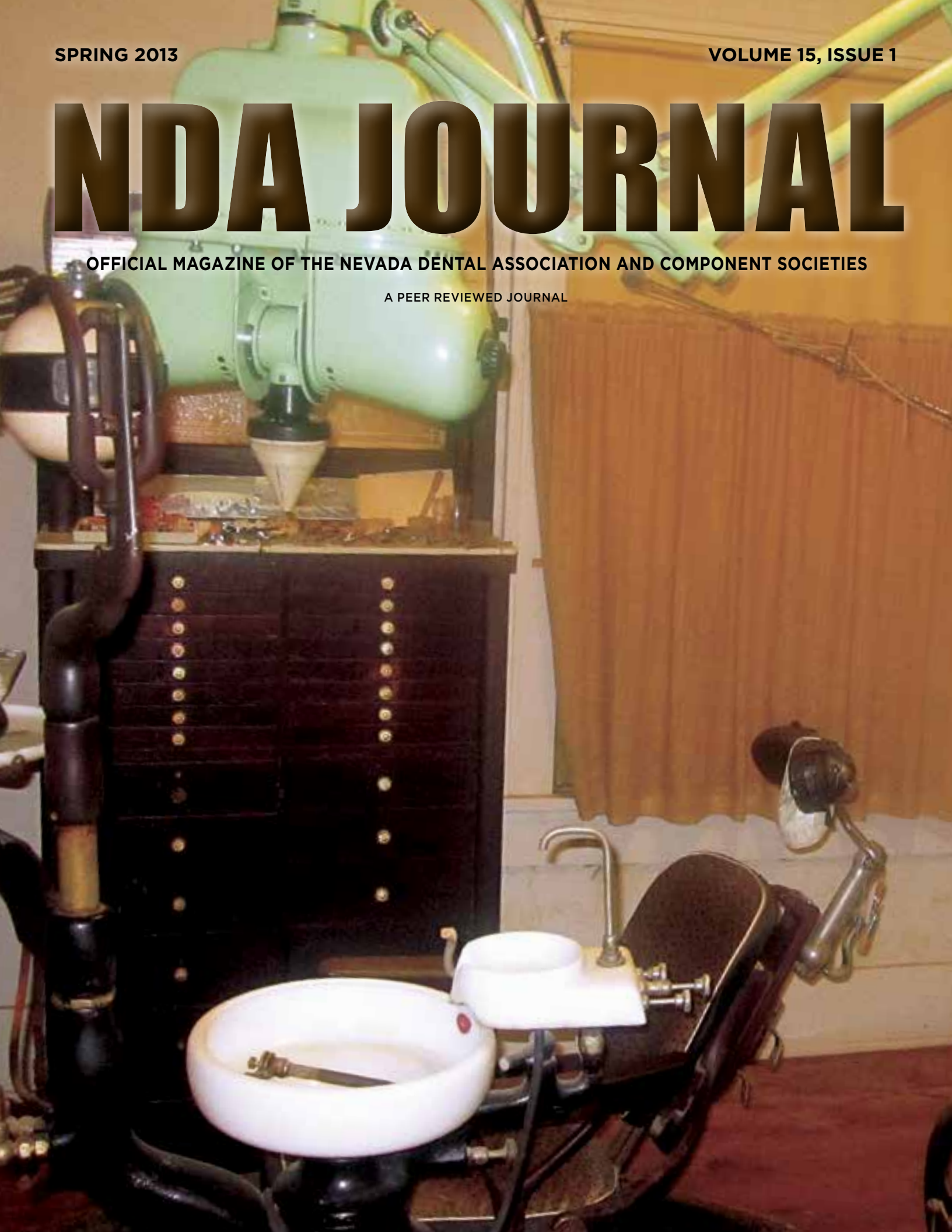
SPRING 2013

VOLUME 15, ISSUE 1

NDA JOURNAL

OFFICIAL MAGAZINE OF THE NEVADA DENTAL ASSOCIATION AND COMPONENT SOCIETIES

A PEER REVIEWED JOURNAL



Protecting dentists.

It's all we do.®

For more than three decades, we've had a singular focus on protecting dentists. Which is why we insure nearly 18,000 of the profession's finest and are endorsed by the Nevada Dental Association. We offer:

- Professional Liability
- Office Property
- Employment Practices Liability
- Workers' Compensation
- Life/Health/Disability
- Long-Term Care
- Business Overhead Expense
- Home, Auto & Umbrella

Coverage specifically underwritten by The Dentists Insurance Company includes Professional Liability, Office Property, and Employment Practices Liability. Workers' Compensation, Life, Health, Disability, Long-Term Care, Business Overhead Expense, Home, Auto & Umbrella products are underwritten by other insurance carriers and offered through TDIC Insurance Solutions.

