer’s.”¹

The average life expectancy is 75 years for a U.S. newborn male and 80 years for a female. As a consequence of the general health of individuals who have reached the older ages, however, the average life expectancy of a 65-year-old male and female is 82 years and 85 years, respectively.^{12,13}

The fact is that any planning for the services of the elderly must take into consideration the reality of the potential long-term needs of this population. For example, the Census Bureau projects that by 2030, there will be more than 3 million 90-plus-year-olds in the United States.¹⁴

In terms of addressing the care of the elderly, several factors must be taken into consideration, including health factors, the use of health services, and morbidity rates.

General health concerns:

- One-quarter of noninstitutionalized elderly are in fair or poor health.
- Two-thirds of elderly men and more than 70 percent of elderly women have hypertension.
- One-third or more of elderly men and women are obese.

- Almost one-quarter of noninstitutionalized elderly have been diagnosed with diabetes.
- Almost 10 percent of the elderly currently smoke cigarettes.

The use of health services:

- More than a quarter of a billion ambulatory care visits are made by the elderly to physician offices, hospitals, and outpatient departments.
- There are more than 1.3 million elderly nursing home residents.
- Approximately 58 percent of the elderly reported a dental visit in the past year.

Mortality:

- The leading causes of death of the elderly are heart disease, cancer, and stroke.¹³

Who Will Pay the Costs of Health Care for the Elderly?

Dependency ratios are an indicator of the potential burden on those in the working-age population.

$$\text{Old-age dependency} = \frac{\text{Population aged 65 years and over}}{\text{Population aged 20-64 years}} \times 100$$

Between 2010 and 2030, the old-age dependency ratio will increase rapidly as the population of baby boomers moves into the 65-years-and-over category. The realities are:

- Greater numbers of older individuals will be dependent on smaller numbers of working-age persons to provide the financial support for health care services.
- The smaller working-age population will need to continue its support for youngsters under 20 years of age.¹⁵

As to actual costs of health care, in 2006 the average annual expenditure for the major components of health care among Medicare enrollees increased with age, from \$11,300 for the 65–74 age group to \$23,700 for the 85-years-and-older population.¹⁶ Elderly persons in better health have a longer life expectancy than those in poorer health but have similar cumulative health care expenditures until death. A person with no functional limitation at 70 years of age has a life expectancy of 14.3 years and expected

cumulative health care expenditures of about \$136,000 (in 1998 dollars). A person with a limitation in at least one activity of daily living has a life expectancy of 11.6 years and expected cumulative expenditures of about \$145,000. Persons who are institutionalized at the age of 70 have cumulative expenditures that are much higher than those for persons who are not institutionalized.¹⁷

Conclusion

The use of “mega numbers and proportions” is important to provide a general perspective, but more local and individual impact considerations afford a personal understanding for health care providers and the general public to derive an appreciation of the developing realities when one in five residents of this country will reach the milestones of older age.

As to the particular perspective of the dental practitioner, given the continuing decrease in edentulous rates,¹⁸ the average elderly patient (with the anticipation of a potential increase in life expectancy) is expanding the use of dental services. In 2008, Massachusetts ranked 25th, with 18.3 percent of the elderly reported to be edentulous. Hawaii was ranked first with a 9.8 percent rate, and West Virginia was ranked 50th with a 37.8 percent rate of edentulism. Nationally, the rate of edentulism for the elderly was 18.5 percent.¹⁹

The need exists to comprehend the physical, psychological, economic, and family conditions, along with the seemingly endless array of related factors that affect older patients. But the reality is that despite the many changes individuals face as they age, the limited availability of dental insurance, and economic difficulties, elderly patients increasingly are reporting the use of dental services. The question remains, is your practice prepared for the increasing numbers of elderly coming to your neighborhood? ■

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Ten Under 10

Since 2005, the JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY, in conjunction with the MDS Standing Committee on the New Dentist, has been shining a spotlight on the “Ten Under 10”—10 MDS member dentists who have been in the profession for 10 years or less. On the following pages, you will meet the 2011 Ten Under 10 honorees and learn more about their thoughts on organized dentistry, the challenges they faced when they first left dental school—and continue to face today—and the ability to maintain a work-life balance, among other topics.

To qualify for selection for the Ten Under 10, dentists must have graduated from dental school in the past 10 years, be current MDS members, and have made a significant contribution to the profession, their community, or organized dentistry—or all of the above. A call for nominations was sent to MDS member dentists in the fall and solicited on the MDS website and *Membership Matters* newsletter. Nominations were reviewed and final selections were chosen by the MDS Standing Committee on the New Dentist in December.

Congratulations to the 2011 Ten Under 10—the future of organized dentistry.

Viviana Avila-Gnau, DDS



Current Residence: Medford
Hometown: Bogotá, Colombia
Office Location: Tufts University School of Dental Medicine
Specialty: General Dentistry
Dental Education: Pontificia Universidad Javeriana, Bogotá, Colombia (DDS); Loma Linda University (DDS); American Academy of General Dentistry (Pre-Fellow)

What do you like about being a dentist?

First of all, I love the satisfaction of interacting with patients, helping them to overcome their fear of dentistry, and seeing them become more relaxed and more motivated about their treatment as they get to know me and trust me. The appreciation they show in return is priceless and can make any day—no matter how hard—feel worth it.

At the same time, it's satisfying to know that by helping them to better understand their dental health and to overcome their apprehensions about going to the dentist, you make it more likely that they will take better care of their teeth at home and continue with regular dental checkups in the future.

Another aspect of dentistry that I really enjoy is teaching. It has been very rewarding working with dental students to help them integrate their classroom knowledge and put all of their dental theory into practice—from patient management to diagnosis to treatment planning. It's great to see students progress from their first hesitant days in the clinic to the point where they are confident and eager to graduate so they can practice on their own.

What's the biggest challenge you've faced in your career thus far?

Getting my dental license in the United States was a very challenging process. I'm certainly glad that I did it, but it was a huge commitment. I had already completed five years of dental school and one year of government-mandated social service in Colombia in order to get my license there. To practice in the United States, however, requires at least two additional years of dental school here.

The subject matter itself was the same as I had learned in Colombia, so that wasn't the problem. The hard part was the process, which started with English classes before anything else. I then moved on to studying—by myself—for Parts I and II of the national boards. Foreign-trained dentists seeking licensure in the United States need high scores on these exams—without the benefit of the exam preparation provided in dental schools here—just to be considered for admission to a program. There are not that many dental schools that offer licensure programs for foreign-trained dentists, and the ones that do have a very limited number of spots.

This process really tests your perseverance, but I was motivated by my passion for the profession. Though I could have pursued many other career options requiring far less time, effort, and financial resources, I really couldn't see myself doing anything but dentistry.

Shortly after you moved to Massachusetts, you became active in the MDS. What made you decide to get involved?

I believe that the local dental societies are the center of action

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Carolyn Coppe, DMD



Current Residence: Charlestown
Hometown: Lexington
Office Locations: Lexington and Boston
Specialty: Pediatric Dentistry
Dental Education: Harvard School of Dental Medicine (DMD) and University of California, San Francisco (Pediatric Residency)

What do you like about being a dentist?

For me, it's the children. I feel fortunate that my profession allows me to help children. Children are truly amazing and almost always surprising. I recently treated a young girl, and after administering local anesthesia, she refused to cooperate and left the office. Twenty minutes later, she returned and said she wanted to try. She was able to complete her appointment and left the office happy and very proud of herself. It was so rewarding for me to know that I helped her realize she could do it. I am looking forward to the lifelong relationship that I am creating with her. My father and I have patients coming to our office whose parents came to the office when they were children, and I am hoping that I can carry on this tradition.

What's the biggest challenge you've faced in your career thus far?

Starting my career here in Boston while my husband finished up his oral and maxillofacial surgery residency program at the University of California, San Francisco (UCSF) was the biggest challenge. I spent two years traveling back to San Francisco monthly. While there, I was also teaching at UCSF's Pediatric Dental Residency Program. It was exhausting, but well worth it.

As a pediatric dentist, what are your thoughts on access to care for children?

It needs improvement. There are still too many children in the United States who don't have access to dental care. It is not isolated to rural areas, but rather is a national crisis that 54 percent of school-age children have some form of dental disease.

Do you volunteer with any other organizations, either related to dentistry or not?

I am on the board of the UCSF Pediatric Dentistry Alumni Group. I also work with Great Shape Jamaica, through which I have traveled to Jamaica to provide dental care for island children. I am also currently involved in establishing a sealant program for Jamaica.

How do you balance your personal and professional lives?

With a five-month-old infant, the balancing has been evolving. One of the nice things about pediatric dentistry is that it is easy for my baby to stop by the office for a visit, and he always brings a smile to my face and to everyone else's in the office, as well. My husband is an oral and maxillofacial surgeon at Massachusetts General Hospital, so with both of our busy schedules, it can be tough. We just make the most of the free time we have. ■

Mark Doherty Jr., DMD



Current Residence: Taunton
Hometown: Lakeville
Office Locations: New Bedford, Swansea,
and Raynham
Specialty: Endodontics
Dental Education: University of Pennsylvania
School of Dental Medicine and Boston University
Henry M. Goldman School of Dental Medicine

What do you like about being a dentist?

There are several things I like about dentistry. In my family, I am carrying on a tradition that gives me a great sense of pride. My great-great-grandfather (Martin Conroy) was a dentist in Ireland and my great-grandfather (James Conroy Sr.) was one of the first dentists in the Taunton area. My great uncle (James Conroy Jr.), father (Mark Doherty Sr.), and cousin (William Conroy) are also dentists. In addition, I love interacting with patients, diagnosing disease, and eradicating oral infection and pain.

What's the biggest challenge you've faced in your career thus far?

As with most new practitioners, the biggest challenge for me was becoming efficient. It, of course, took time, but with practice and good mentoring, it eventually clicked.

You're an associate in an endodontic practice, but you also devote a good amount of your time to serving patients at the Taunton Oral Health Center (TOHC). What inspired you to decide to split your practice time this way?

At Southcoast Endodontics, I am scheduled to work four days a week. I love what I do and really wanted to work more.

After about a year of working in private practice, my father asked me if I would like to work for him at the TOHC one to two days a week. He explained to me that there was a huge demand for endodontics for the uninsured, underinsured, and children under 21 who were from the Department of Youth Services detention centers and the Department of Social Services. As I began working on these kids, I thought to myself, "What could be worse than being in a detention center with a toothache?" I felt bad for these kids because they were not getting the treatment they needed, and I felt like it was my duty to do it. I clicked with the majority of these kids from the start. They were my inspiration.