Endorsed by
NEVADA DENTAL ASSOCIATION

800.733.0633
tdicsolutions.com

The Dentists Insurance Company

tdic®

If You Want Real Success In Dentistry Find A Niche You Can Dominate!

Check out the TV ad on my website www.mytvdentist.com
That TV spot cost me *only* $4 ... in primetime.
I Can Do This For You Too!

The 'niche' amazingly is not about dentures...
It's all about implants, crown & bridge, and root canals...
All High Production Dentistry!

I have gone from generating $35,000 to over $300,000 per month doing just this. If you are interested in doubling or tripling your revenue in less than a year call me today! 619.461.2000
I've got great information for you!

Howard B. Feffer DDS
Has lectured to Dentists nationwide on
"Practice Building Without Stress"

AFTCO

TRANSITION CONSULTANTS

Call 1-800-232-3826 or visit us online at www.AFTCO.net for a free practice appraisal, a $2,500 value!

AFTCO is the oldest and largest dental practice transition consulting firm in the United States. AFTCO assists dentists with associateships, purchasing and selling of practices, and retirement plans. We are there to serve you through all stages of your career.

Richard A. Racanelli, D.M.D.

has joined the practice of

Jessy S. Sidhu, D.M.D.

Las Vegas, Nevada

AFTCO is pleased to have represented both parties in this transaction.

AFTCO is the only company that has sold dental practices with a cumulative value of over $1,500,000,000

Administrative Offices

NDA Executive Offices

Robert H. Talley, DDS, CAE
Exec. Director
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147
PHONE 702-255-4211
TOLL-FREE 800-962-6710
FAX 702-255-3302
robert.talleydds@nvda.org
www.nvda.org

PRESIDENT	Gilbert A. Trujillo, DDS
PRESIDENT ELECT	Stephen Rose, DDS
VICE PRESIDENT	Mark J. Handelin, DDS
SECRETARY	Brad Wilbur, DDS
TREASURER	Dwyte Brooks, DMD
PAST PRESIDENT	Michael P. Banks, DDS

Nevada State Board of Dental Examiners

Debra Shaffer, *Interim Exec. Director*
Rick B. Thiriot, DDS, *DSO Coordinator*
Candice Stratton, *Licensing Specialist*
6010 S Rainbow Blvd, Ste A1
Las Vegas, NV 89118
PHONE 702-486-7044
TOLL-FREE 800-DDS-EXAM
FAX 702-486-7046
nsbde@nsbde.nv.gov
www.nvdentalboard.nv.gov

Northern Nevada Dental Society

Lori Benvin, *Exec. Director*
161 Country Estates Circle, Ste 1B
Reno, NV 89511
PHONE 775-337-0296
FAX 775-337-0298
nnds@nndental.org
www.nndental.org

PRESIDENT	Jason Ferguson, DDS
VICE PRESIDENT	Frank Beglin, DDS
SEC./TREAS.	Perry Francis, DDS
PAST PRESIDENT	Quincy L. Gibbs, DDS*

* Non-voting member. Attending school at UCSF for three years.

Northeastern Nevada Dental Society

Robert H. Talley, DDS, CAE
Exec. Director
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147
PHONE 702-255-4211
TOLL-FREE 800-962-6710
FAX 702-255-3302
www.nenvds.com

PRESIDENT	Todd Wilkin, DDS
VICE PRESIDENT	Jamie Rudolf, DDS
SEC./TREAS.	Jeremy Keener, DDS
PAST PRESIDENT	Rick Stevens, DDS

Southern Nevada Dental Society

Bob Anderson, *Exec. Director*
8863 W Flamingo Rd, Ste 101
Las Vegas, NV 89147
PHONE 702-733-8700
FAX 702-733-6062
s_nds@hotmail.com
www.sndsonline.org

PRESIDENT	Brendan Johnson, DDS
PRESIDENT ELECT	Byron M. Blasco, DMD
SEC./TREAS.	Lydia Wyatt, DDS
PAST PRESIDENT	Joel Casar, DMD

American Dental Association

211 E Chicago Ave
Chicago, IL 60611-2678
PHONE 312-440-2500
TOLL-FREE 800-621-8099
FAX 312-440-7494
www.ada.org

ADA DELEGATES
Dwyte Brooks, DMD
Jade Miller, DDS
Gilbert A. Trujillo, DDS

NDA Committees

Council on Access, Prevention and Interprofessional Services
Michael Sanders, DMD—Chair