How is your approach different in treating patients at your private practice versus the health center?

There really is no difference between treating the two. The way I view it is, people are people and we all have different personalities. Some of the kids who come to the TOHC have had some tough times, and consequently, may put up more of a front and be more outspoken. However, if you recognize what they have gone through and figure out how to connect with them, barriers can be broken and treatment can go smoothly.

When you're not working, what do you do with your free time?

I like to work hard, but I like to play even harder. With my free time, I like to travel with my beautiful wife and three children. I am also very committed to martial arts, working out, snowmobiling in Maine, and sportfishing. ■

Yael Frydman, DMD



Current Residence: Boston
Hometown: Buenos Aires, Argentina
Office Locations: Boston and Brookline
Specialty: Orthodontics
Dental Education: Universidad de Buenos Aires (DMD); Universidad Maimonides (orthodontics); Boston University Henry M. Goldman School of Dental Medicine (DMD)

What do you like about being a dentist?

I love the fact that we are in the business of helping people improve their quality of life. It's so exciting being able to enrich people's lives by improving their smile. The most fulfilling moments are when the braces come off and patients see their beautiful white, wireless smile for the first time. The cases that I enjoy the most are those that require a multidisciplinary team approach. Although more difficult and time-consuming, being able to interact with talented colleagues, planning together the best approach possible for a patient's rehabilitation, and contributing to the success of a complex case fascinates me and is very satisfying.

What's the biggest challenge you've faced in your career thus far?

Aside from having to go back to doing dentures and root canals for my DMD homologation after moving to the United States—I thought I'd never have to do those again!—I would have to say finding the great teams I work with. There's very good dentistry everywhere, but a great team of multidisciplinary dentistry, unfortunately, isn't as readily available. Communication and knowing the limitations of the treatment we can provide as solo practitioners are key. Joining our efforts makes treatment so

superior in final results, and the journey much more fun. The colleagues I work with share my treatment philosophy and point of view, we trust each other's abilities and perspectives, and the fact that we are all under the same roof makes this approach much easier for the patient. Within an hour, patients are seen by the restorative dentist, and consults take place with the endodontist, periodontist, and/or orthodontist when needed, records are taken, and by the next visit, a comprehensive treatment plan is ready.

You serve on the MDS Council on Membership. What do you feel is the biggest barrier to getting new dentists to join the Society?

I believe the biggest barrier is indifference. Everybody is so immersed in their own routine that it is hard to take the time to participate and get involved. We are working really hard to get all new members' interests tickled so they want to come back. Also, a huge number of dentists really don't know what we do and how important organized dentistry is for the present and future of our profession.

In addition to practicing orthodontics, you are a clinical assistant professor and course director for predoctoral orthodontics at the Boston University Henry M. Goldman School of Dental Medicine. How do you balance your time between the two?

That's the fun part! My job is never the same. Luckily, I haven't yet driven to the wrong practice; maybe when that day comes,

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David M. Kim, DDS



Current Residence: Cambridge
Hometown: Seoul, South Korea
Office Location: Boston
Specialty: Periodontics
Dental Education: University of Maryland Dental School (DDS); Harvard School of Dental Medicine (DMSc, Certificate in Periodontics)

What do you like about being a dentist?

Dentistry has always been an appealing specialty to me because, by working closely with our patients, we are enabled to help control their problems, dramatically improve their overall oral and systemic health, and improve their quality of life. In addition, dentistry requires attention to detail, patience, and precision in technical skills and a thorough knowledge of the literature. Thus, being a dentist means becoming a lifelong learner. The concept of periodontal therapy being the foundation for a successful clinical outcome was a strong motivator for me to become a specialist. In addition, there are numerous ongoing research projects for the development of new periodontal therapies and improvement of our classical techniques that triggered my interest to pursue research in oral biology.

As a dentist, it is very easy to find an opportunity to serve people with need in underdeveloped countries. I had the privilege of being involved with a number of short-term dental mission trips to countries such as Albania, the Dominican Republic, Ukraine, and Nicaragua. This past March, I organized a dental mission trip to Colombia with our dental students to provide much-needed dental care. We worked with the Christian missionaries to serve the homeless and street children.

What's the biggest challenge you've faced in your career thus far?

Successfully balancing my responsibilities and accomplishing my goals of teaching, private patient care, and research has been most challenging, but at the same time extremely rewarding. I had to learn at the outset to be very well organized in order to accomplish the myriad different tasks each day.

You are assistant professor and director of the predoctoral periodontics program at the Harvard School of Dental Medicine (HSDM). What made you decide to pursue a career in dental education?

I appreciate the importance of providing students with excellence in dental education, as my passion in teaching and research comes from my mentors—Drs. Joseph Fiorellini, Howard Howell, Nadeem Karimbux, Paul Levi Jr., and Myron Nevins—who have influenced my teaching, learning, and research. I am very fortunate to work very closely with them, and our relationships have grown deep as they guide my career path and motivate me to become an excellent educator. In addition, my father was a full-time educator for nearly 40 years and chair of the Biomaterials Department at the Seoul National University Dental School. I appreciated how much he was in love with the work that he was doing because, as he said to me, he was “planting a seed in the young students for their future careers.”

You're the recipient of the Outstanding Teaching and Mentoring Award from the American Academy of Periodontology and the Distinguished Junior Faculty

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Seth Latimer, DDS, MS



Current Residence: Boston
Hometown: Barnstable
Office Location: Hyannis
Specialty: Pediatric Dentistry
Dental Education: Loma Linda University (DDS, MS in pediatric dentistry)

What do you like about being a dentist?

I enjoy the opportunity to help a wide variety of patients with their oral health needs, including patients with special needs.

What's the biggest challenge you've faced in your career thus far?

The biggest challenge in my career has been finding time to serve my patient population while still making time to keep up with current advances in medicine and dentistry, through reading *Pediatric Dentistry*, the journal of the American Academy of Pediatric Dentistry, among others.

You've served on the MDS-PAC/MDS People's Committee since 2009. How can the MDS-PAC improve the lives of dentists?

The MDS-PAC/MDS People's Committee serves as a vehicle for dentists to have an ongoing voice in determining how legislation on a statewide level affects the dental profession. The top priority for this year's legislative cycle is stopping dental insurance companies from telling dentists what they can charge for procedures that the insurance company does not cover. It is also important to note that a portion of every member's donation to the MDS-PAC helps to further dentist- and patient-friendly legislation on a national level.

Shortly after graduating from dental school and starting your career, you became involved in the MDS. What would you say to get other new dentists involved in organized dentistry?

The opportunity to work with a variety of dentists who are volunteering their time to help advance the dental profession is a very rewarding experience. As a new dentist who graduated from dental school and moved to a new part of the country, involving myself with the MDS was also a great way to meet my colleagues here in Massachusetts.

Do you volunteer with any other organizations, either related to dentistry or not?

I guest lecture for the dental hygiene program at Cape Cod Community College and am serving as assistant treasurer for the Cape Cod District Dental Society.

How do you balance your personal and professional lives?

Maintaining a balance between my personal and professional lives can prove to be a particularly difficult feat, factoring in the long hours and stressful responsibilities. I do make time in my weekly schedule to hit the gym to help relieve stress and maintain a healthy mental attitude. I also focus on the importance of maintaining a healthy social life. In doing so, this translates to personal and professional fulfillment. ■

Romesh Priyanthan Nalliah, DDS



Current Residence: Boston
Hometown: Adelaide, Australia
Office Location: Boston
Specialty: General Dentistry
Dental Education: University of Adelaide,
South Australia

What do you like about being a dentist?

As dentists, we have the opportunity to meet people from all walks of life. This experience has taught me how similar all human beings are. Whether they are Harvard professors or rural-dwelling Aboriginal Australians, they all laugh at the same things and fear the same things.

What's the biggest challenge you've faced in your career thus far?

That would be giving up a lucrative career in private practice to follow my interests in research and education. Following my heart was the hardest, and best, decision I ever made.

You managed a community outreach program in rural Australia treating underserved children. What, if any, parallels can you draw between access-to-care issues in Australia and the United States?

Although the burden of dental disease may be falling in both countries, the prevalence is increasing in small pockets of the population. This is true of both Australia and the United States.

Your focus has been on public health dentistry. How do you plan to pursue that in the United States?

In Australia, access to care for low-income groups is quite satisfactory due to federal government initiatives. In Australia, I went out to rural regions to help those who couldn't

get access to care. Here, I just have to walk 15 minutes south of my office on Longwood Avenue to Roxbury to find those who cannot access dental care. I feel that the challenges are greater here, and there is more work to be done to achieve equality.

As a dental educator, how do you think more dental students can be encouraged to pursue academic careers?

I encourage students to find out what they are passionate about. I've learned from a mistake I made early in my career: I followed the popular choice of private practice rather than searching my heart to find what would make me happy. One thing I am proud to say about the Harvard School of Dental Medicine is that we teach our students that dentistry is a broad field. It is our responsibility to keep showing our students what a wide range of career choices they can make after graduating from dental school.

You are a participant in the 2009–2011 MDS Leadership Institute Program. What drew you to the program and what have you learned from it?

When I applied for the Leadership Institute, I was a new faculty member with limited experience in leadership. My role at Harvard called for managing all clinical and academic progress for one-quarter of the predoctoral students, and I needed to develop as a leader. I gained much more than leadership skills from participating in the program. I have met extraordinary people with whom I have had clinical, educational, and community service collaborations. I have also had the opportunity to work with special needs organizations, the MDS, and the talented individuals in the Leadership Institute. This has been a rich learning experience for me. ■

Jared Reid, DMD



Current Residence: Northampton
Hometown: South Deerfield
Office Location: South Deerfield
Specialty: General Dentistry
Dental Education: Boston University Henry M.
Goldman School of Dental Medicine (DMD);
U.S. Navy (AEGD)

What do you like about being a dentist?

One of the keys to happiness is enjoying your job, and I wake up every morning thrilled to get to practice dentistry. I enjoy the artistry that dentistry requires. However, the benefits of the job go beyond the workday. I prize being a part of a close-knit professional community here in western Massachusetts. In addition, I appreciate the balance of practicing dentistry: having the time to hone my craft without giving up quality time with my family.

What's the biggest challenge you've faced in your career thus far?

Transitioning from dentistry in the Navy to a private practice in western Massachusetts was trickier than I expected. As a naval dentist, all I had to concentrate on was dentistry. Now, that's only one part of my job. I have to think like a small business owner, in addition to continually strengthening my dental skills. Bridges and crowns are the easy part; a lot of my time is now spent thinking about overhead, treatment plan acceptance, and staffing, just to name a few things.

How did your experience in the U.S. Navy affect how you practice dentistry?

The experience in the Navy provided me with continued education, confidence, and a patient base to practice a multitude of various procedures, both common and unique. To be able to focus on the practice of dentistry without any other responsibilities for those three years beyond dental school was tremendously helpful for my development as a skilled dentist.

Do you volunteer with any other organizations, either related to dentistry or not?

This year, I have had the privilege of serving as the president of the Hampshire Dental Society, a local study club. I have been involved with the local MDS district and volunteered as a room coordinator and presiding chair at the Yankee Dental Congress. I have spoken to preschool children about the importance of oral health, as well as voluntarily fashioned custom mouthguards for local high school sports teams.

You practice with your father, Dr. James Reid. What is it like working with family?

My father and I have a wonderful working relationship, in large part because we have so much in common. Not only are our philosophies in both dentistry and life similar, but veteran patients even compare my appearance to that of my father in the early years of his practice. It's also been hugely helpful to work alongside a resource like my dad—he is a constant source of wise advice. Having a trusted, caring partner with 40 years of experience is invaluable to me as a young dentist. ■

Anubha K. Sacheti, DMD



Current Residence: Cambridge
Hometown: Glastonbury, Connecticut
Office Locations: Waltham and Auburn
Specialty: Pediatric Dentistry
Dental Education: Harvard School of Dental Medicine (DMD, GPR); Boston University Henry M. Goldman School of Dental Medicine (Pediatric Dentistry Program)

What do you like about being a dentist?

I love working with children and educating their parents about good oral health practices. I also love sitting on the state's oral health consortium, which allows me to interact with all of the different players in providing oral health for children.

What's the biggest challenge you've faced in your career thus far?

It's definitely mixing pediatric dentistry with pregnancy and motherhood. I have almost stopped using nitrous oxide, avoided induction during my general anesthesia cases, and have dodged many X-rays during my second pregnancy. But I think being a parent makes me a much better pediatric dentist. I have a greater understanding of the challenges that my patients' parents face. I have learned many tricks to convince my 2½-year-old daughter to brush her teeth. We first start with "the driveway" (aka her tongue) and then proceed to her "upstairs teeth" and then her "downstairs teeth."

As Massachusetts state leader for the Head Start Dental Home Initiative project, what do you think is the number one barrier to access to care for children in the state?

Finding enough dentists to provide age 1 dental exams, which are required for Early Head Start children in Massachusetts. Most dentists begin seeing children at age 3, but the American Academy of Pediatric Dentistry and the American Academy of Pediatrics call for an age 1 dental visit. So we need a paradigm shift where dentists are comfortable seeing young patients. Earlier visits will allow for earlier education and hopefully prevent future decay.

Besides programs for children, do you volunteer with any other organizations, either related to dentistry or not?

I volunteer at my daughter's cooperative preschool as a parent helper. I also enjoy speaking at homeless shelters, where I can teach better oral health practices to adults and their children.

With a young child, how do you balance your personal and professional lives?

I work part-time! Both my hospital case schedule and my Head Start schedule are flexible. My husband travels a great deal for work, so we have instituted date night every other week. Nonetheless, making sure our schedules match and that we have good child care is a constant challenge. ■

Frank Schiano, DMD, CAGS



Current Residence: Brookline
Hometown: Monroe, NY
Office Location: Boston
Specialty: General Dentistry
Dental Education: Boston University Henry M. Goldman School of Dental Medicine (DMD and AEGD)

What do you like about being a dentist?

Where do I begin to answer this question? The old cliché "I like helping people and working with my hands" is, of course, true. But being a dentist goes far beyond that. I enjoy the education, hard work, and personal and professional relationships with patients, their families, and other colleagues. I enjoy freedom—and by freedom, I mean opportunity. As a dentist, there are so many career options to choose from, such as dental education, community and public health, private practice, etc. Being a dentist also allows me the opportunity to constantly pursue excellence in other aspects of my life, not just within the profession. It teaches me honesty, compassion, respect, dedication, and commitment.

What's the biggest challenge you've faced in your career thus far?

The biggest challenge I have had to face in my career thus far has to be capturing the centric relation record on a Somali immigrant during an intermaxillary records appointment for a complete upper and lower denture, over the phone using an interpreter. I can think of a few others. I look at every challenge the same way: as a learning experience and a chance to be successful. I became the dental director of the Whittier Street

Health Center while completing my AEGD at the Boston University Henry M. Goldman School of Dental Medicine. I had not yet treated a patient outside the walls of the school, and overnight I had a staff of 17 other dentists, hygienists, assistants, and office personnel to directly supervise. A lot of

responsibility and trust was placed on me. I had to "grow up" real fast and learn clinical dentistry, office management, and state and federal regulations at a pace that I did not think was possible. Understanding cultural competency as it relates to managing a diverse staff and treating patients from all over the world has been quite the learning experience. Looking back, accepting that challenge has made me the person and professional I am today.

You are the director of dentistry at the Fenway Community Health Center. Why did you decide to go into public health dentistry?

As a community health center dentist, I get to travel the world without leaving my office. I have met people from almost every ethnic, cultural, and religious background you can imagine. Perhaps one of the most significant reasons I decided to go into public health dentistry was to help educate others that public health dentistry is not just "welfare dentistry." This is an unfortunately common misconception. Every community health center and hospital has a mission. The common theme is to provide access to high-quality primary care services and promote wellness. A public health dentist plays such an enormous role in the overall health of a community by

Continued on page 28

Viviana Avila-Gnau, DDS, continued from page 23



for the profession. I really didn't know too many people involved with dentistry in Massachusetts when I moved here, so I figured the MDS would be a great place to start. After contacting them to let them know that I wanted to get involved, I got an immediate response and very helpful guidance. Since then, and as a result of my affiliation, I've met many wonderful people who work very hard for our profession, and I've been involved in numerous different dentistry-related activities and groups.

You serve on the board of the Massachusetts Hispanic Dental Association (HDA). How do you see the MDS and the HDA working together in the future?

I think we have already started laying the groundwork for what can be a great partnership between the MDS and the HDA. The HDA really values the efforts that have been made in this regard by MDS Past President Dr. David Samuels in his role as chair of the Inclusion Task Force. Additionally, the HDA is pleased to announce that its first symposium on dental careers will take place on June 24, 2011, and Dr. John Fisher, current MDS president, will be one of the event speakers. I'm confident that further efforts like this one will continue to strengthen the ties and the working relationship between the MDS and the HDA.

When you're not working, what do you do with your free time?

I believe it's important for all of us to dedicate a little time to ourselves. Personally, I like to work out; it really helps me to de-stress after a long day. And I love music and dancing—which are part of my workouts—so that keeps me happy. I also like to volunteer, which occupies a lot of my free time. What I like most of all, however, is spending time with my wonderful husband. ■

Yael Frydman, DMD, continued from page 24



I'll think about taking a really long vacation! I love what I do, and I think I've found a good balance between private practice and academia. I get to teach what I do on a daily basis, trying to get that same message across.

Do you volunteer with any other organizations, either related to dentistry or not?

I've volunteered for a few years with the Argentinean Jewish Relief Campaign, organizing events and raising funds to help fellow Argentineans during our socioeconomic crisis. I'm also trying to get more involved with Family Service of Greater Boston to improve the lives of children, youths, and their families. This organization has touched the lives of so many and continues to do so. I strongly believe in giving back, and this is a very rewarding way of doing it.

When you're not working, what do you do with your free time?

What is that? We have a soon-to-be two-year-old daughter, so now you may understand my initial reaction. I try to spend as much time as I can with my family and friends; you have to be able to find a balance between work and play to find true happiness. I love to experiment in the kitchen—it's my kind of therapy. ■

David M. Kim, DDS, continued from page 25



Award from HSDM. What do you like most about teaching dental students?

My teaching experience has shown me that dental students are serious and eager to learn. They want to be the very best, and it is my responsibility to provide them and our faculty with as many

resources as possible to stimulate dialogue and shared learning. I am always fascinated to see my students learn and develop an understanding of their subjects in what, to me, is such a short time. Furthermore, I am intellectually challenged by our students and colleagues, which allows me to continually grow.

You were recently selected as a participant in the 2010-2012 MDS Leadership Institute Program. What drew you to the program and what do you expect to get out of it?

I decided to apply for the Leadership Institute because of my desire to be involved with organized dentistry and to interact with dentists within the community. This was an opportunity to serve our community, as well as make decisions that will benefit our specialty. It is another means of expanding my education, as well as developing long-term friendships with my colleagues, which will enhance my teaching, research, and patient care. ■

Frank Schiano, DMD, CAGS, continued from page 27



treating oral disease. Thus, we are responsible for participating in the interdisciplinary health care of our patients by constantly interacting with physicians, pediatricians, psychiatrists, nurse case managers, and other professionals. It is win-win for everyone involved, but most importantly for the patients living

in our communities.

You are a participant in the 2009–2011 MDS Leadership Institute Program. What drew you to the program and what have you learned from it?

For most of my life, I have held supervisory roles and leadership positions. I have never really had the opportunity to learn about the various styles of leadership and to reflect on my own effectiveness as a leader. It may be a quality that comes naturally to some people; however, there is always room for improvement. The MDS Leadership Institute Program has helped me to mature professionally and given me the knowledge to understand how to gain the trust and respect of both superiors and supervisees. Since my participation in the program, I have gained confidence in my ability to make important decisions that may have a big impact on others, and I have learned how to work more effectively in a team setting.

You have been a volunteer at the Yankee Dental Congress, a Leadership Institute participant, and a member of the Boston Pilot Group Task Force. What would you say to get other new dentists involved in organized dentistry?

This is perhaps one of the biggest challenges we face as the future of dentistry and dental education evolves. What I would say to new dentists is that they need their voices to be heard. Without involvement in organized dentistry, our profession will not progress into the future; dentistry will not evolve. Organized dentistry keeps us together. We teach each other and learn from each other, and we help to make things better for each other and our patients. ■

American Heart Association Updates CPR Guidelines



JEFFREY TSAI

CHRISTOPHER TUNG

MORT ROSENBERG, DMD

Mr. Tsai and Mr. Tung are dental students at Tufts University School of Dental Medicine (TUSDM). Dr. Rosenberg is professor of oral and maxillofacial surgery at TUSDM and associate professor of anesthesiology at Tufts University School of Medicine.

The introduction of the updated 2010 American Heart Association (AHA) guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care (ECC) marks the 50th anniversary of CPR. These latest science-based recommendations, which are an accumulation of developments in resuscitation science since 2005, cover changes in a variety of topics, such as CPR, automated external defibrillators (AEDs), and recommendations for advanced care—advanced cardiac life support (ACLS) and pediatric advanced life support (PALS)—by health care providers.

As licensed health care professionals, dentists must remain current in basic life support—health care provider (BLS-HCP) CPR and should integrate these updated 2010 guidelines into their daily practice. Incorporation of these new guidelines will allow dentists to better prepare for emergency situations that may arise in the dental setting by chance or as a direct result of dental treatment.

The revised guidelines apply to both the layperson and the certified health care provider. While this review highlights important changes within the new 2010 guidelines, it is no substitute for proper training obtained by successfully completing an updated basic life support (BLS) course. This article is a synopsis of the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science.¹

The Change from “A-B-C” to “C-A-B”

In the previous 2005 AHA guidelines, no change was made to the “Airway, Breathing, Compressions” (A-B-C) sequence of CPR. However, the 2010 guidelines place a larger emphasis on the importance of starting chest compressions sooner, thus changing the sequence of CPR from “A-B-C” to “C-A-B” for both adult and pediatric patients. In the majority of patients undergoing cardiac arrest, early and effective chest compressions and defibrillation are the key elements to patient survival. Compressions have been shown to generate critical blood flow, oxygen, and energy delivery to the heart and brain. Because of their importance in patient survival rates, chest compressions should not be delayed. Airway and breathing are still both critical components of CPR, and they are only minimally postponed until the completion of the first cycle of chest compressions. In the old “A-B-C” sequence, chest compressions were frequently delayed while the responder opened the airway by positioning the head using the head-tilt chin-lift method, attained a seal for mouth-to-mouth rescue breathing, or retrieved barrier devices or other ventilation equipment. The “C-A-B” sequence allows the responder to begin chest compressions earlier in CPR.

Several other aspects of delivering chest compressions have also changed under the 2010 guidelines. The delivery of more compressions at a higher rate and of greater quality during CPR has been shown to improve survival rates. The revised guidelines emphasize a compression rate of at least 100 compressions per minute, a change from the previous recommendation of “approximately” 100 compressions per minute.

Additionally, chest compressions on adults should be performed to a depth of at least 2 inches, an increase in depth from the previous recommendation of 1.5 to 2 inches. For pediatric patients, the chest should be compressed to at least one-third the depth of the chest, corresponding to approximately 1.5 inches in an infant and 2 inches in a child.

Assessment of the Patient Prior to CPR Is Still Critical

While the “C-A-B” ordering is the significant change from the previous guidelines, the responder still must properly assess the patient prior to performing chest compressions. In the 2005 AHA guidelines, the responder checked for patient responsiveness, breathing, and pulse within the “A-B-C” sequence. These assessments must still be performed by the responder prior to the new “C-A-B” sequence, though at a more rapid pace to minimize delays in delivering CPR. Patient responsiveness, breathing, and pulse should now all be simultaneously assessed at the same time for less than 10 seconds in total. Detecting a pulse can be difficult, even for trained health care professionals. Thus, if the patient’s pulse is absent, or cannot be felt within this 10-second time frame, the provider should immediately begin the “C-A-B” sequence.

Assessment of breathing using the “look, listen, and feel” algorithm has been eliminated in the 2010 guidelines, as it was found to be time-consuming and often inconsistently performed. Instead, the provider must be alerted to unusual presentations of sudden cardiac arrest by assessing for patient responsiveness and the absence of “normal” breathing. Atypical presentations, such as gasping respirations, may confuse the rescuer and delay CPR.

Using clinical judgment, the provider must tailor the sequence of actions as necessary in order to properly rescue a patient. A lone health care provider who witnesses a victim suddenly collapse may assume that the emergency is due to cardiac arrest. After assessing the patient for unresponsiveness and abnormal breathing, the provider should then immediately activate the emergency response system (call for help), get and use the AED, and proceed with CPR. Contrastingly, if the patient is presumed to be a victim of drowning or asphyxiation, the rescuer should instead complete five cycles of CPR prior to activating the emergency response system.

Conclusion

Because of these numerous changes in CPR, the dentist should not wait until his or her next refresher course in order to be trained in the updated guidelines. While these new guidelines do not imply that care using past guidelines is either unsafe or ineffective, the 2010 AHA guidelines introduce new treatments and remove ineffective procedures based on the intensive evaluation of evidence and the consensus of experts since the last update.

As health care professionals who often treat compromised patients and administer drugs in a stressful environment, we may be required to provide emergency resuscitation and should thus ensure that our offices are well equipped to handle potential cases of cardiac arrest during the perioperative dental appointment. This includes properly trained staff, a source of oxygen, airway equipment that allows for positive pressure ventilation (e.g., a bag-valve-mask system), and an AED.

These updated 2010 AHA guidelines represent the continuing evolution of CPR and resuscitation science. It is the responsibility of the dentist and the dental team to learn and continually practice their applications. Our profession and the public demand this to continue to ensure patient safety. ■

Reference

1. Field JM, Hazinski MF, Sayre MR, et al. 2010 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care science. *Circulation*. 2010;122:S640-S656.

Key Changes to Basic Life Support Guidelines

- ♥ The sequence of CPR has been changed from “Airway, Breathing, Compressions” (A-B-C) to “Compressions, Airway, Breathing” (C-A-B).
- ♥ Compressions should be performed at a rate of at least 100 compressions per minute and to a depth of at least 2 inches for adults and at least one-third the depth of the chest (about 1.5 to 2 inches) for pediatric patients.
- ♥ The “look, listen, and feel” algorithm has been removed from CPR. Instead, the provider should quickly assess responsiveness, abnormal breathing, and pulse in less than 10 seconds prior to performing CPR.
- ♥ For infants less than 1 year of age, a manual defibrillator is preferred. However, if none is available, an AED with a pediatric dose attenuator can be used. If neither is available, then an AED without a dose attenuator may be used.
- ♥ Because the etiology of neonatal arrests is almost always asphyxia, the A-B-C sequence is retained for resuscitation of neonates unless there is a known cardiac etiology.
- ♥ “Compression-only CPR” is now the recommended CPR technique for the untrained individual, with an emphasis to “push hard and fast” on the center of the chest.
- ♥ More updates to the guidelines, such as for advanced cardiovascular life support in a hospital setting, include expanded emphasis on post-cardiac arrest care.

Source: Adapted from the American Heart Association 2010 CPR Updates and New 2010 ECC CPR Guidelines.

YOUR DENTAL CONNECTION

BILL DONNELLY, CONTRIBUTING WRITER

Mr. Donnelly is a freelance writer based in Watertown.

A fierce winter storm couldn't disconnect nearly 28,000 dental professionals from their peers during the annual Yankee Dental Congress (YDC) at the Boston Convention and Exhibition Center (BCEC) held January 26–30, 2011. As storm clouds gathered and a steady snow fell along the Boston Seaport, the Yankee Dental Congress convened for the 36th time, this year with “Your Dental Connection” as its official theme.

As the BCEC opened its doors Thursday morning, the lobby and Exhibit Hall floor were filled with dental professionals excited by the variety of professional, educational, and social opportunities within. After positive feedback last year, YDC once again featured the popular Live Dentistry Theater, while adding several new

programs, including the Dental Office Design Pavilion—a central source for ideas, displays, and information on designing your dental office—and the new High-Tech Playground, hosted by MDS member Dr. Paul Feuerstein. This space encouraged participants to explore new and emerging dental science devices, hardware, and technology directly and in a “hands-on” manner, without the pressure of salespeople.

In addition to the exhibition and educational activities, YDC featured plenty of fun and entertainment, as well. Each day, the second annual MDS Foundation Wall of Wines fundraiser presented wine lovers with the chance to donate \$20 and pick from a wall-sized wine rack, potentially taking home some very fine bottles at a fraction of their value. On Thursday night, the BCEC Ballroom transformed into New Orleans for

Yankee's Fat Thursday Carnival, a Mardi Gras party featuring music, drinks, face painting, prizes, and living statues, all with a “Big Easy” touch.

The Friday afternoon Beer and Wine Reception on the Exhibit Hall floor hit the spot for tired attendees, who enjoyed complimentary wine and beer, along with snacks and good company to end the day. Lastly, on Friday night, the Fab Four, a Beatles tribute performance act, took the Yankee Dental Congress on a magical mystery tour, revisiting the 1960s heyday of the “Lads from Liverpool.”

And in the end, YDC 36 may have been a long and winding road, but in keeping with the theme of “Your Dental Connection,” it certainly helped dental professionals from all over New England—and the world—come together.





VIEWPOINT

VINCENT DEANGELIS, DMD

Dr. DeAngelis has served as editor of the Northeastern Society of Orthodontics, associate clinical professor of orthodontics at Harvard School of Dental Medicine, president of the Massachusetts Society of Orthodontics, and president of the Edward H. Angle Society of Orthodontists, Eastern Component. He is a recipient of the Outstanding Teacher Award from the Harvard Society for the Advancement of Orthodontics and the Frederick Moynihan Award from the Massachusetts Association of Orthodontists, and he is a Fellow of the International College of Dentistry.

TO EXTRACT OR NOT TO EXTRACT, THAT IS THE QUESTION

Introduction

OVER A SPAN OF DECADES, THE pendulum of orthodontic treatment methodology has swung between nonextraction and extraction therapy with high frequency. The reasons for the vacillation and confusion among thoughtful clinicians are complex, and they persist today. This clinical perspective will examine the multitude of factors the clinician weighs in arriving at a sound treatment plan, the rationale that leads to a final decision, and the genesis of the controversy.

Diagnostic Parameters

The mandibular dental arch-size/tooth-size ratio is a paramount factor in orthodontic diagnosis and must be addressed early to determine whether its arch size can accommodate 10 ideally aligned, well-positioned teeth within that existing arch length. Generally, the arch length is measured as the circumference of the arch from the mesial of the first permanent molar to the mesial of the contralateral first molar. The determination is made as to whether there is sufficient, insufficient, or excess arch length to accommodate four premolars, two canines, and four incisors. The availability of leeway space in the transitional dentition as deciduous molars are replaced by premolars is carefully considered in the assessment. If it is determined that insufficient space exists, the clinician must decide whether the mandibular arch length can be increased by proclining the incisors, distalizing the molars, or expanding the arch transversally, or whether a combination of all three modifications is advisable. Certain factors are considered in each of these three possibilities. Can the facial profile tolerate the proclination of incisors? Will the proclination create periodontal dehiscences? Will this procedure create an excessively convex profile, and will this forward movement of the incisors be stable or require indefinite retention? Can the molars be distalized considering the presence of second molars, and if they can, will the



second molars be impacted? If the arch is expanded transversely, will that expansion be stable considering the role of the functional matrix in determining arch form, and can the periodontium tolerate this expansion?

Assuming, after all these factors are considered, that there is adequate space within the mandibular arch to accommodate the well-aligned, well-positioned 10 teeth, this is considered a nonextraction arch. The maxillary arch can usually be adapted to the resulting ideal mandibular arch by a combination of molar distalization if indicated, skeletal/dental expansion, or proclination of incisors to attain an ideal overjet and overbite with proper dental alignment. A major perennial topic of contention among orthodontists is the assessment of how much variation from the oral functional matrix that dictates the form and length of the dental arches is acceptable. Basically, the dentoalveolar stability and

the periodontal tolerance to expansion to avoid extractions are in question.

In this compatible mandibular arch-size/tooth-size situation, when a Class I malocclusion exists, maxillary molar distalization would not be indicated, while a Class II occlusion would likely require a combination of maxillary molar distalization and mandibular forward growth in the still-growing patient with the assistance of a functional appliance such as maxillary headgear. Generally, in the adolescent, treatment begins as the maxillary first premolars emerge, and not sooner, to achieve an ideal, timely nonextraction treatment result.

If, however, the measurement of mandibular arch-length/tooth-size ratio, after considering all the aforementioned criteria, reveals inadequate space to align the 10 teeth mesial to the mandibular molars, the amount of deficiency determines the treatment plan. Ordinarily, a less than 3 mm deficiency can be resolved by judiciously reducing the mesiodistal width of some

or all of the 10 teeth, while greater than 3 mm tends to require extractions in the opinion of some. Others disagree vehemently with this assessment and seemingly have no restrictions on the amount of dentoalveolar expansion acceptable to gain space to accommodate the full dentition. The clinician who is wary of that course of treatment and is convinced of the need for extractions must next decide whether first or second premolars should be removed to resolve the deficiency. This decision is based on several factors, including facial profile, amount of mandibular arch crowding, and molar relationship. If the profile is favorable—not requiring retraction of incisors to reduce a facial convexity—and there is minimal crowding, the second premolars are likely the targets of choice for extraction to avoid inadvertently retracting the incisors during space closure, which could adversely affect the facial profile. While the need to retract the incisors to improve a convex facial profile in the presence of a greater amount of crowding would favor first premolar extractions, normally the corresponding premolars in the maxillary arch are extracted.

When a Class II molar tendency exists with a moderate amount of dental-arch crowding in the absence of growth potential in adults, the mandibular second premolars are favored for extraction to facilitate molar correction by mesializing mandibular molars and avoiding retraction of sagittally well-placed incisors. In this situation, either maxillary first or second premolars may also be extracted.

Conversely, when there is excess mandibular arch length relative to tooth size, spacing exists. In this scenario, space closure is carefully managed to avoid unwanted incisor retraction, which could excessively flatten the facial profile. Therefore, the posterior teeth are moved mesially while maintaining the incisor sagittal position. However, if incisor retraction is desirable, the spaces are closed by uprighting the incisors, thereby improving an excessively convex profile. Appropriate biomechanics are applied to produce the desired outcome. Once again, the maxillary dental arch can be adapted to the shape of the mandibular arch.

Simultaneously, the clinician must monitor and redirect growth of the facial-skeletal pattern in all growing patients. A combination of both dentoalveolar and skeletal apical base management is required in the adolescent. The sagittal relationship of maxilla to mandible, as well as vertical height and divergence between the apical bases of the jaws, is assessed by cephalometric analyses. These factors determine the appropriate orthopedic therapy, as well as therapeutic modifiability for each growing patient. The amount of divergence often determines whether extractions are indicated or contraindicated. Usually, extractions are avoided in deep overbite/hypodivergent skeletal patterns, such as in the Class II, division 2 patient. While in the adult, only dentoalveolar changes are anticipated in resolving the malocclusion, unless orthognathic surgery is indicated to resolve a skeletal dysplasia.

Selection of Teeth for Extraction After Considering Various Parameters

Several indications were previously discussed for determining the rationale for first versus second premolar extractions. Other extraction alternatives are considered by the clinician depending on one's objectives. For example, in the Class II patient where distal-

ization of maxillary molars is indicated, extraction of maxillary second permanent molars is considered to facilitate that procedure, anticipating the ultimate replacement of the second molars by radiographically evident, well-formed third molars.

In fact, some clinicians consider extraction of all four second molars in borderline extraction cases to gain arch length by facilitating bimaxillary first molar distalization. This alternative avoids premolar extractions. However, this is a dangerous procedure since even when the four third molars appear to be in a favorable position radiographically to replace the second molars, the mandibular third molars sometimes inexplicably turn to a horizontal position subsequently and present serious orthodontic problems. Moreover, their long-term prognosis becomes problematic. The maxillary third molars, however, are more predictable and erupt favorably to replace the second molar extracted teeth.

Dentoalveolar Adjustments

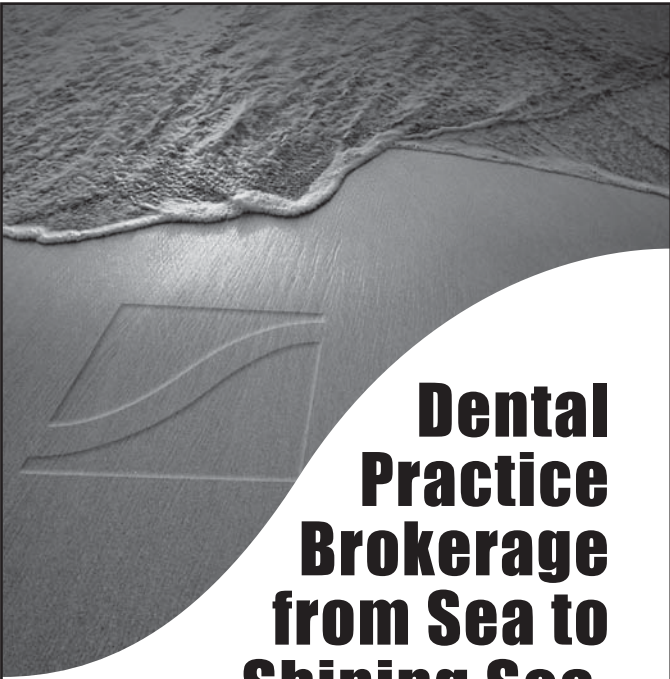
In the 1950s and beyond, some clinicians deemed it necessary to extract six permanent teeth: the four first premolars, as well as the maxillary permanent first molars. These orthodontists believed that the maxillary molars should not be moved distally in the ubiquitous Class II patient. Instead, only dentoalveolar modifications in the occlusion were sought. (This belief was later modified.) Therefore, in the severely crowded Class II patient, both the crowding and the molar correction could be resolved by dentoalveolar adjustments as the maxillary permanent second molars were guided into a Class I relationship and the third molars subsequently replaced the second molar positions in time.

Another plan for the patient with localized mandibular anterior crowding is the extraction of a mandibular incisor only. While this resolves the anterior tooth crowding, the final occlusion usually results in a mild overjet since the six maxillary anterior tooth arc circumscribes the resulting five mandibular anterior tooth arc.

Yet another alternative extraction plan in some Class II patients is the extraction of maxillary first and mandibular second premolars. This plan addresses the common practice of extractions closest to the dental disparity. The maxillary first premolar extractions permit resolution of an overjet/anterior crowding, while extraction of mandibular second premolars in these cases with minimal crowding allows an easier correction of the Class II relationship by protraction of the mandibular molars when growth of the mandible is not expected.

In the adult Class II dentoalveolar malocclusion, where a Class II molar relationship exists and the maxillary anterior teeth exhibit crowding and/or a protrusion with a relatively normal mandibular arch alignment, maxillary first or second premolars may be extracted. This treatment plan addresses the maxillary anterior disparity leaving a perfectly functional Class II molar relationship, while the mandibular arch is aligned without extractions.

In the Class III patient undesirous of orthognathic surgery to fully correct an apical base dysplasia, which may include a retrognathic maxilla, a prognathic mandible, or a combination of both, dentoalveolar camouflaging of the Class III condition can be achieved. Extraction of only first or second mandibular premolars allows the retraction and alignment of the man-



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dibular anterior teeth to correct the anterior cross bite. In this plan, the Class III molar relationship remains but the anterior dentoalveolar disparity is resolved. However, the Class III skeletal relationship and facial profile persist.

Selection of teeth for extraction may also be dictated by dental health, agenesis, and esthetics. An example of the latter is the author's preference for maxillary second premolar extractions, generally, since the longer clinical crown of the first premolar distal the canine is more esthetic. Also, the exodontist prefers extracting the single-rooted second premolar rather than the more difficult multirrooted first premolar when the choice is presented.

Conclusion

This clinical perspective on orthodontic diagnosis is far from a comprehensive review of the multitude of variables the orthodontic clinician ponders in the treatment planning of each patient. However, it is designed to help enlighten the reader on the complexity of arriving at a valid individualized treatment plan for resolution of the various malocclusions the clinician treats daily.

Finally, and most importantly, the question remains: Will the ultimate decision and treatment result tend to be unstable and thus require a lifetime of retention, and will the teeth and paradental tissues withstand the potential consequences of non-extraction treatment versus one of the alternatives discussed in this viewpoint? These are enigmatic questions that have influenced the metronomic controversy in orthodontic diagnosis, treatment planning, and biomechanics for nearly a century. Today, widely disparate opinions persist on the appropriate treatment methodology among thoughtful, well-meaning practitioners. ■

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A Clinico-Pathologic Correlation



Figure 1. Multifocal melanoacanthoma of the buccal mucosa resembling the appearance of the one found on the floor of the mouth in the patient discussed in this article. (Image courtesy of Dr. Michael Kahn.)

SHAWN MARSH, DMD

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NEOPHYTOS DEMETRIADES, DDS

Dr. Marsh is an oral and maxillofacial surgery resident, Dr. Kahn is professor and chair of the department of oral and maxillofacial pathology, and Dr. Oreadi and Dr. Demetriades are assistant professors in the department of oral and maxillofacial surgery at Tufts University School of Dental Medicine.

Case Presentation

A 77-year-old woman was referred to the oral and maxillofacial surgery clinic at Tufts University School of Dental Medicine for evaluation of multiple pigmented lesions on the floor of her mouth. The patient stated that she had noticed multiple “white spots” on the left floor of her mouth with associated soreness for the past three to four months. Additionally, the patient reported multiple, asymptomatic, static brown lesions at the same location for many years. She was seen one month prior to presentation in our clinic by a private practice oral surgeon, who performed three separate biopsies that were diagnosed, respectively, as hyperkeratosis with mild dysplasia and melanoacanthoma; hyperkeratosis with moderate-to-severe dysplasia and melanoacanthoma; and hyperkeratosis with moderate dysplasia. The patient denied odynophagia, dysgeusia, paresthesia, or xerostomia. She does wear maxillary and mandibular complete removable dentures, which the patient reports are well fitting, and she denies any history of trauma to the area.

The patient’s past medical history was significant for pernicious anemia, hypertension, hypercholesterolemia, osteoarthritis, gastroesophageal reflux disease, and hiatal hernia. Social history was significant for the use of cigarettes for more than 17 years; however, the patient quit smoking approximately 42 years ago. She denied persistent alcoholic beverage consumption and recreational drug use.

Clinical examination of the oral cavity revealed edentulous maxillary and mandibular alveolar ridges. Bilateral, erythematous lesions with dispersed white patches surrounded by brown macules were noted on the floor of her mouth. Palpation of the lesions revealed no evidence of induration, tenderness, or distension. The remainder of the oral cavity revealed no significant pathologic findings. Furthermore, no signs of submandibular or cervical lymphadenopathy were present.

A computed tomography (CT) scan of the head and neck, performed with IV contrast, was done to further evaluate the size and extent of the lesions, as well as to rule out occult cervical lymphadenopathy. The imaging revealed a symmetrical floor of the mouth and tongue with no findings related to the lesions. In addition, there was no cervical lymphadenopathy noted, nor was there evidence of intrabony lesions.

Differential Diagnosis

- Leukoplakia associated with melanocytic nevi
- Melanotic macules
- Oral melanoacanthoma
- Malignant melanoma

Microscopic Findings

Histologic sections showed a wedge of mucosa surfaced by stratified squamous epithelium exhibiting hyperkeratosis with mild-to-severe disruption of the maturation sequence (i.e., dysplasia). Specifically, the lower one-third to two-thirds of the epithelium's thickness exhibited anisocytosis, anisonucleosis, atypical mitotic figures, hyperchromatism, increased nuclear/cytoplasmic ratio, and cellular pleomorphism. Also noted was the presence of numerous melanin-laden dendritic cells and melanocytes distributed throughout all levels of the epithelium. (See Figures 2 and 3.) The lamina propria was composed of fibrous connective tissue with mild to mild-chronic inflammation.

Diagnosis

Oral melanoacanthoma with concomitant epithelial mild-to-severe dysplasia

Discussion

Oral melanoacanthoma is a rare, pigmented oral lesion that has been reported in the dental literature less than 100 times and entails only 0.9 percent of biopsies of solitary pigmented lesions.¹ It is classically described as a dark brown to black macule or slightly elevated lesion that rapidly occurs, most often secondary to trauma. Lesions tend to be solitary, continue to grow rapidly, occur more often in females, and are most commonly found on the buccal mucosa. Oral melanoacanthoma often completely resolves after incisional biopsy or may spontaneously resolve. The clinical significance of this lesion is its ability to mimic oral melanoma, thus biopsy is required to rule out malignancy.

Melanoacanthoma of the oral cavity is a relatively rare, benign lesion and is thought to be due to a non-neoplastic, reactive process in contradistinction to cutaneous melanoacanthoma, which is believed to be an irritated seborrheic keratosis.¹⁻³ Cutaneous melanoma was first reported by Bloch et al. in 1927 as a benign lesion that contained dendritic melanocytes and keratinocytes.^{3,4} In 1978, oral melanoacanthoma was first reported by Tomich et al., and subsequent studies have determined it is most often found on the buccal mucosa, but can also occur on the labial mucosa, palate, and gingiva.^{2,4,5}

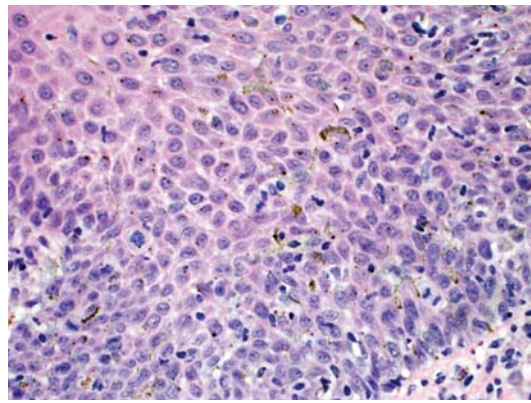


Figure 2. Low-power photomicrograph shows mildly dysplastic stratified squamous epithelium with numerous melanin-laden dendritic cells involving the basal cell layer, as well as the spinous layer (hematoxylin and eosin, original magnification 10X).

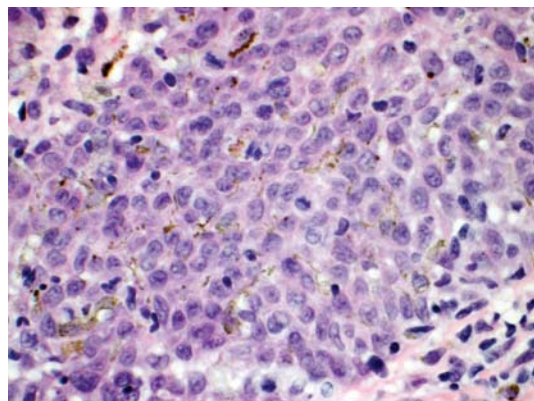


Figure 3. Medium-power photomicrograph shows mildly dysplastic stratified squamous epithelium with numerous melanin-laden dendritic cells involving the basal cell layer, as well as the spinous layer. Loose melanin pigment is also noted in individual keratinocytes (hematoxylin and eosin, original magnification 20X).

African American females have the highest incidence, but reports in Caucasians, Asians, and Hispanics, of either gender, have also been published.^{2,5} Oral melanoacanthoma is most often reported to occur in the third and fourth decades of life, but ranges from the first to the seventh.^{2,6} Neville et al. reported that the female-to-male ratio was approximately 2:1; however, the ratio has been reported as great as 7:3.^{2,6}

The clinical differential diagnosis for pigmented lesions of the oral cavity should include melanotic nevus, melanotic macule, melanoacanthoma, malignant melanoma, foreign body (e.g., amalgam tattoo), heavy metal ingestion, post-inflammatory pigmentation, and melanosis secondary to active smoke tobacco use. Vascular lesions, such as hemangioma, and systemic disorders such as Peutz-Jeghers syndrome and Addison's disease, can have multiple pigmented oral

mucosa lesions as one of their manifestations. If the systemic disease is known, then biopsy is often unnecessary, as malignant change of the pigmented lesions is rare; however, if the underlying cause of the pigmented lesion(s) is unknown, biopsy is required to rule out malignant melanoma.^{1,2,7}

While there is no unanimity of opinion with regard to the cause of oral melanoacanthoma, the most common cause is believed to be secondary to direct or indirect physical trauma (e.g., toothpick, dentures, foreign body).^{1,8} Previously, it was thought by some that trauma due to cigarette smoking could cause oral melanoacanthoma (i.e., direct heat contact and combustible products); however, it was determined subsequently that the resultant pigmentation was a separate condition—smoker's melanosis—that usually resolves upon smoking cessation.⁹ Also, the histopathology of smoker's mel-

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anosis is unlike oral melanoacanthoma, but instead is identical to focal melanosis (melanotic macule). Oral melanoacanthoma also differs from smoker's melanosis, since it has a strong tendency to undergo spontaneous resolution with or without an incisional biopsy procedure.^{1,2}

The microscopic features of oral melanoacanthoma include mild epithelial acanthosis and spongiosis, as well as dendritic melanocytes and melanin-laden dendritic cells distributed throughout all layers of the surface epithelium, rather than the melanocytes being confined to the basal cell layer.² Dendritic melanocytes are not pathognomonic for oral melanoacanthoma and have been seen in malignant conditions such as melanoma and squamous cell carcinoma.^{2,6} Thus, although unique, it is not surprising that dendritic melanocytes were seen in potentially malignant epithelial dysplasia, as well as the patient's subsequently diagnosed squamous cell carcinoma.

Treatment

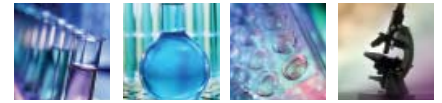
Following the microscopic findings of the patient's incisional biopsies, it was decided to excise the multiple white patches and associated pigmented lesions. The specimen from the midline floor of the mouth demonstrated invasive, well-differentiated squamous cell carcinoma with a tumor within 1 mm of the surgical margin. Therefore, the patient underwent a second local excision, which demonstrated surgical margins free of tumor. The patient tolerated the procedures well and has been disease-free for five months with continued close follow-up. If there is a visible recurrence or suspicion of clinical recurrence, the patient will undergo additional surgical diagnostic procedures.

Conclusion

Despite the benign nature of melanoacanthoma, an incisional biopsy should be performed to rule out malignant melanoma or other types of malignancies with associated pigmentation. Patients, particularly African American women, with risk factors such as current cigarette smoking and/or ill-fitting dentures, are at higher risk for development of oral melanoacanthoma and should be treated appropriately. ■

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ORAL ULCERATION WITH CIRCUMFERENTIAL WHITE RIM: CLINICAL SIGNIFICANCE



Figure 1. Traumatic ulceration of the lateral tongue demonstrating peripheral white rim. (Image courtesy of Dr. Edmund Cataldo.)

ORAL ULCERATIVE LESIONS ARE FREQUENTLY ENCOUNTERED in clinical practice and often pose a diagnostic challenge. As a multitude of factitial, infectious, immune-mediated, and neoplastic conditions are associated with oral ulcerative lesions, accurately pinpointing the etiology is imperative. Based upon our experience and supported by anecdotal reports in the litera-

ture, one clinical feature suggestive of a traumatic etiology is the presence of a peripheral white border circumscribing the margin of the ulcer bed.

Histopathologically, this white “halo-like” border represents a peripheral zone of hyperkeratosis and epithelial hyperplasia.¹ This feature is likely related to a reactive response of the epithelium adjacent to the focus of traumatic injury.^{1,2} Although neoplastic lesions frequently arise adjacent to areas of leukoplakia, this well-demarcated peripheral “halo” is typically lacking in such lesions and should bring an ulcer of traumatic origin to the forefront of the clinician’s differential diagnosis.

Further, a solitary ulcerative lesion devoid of a circumscribed keratotic border should be viewed with a high index of suspicion for neoplasia/malignancy. Despite the fact that a keratinized periphery may suggest benignity, such observations are not unconditional, and if clinical suspicion persists, a biopsy with submission of lesional tissue is requisite for definitive diagnosis. ■

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Sequence of Events: Caries to Osteomyelitis



Figure 1. Bitewing radiograph demonstrating extension of demineralization due to caries from the distal surface to the pulp chamber of the maxillary right first molar.

Dental caries is an infectious disease that results in demineralization of dental hard tissues. This results from an interplay of the tooth structure, the microflora, and dietary factors. The initial carious lesion is a subsurface demineralization without clinical cavitation that may or may not be visualized radiographically. Demineralization may extend well into dentin without any cavitation of the outer surface clinically. Without intervention, demineralization may progress through enamel, dentin, and, finally, through pulp. (See Figure 1.)

When demineralization through carious process reaches the pulp, the oral microflora have a direct port of entry into the pulp chamber and root canal, and eventually to the periapical tissues upon exiting through the apical foramen. This process turns the pulp necrotic and eventually non-vital. Radiographically, there is no evidence regarding the vitality of the tooth; this has to be determined clinically. Toxic metabolites from the necrotic pulp exit the apical foramen and incite an inflammatory reaction in the apical periodontal ligament and periapical bone. This condition is known as apical periodontitis. (See Figure 2.) The radiographic findings include loss of lamina dura and widening of apical periodontal ligament space (PDL). The loss of lamina dura is a subtle radiographic change and is often overlooked. Radiographic manifestation of periapical inflammations

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Figure 2. Periapical radiograph showing cariously involved mandibular left second premolar, first and second molar. Note the loss of the apical lamina dura with slight widening of the PDL space involving the second premolar (apical periodontitis). The first molar demonstrates a small area of periapical radiolucency, in addition to loss of lamina dura (periapical rarefying osteitis).

requires 30 to 50 percent mineral loss to be detectable, and this usually takes one to two weeks' time. As the very early lesions do not show any radiographic changes, diagnosis of these lesions is dependent solely on clinical symptoms.

As the disease progresses, the subtle changes involving the apical PDL (apical periodontitis) extends into the surrounding bone, resulting in bone resorption (periapical rarefying osteitis). This appears as a well-defined radiolucent region associated with apex of the concerned tooth. (See Figure 3.) Periapical rarefying osteitis could represent periapical abscess, granuloma, or a radicular cyst, histologically. The periapical inflammation may also stimulate formation of bone surrounding the apices of roots known as periapical sclerosing osteitis. (See Figure 4.) These two osseous reactions may also occur concomitantly. The sclerotic reaction of the surrounding bone may be limited to a small region or can be extensive to include the inferior cortex of the mandible. Chronic cases may cause external resorption of the apices of roots. (See Figure 5.) Periapical inflammatory changes adjacent to the floor of the maxillary sinus may cause periosteal reaction or periostitis involving the floor of the sinus, referred to

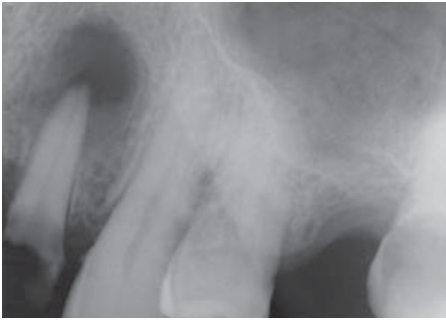


Figure 3. Periapical radiograph showing grossly carious crown of the maxillary left lateral incisor with a well-defined periapical radiolucent area (periapical rarefying osteitis).

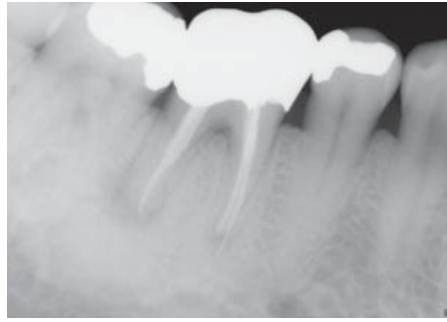


Figure 4. Periapical radiograph showing endodontically treated mandibular right first molar. The second molar has a large metallic restoration. There is an ill-defined area of sclerosis of the periapical bone, which extends inferiorly and posteriorly (periapical sclerosing osteitis).

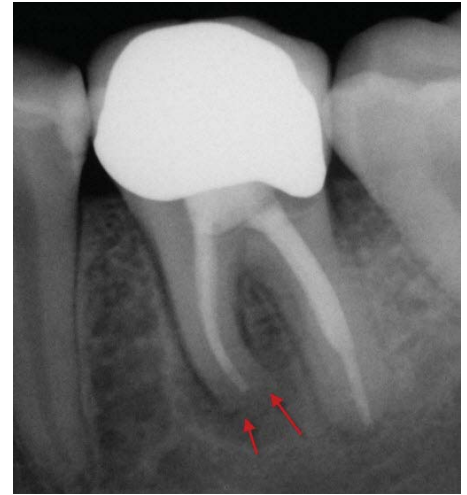


Figure 5. Periapical radiograph showing an endodontically treated mandibular left first molar with a well-defined periapical radiolucent area associated with the apex of the mesial root. Note the irregular margin of the apex and the shorter length of the root (external root resorption).

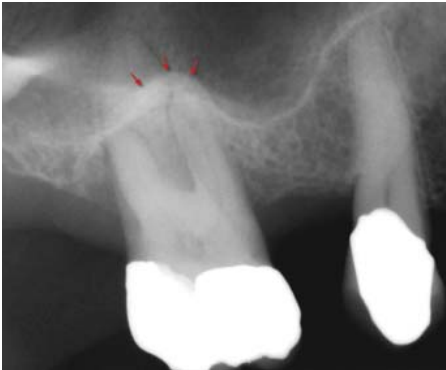


Figure 6. Periapical radiograph showing a heavily restored maxillary right first molar. Note the thickening and elevation of the floor of the sinus in relation to the mesiobuccal root (periostitis or "halo sign").

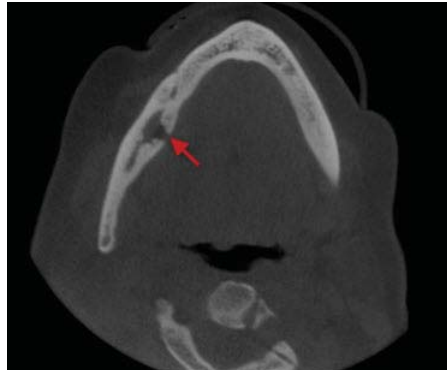


Figure 7. Axial cone-beam computed tomography (CT) section with chronic osteomyelitis showing a mixed sclerotic-lytic area in the right body of the mandible with a fistula opening on the lingual cortical plate.



Figure 8. Cropped panoramic image showing endodontically treated mandibular right first and second molars with periapical radiolucent areas. The bone of the entire segment appears diffusely sclerotic in reaction to the inflammation (diffuse sclerosing osteomyelitis).

as the "halo sign," with adjacent mucositis in the maxillary sinus. (See Figure 6.)

In the absence of intervention and compromised host defense, the periapical inflammation may spread to involve the bone marrow, cortex, and cancellous bone, including the periosteum, resulting in osteomyelitis. The early stages of acute osteomyelitis may not be detectable radiographically. The first radiographic evidence is a decrease in density of bone, and localized or scattered regions of radiolucency with ill-defined periphery. Inflammatory exudates may elevate the periosteum and form bone underneath the periosteum, referred to

as proliferative periostitis. Periodic deposition of bone in this manner may lead to an "onion-skin" appearance of the outer surface of the bone, seen as several radiopaque lines adjacent to the mandibular cortex. With chronic osteomyelitis, there are more sclerotic areas, leading to a mixed radiolucent-radiopaque appearance of the involved bone. There is formation of sequestrum or islands of dead/necrotic bone, which appear more radiopaque than the surrounding bone. In severe cases, there may be fistula formation (see Figure 7) or pathologic fracture of the involved bone. Diffuse sclerosing osteomyelitis reflects a more sclerotic-

appearing bone, along with enlargement of bone and subperiosteal bone formation. (See Figure 8.) Certain local and systemic conditions causing compromised bone vascularity may predispose the jaws to osteomyelitis. Some of the local and systemic contributors are long-term bisphosphonate therapy, radiation therapy, diseases of the bone, such as Paget's disease of bone, florid osseous dysplasia, or osteopetrosis, among others.

Accurate diagnosis and timely intervention may be helpful in disrupting the cascade of events mentioned above before significant damage occurs to the involved structures. ■



BOOK REVIEWS

NORMAN BECKER, DDS, EDITOR EMERITUS

Editors' Note: This issue marks Dr. Norman Becker's final Book Reviews column for the JOURNAL. Beginning with the Summer 2011 issue, Dr. Todd Belfbecker will assume writing responsibilities for the column. For more on Dr. Norman Becker, please see "An Appreciation" on page 4 and "Dr. Norman Becker—A Personal Tribute" on page 12.

The Fearful Dental Patient—A Guide to Understanding and Managing ARTHUR A. WEINER

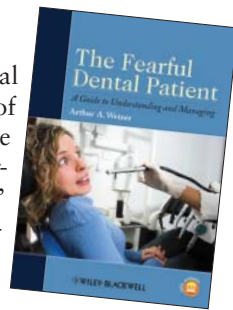
Wiley-Blackwell

Dr. Arthur Weiner, a professor of general dentistry at Tufts University School of Dental Medicine, has created a complete guide to the chairside understanding of the varied etiological factors responsible for patients' negative behavior and fear, as well as evidence-based modalities for their management.

A quick glance at some of the chapter titles indicates the value and the expanse of the advice the text offers:

- The Basic Principles of Fear, Anxiety, and Phobias: Past and Present
- Factors Affecting the Psychological Collection and Identification of the Fearful Dental Patient
- Chairside Management of the Fearful Dental Patient: Behavioral Modalities and Methods
- The Pharmacological Basis of Pain and Anxiety Control
- Management of Complicated, High-Risk Patients with Psychiatric Co-Morbidities
- Understanding and Managing the Fearful and Anxious Child
- The Geriatric Psycho-Physiological Factors Associated with Aging and Dental Anxiety
- Fear and Anxiety Management for the Special Needs Patient

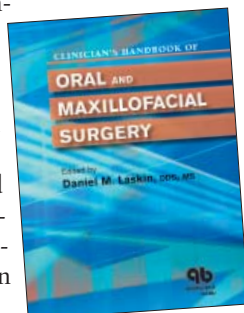
Do not let the chapter titles fool you into thinking that this is a dense academic text requiring deep concentration. Dr. Weiner has included photographs and cartoons that make the text lighter yet still academic and, thus, a good teaching tool.



Clinician's Handbook of Oral and Maxillofacial Surgery DANIEL M. LASKIN, EDITOR

Quintessence Publishing

The teacher and clinician in Daniel Laskin prompted him to organize a group of contributing authors to compile this "handbook" of oral surgery. The main intent of this text is to provide important information from areas of oral and maxillofacial surgery in a concise and easily searchable format, including situations in which immediate answers to clinical problems may be necessary. Dr. Laskin selected the authors based on their clinical expertise and ability to know not only the questions that may arise, but the information that will answer those questions.



At the same time, reading the text with the goal of understanding procedures in advance provides the clinician with information on what to expect. An outline of a typical chapter demonstrates the value of the text:

Chapter 3—Laboratory Tests and Their Interpretation. This chapter includes information on: hematology collection techniques; site equipment; collection tube types; evaluation technique analysis; definition of terms; differential diagnosis; morphology of cells; and blood chemistry tests and their relation to electrolytes, renal function, liver function, acute myocardial infarction, metabolic bone disease, and other tests.

These tests listed above can be used in diagnosis and treatment planning and provide a basis for intelligent consultation discussions. Thus, it is a handy compilation of relevant information for trainees in oral and maxillofacial surgery, as well as those in hospital-based specialties.

Immediate Loading— A New Era in Oral Implantology TIZIANO TESTORI, FABIO GALLI, AND MASSIMO DEL FABBRO, EDITORS

Quintessence Publishing

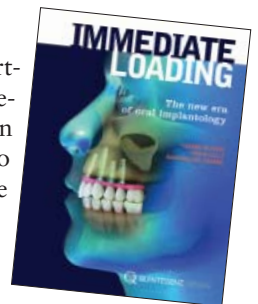
The editors, all heads of different departments of the IRCCS Galeazzi Orthopaedic Institute in Milan, Italy, have called upon colleagues of the institute's implant group to put together a text that will no doubt become a classic in its field.

With the aid of case studies, lecture notes, photographs, and slides, the reader gains a clear understanding of the aspects of immediate loading in oral implantology and the biological and biomechanical foundations of immediate loading age, and how these relate to the latest-generation implant surfaces, medical history, diagnostics, surgery, prosthetics, and medico-legal issues.

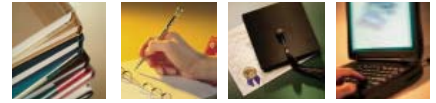
One significant feature of the text is that it places the patient at the center of the treatment plan. The idea is that the patient is the protagonist during treatment planning and in the therapeutic strategy, which is adapted to individual requirements to ensure the highest possible esthetic and functional result. This preserves criteria for predictability, reduction of operative times, and patient comfort.

The book is not strictly aimed at experts; it will also prove beneficial to newcomers to the field of implantology, those with a "solid theoretical knowledge of the biological response, the predictability of the various indications, and the correct surgical prosthetic applications."

For any clinician looking to better understand the benefits of immediate load implants, this text, at 586 pages, is well worth the effort. ■



DENTAL EDUCATION



MELISSA CARMAN, MANAGING EDITOR

Highlighting key events taking place in dental education in Massachusetts.

Tufts University

Tufts University School of Dental Medicine (TUSDM) received the 2011 William J. Gies Award for Achievement by an Academic Dental Institution by the American Dental Education Association (ADEA) Gies Foundation. The award was presented in San Diego on March 21.

The annual awards honor individuals and organizations that exemplify dedication to the highest standards of vision, innovation, and achievement in dental education, research, and leadership. The awards are named for dental education pioneer William J. Gies, who in 1926 published the landmark report, *The Gies Report*.



Photo courtesy of ADEA

The Tufts team accepts the Gies Award from William J. Gies II (center)—from left: Joseph Castellana, Dr. Nancy Arbree, Maria Tringale, Dr. Maria Papageorge, Dr. Lonnie Norris, Dr. James Hanley, and Mark Gonthier.

“In a whole variety of areas, [TUSDM] has shown significant achievement,” said Richard W. Valachovic, ADEA executive director and president of the ADEA Gies Foundation, in an article published in *Tufts Now*.

“Although the award goes to the institution, it clearly recognizes the dynamic and substantial leadership of [TUSDM Dean Dr.] Lonnie Norris in identifying these areas of achievement to focus on,” he continued. “It’s not just about the bricks and mortar, but about the research monies that have come in, the innovations in which dental education is delivered to the dental students, the residents and the other post-docs, all the incredible things that have happened during his tenure and under his leadership.”

Dr. Norris, who has been TUSDM dean since 1996, is retiring from the position later this summer.

Boston University

Courtney Brady (DMD 2011) was awarded the Matthew Boylan Scholarship for 2011. Established by the Massachusetts Dental Society and Bank of America in memory of Matthew Boylan, former MDS executive director, the scholarship is awarded annually during the Yankee Dental Congress (YDC) to a Massachusetts resident and dental student who has provided distinguished service to organized dentistry and the community.

Ms. Brady is an active member of the American Student Dental Association (ASDA) and has served as ASDA community outreach chair, Relay for Life team captain, and Oral Cancer Awareness booth coordinator, and participated in National Dental Student Lobby Day. She has also volunteered with Program White Coat, the Health Career Workshop for Health Occupations Students of America, the Roxbury Boys and Girls Club, and the MDS—as both a radiology course instructor and presiding chair at YDC.

“I believe that Courtney is truly deserving of this award because of her outstanding contributions to the GSDM community, both in and out of the classroom,” said Dean Dr. Jeffrey W. Hutter. “She serves as a role model and inspiration to her classmates, and our faculty and staff often comment on what a pleasure she is to work with. She will be an invaluable addition to the profession upon her graduation from the DMD program this May.” ■



Courtney Brady and GSDM Dean Dr. Jeffrey Hutter

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ART OF DENTISTRY

ROY A. SCHONBRUN, DDS

Dr. Schonbrun practices oral and maxillofacial surgery with Connecticut Valley Oral Surgery Associates in western Massachusetts.

CONTINUING ED CRED

ONE WOULD THINK WE ARE IN A NEW AGE OF ENLIGHTENMENT, given the plethora of continuing education courses being offered today. Have we been mired in such an antediluvian mind-set that a turbocharged jumpstart to continuing education is necessary?

Not a week goes by that you don't receive some glitzy advertisement for some glitzy course at some glitzy resort promising to add glitz to your heretofore mundane practice. Now that continuing education has become mandated by licensing boards, as opposed to something you would naturally be inclined to pursue, there is a whole universe of CE options available, not all of which are worthy of the term "education." Some are obvious attempts to cash in on the mandate thing. The half-day or one-day course options seem quite legitimate.

But let's face it, to acquire the requisite number of CE credits in a licensing period by attending these would take a lifetime. Multiday courses now seem to be *de rigueur*. These quasi-scientific events generally offer better mouse traps for your practice rather than something revelatory. Their appeal is the mega CE credits available. These courses must be the brainchild of condo developers or impresarios who organize "fantasy" CE showcases in spectacular locales that encourage spending or gambling lots of money at glamorous places with oversized beds, meals, spas, pools, and casinos. Play the famed 17th hole at Sawgrass, heli-ski the Canadian Rockies, or try your hand at Texas Hold 'Em while you improve your practice's bottom line. Then there are upgrades or enhancements (to wit, "advanced-level" inducements) to keep you coming back. If you didn't have a practice to run, you could probably become a very good golfer, or skier, or gambler. A few do become better dentists, I suppose.

Recently, I received a notice about a two-day course (a modest proposal) on mini-implants. I checked out the course description and there were 16 topics discussed on Day 1 alone and another 16 on Day 2. That's about eight coffee breaks a day. Let's face it, mini-implants can't be that challenging. It's not like preparing the foundation for the new World Trade Center. Two hours, one coffee break should do it.

I remember all too well being enticed by a series of CE courses on medicolegal issues, insurance updates, and office emergency preparedness being offered at the fabulous Doral Resort in Miami.

Five golf courses, all designated by color—Blue Course, Red Course, etc. Attendance at a course (which was a videotape loop, no lecturer or proctor) entailed signing in and heading out for your tee time. I remember asking one attendee, who was hurriedly signing in, when the Blue Cross Blue Shield Program was scheduled. Hearing only the "Blue Cross" part and anxiously looking at his watch, he blurted, "Blue Course tee time 9:00 am."

I began to see the bogus value of this CE offering. Apparently, certain regulatory bodies felt the same way and shut them down—for a while. They're back. Among the "courses" offered is one on retirement planning, which means that tee times will be on the Gold Course, no doubt.

It is possible, if you play your cards right, to satisfy all your CE requirements in one fantastic Dionysian experience. If, by any chance, you actually buy a condo at the venue, you will probably receive an honorary degree and be able to give your own courses. Did I forget to mention all the useful information pertaining to your dental practice that you can obtain at these courses? Well, there are usually some handouts at the concierge desk. Or just ask at the pro shop. ■