Council on Communications
Peter Balle, DDS—Co-Chair
Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD—Co-Chair

Council on Ethics, Bylaws and Judicial Affairs
Dwyte Brooks, DMD—Chair

Council on Government Affairs
David White, DDS—Chair
Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD
Arnie Pitts, DDS

New Dentist Committee
David White, DDS—Chair
David Chenin, DDS
Michael Duboff, DMD

NNDS Health and Wellness Committee
Brandi Dupont, DMD—Co-Chair
James Mann, DDS—Co-Chair
William Clements, DDS
Eric Dean, DDS
Perry Francis, DDS
Gerald Jackson, DMD
Teresa Jackson
Tom Lavin, MS
Randall Pane, DDS
Kathy Pinson
J. Justin Wilkerson, DDS

SNDS Health and Wellness Committee
Richard S. Walker, DDS—Chair
Robert P. Anderson
Pamela Caggiano, DDS
Tyler Christiansen, DDS
Michael M. Day, DDS
Michael Duboff, DMD
Peter A. Mansky, MD
Franson K. S. Tom, MS, DMD

Council on Membership
Brad Wilbur, DDS—Chair
Damian Betancourt, DDS
George Rosenbaum, DDS
Adam Welmerink, DDS

Council on Sessions and Programs
Joel T. Glover, DDS—Chair

Nevada Dental Association
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147-8718
PH 702-255-4211 • 800-962-6710
FAX 702-255-3302
EMAIL info@nvda.org
WEB www.nvda.org

NDA JOURNAL

Editor
Daniel L. Orr II, DDS,
MS (anesth), PhD, JD, MD
editornda@nvda.org

Publisher
LLM Publications, Inc.
800-647-1511
www.AssociationPublications.com

NDA Journal is published four times each year by the Nevada Dental Association and state component societies. All views expressed herein are published on the authority of the writer under whose name they appear and are not to be regarded as views of the publishers. We reserve the right to reduce, revise, or reject any manuscript submitted for publication.

Materials: All articles, letters to the editor, photos, etc. should be sent to Daniel L. Orr II, DDS, via email to editornda@nvda.org. All chapter and committee reports and business communications should be sent to Robert Talley, DDS, Exec. Dir., Nevada Dental Assn., 8863 W Flamingo Rd, Ste 102, Las Vegas, NV 89147, Ph 702-255-4211 or 800-962-6710, Fax 702-255-3302. Materials may be reproduced with written permission.

Subscription: Members receive each publication as a membership benefit paid by membership dues. Non-members may subscribe to the *Nevada Dental Journal* for $50 annually.

Advertising Policy: All advertising appearing in the *NDA Journal* and other Nevada dental publications must comply with the advertising standards of the Nevada Dental Association and its component societies. The publication of an advertisement is not to be construed as an endorsement or approval by the publishers of the product or service being offered in the advertisement unless the advertisement specifically includes an authorized statement that such approval or endorsement has been granted. The publishers further reserve the right to cancel any and all contractual advertising agreements should an advertiser be engaged in litigation concerning their product or service, or should the product or service be in conflict with the standards of the NDA or its component societies.

Advertising rates and specifications are available upon request. Contact Dan Hartzog, LLM Publications, at 800-647-1511 ext 2229 or email danh@llm.com.

Mailing: Send address changes to:
NDA, 8863 W Flamingo Rd, Ste 102, Las Vegas, NV 89147

NDA JOURNAL

SPRING 2013

On the cover: Early dental chair in Pioneer West Museum in Shamrock, Texas. Photo by Billy Hathorn.

YOUR PRESCRIPTION FOR CONVENIENT CREDIT.

Enjoy the freedom of a revolving line of credit[1], designed exclusively for Nevada's medical professionals. We put financing at your fingertips, so you can be prepared for anything, from a new vehicle to real estate, unforeseen expenses or emergencies. And because we understand how hectic your life can get, we make it convenient to access. Apply today. *Bring your banking home.*

CREDIT LINES UP TO

$500,000

RATES AS LOW AS

4.75% VARIABLE APR[2]

[1]Subject to credit approval. Restrictions apply. Must be a medical professional to apply for this product. Other products are available. [2]Advertised rate is variable and based on the Prime Rate as published in the Wall Street Journal (currently 3.25% as of 2.15.13) plus a margin and subject to change monthly. Offer subject to change at any time.

NEVADA STATE BANK
PROFESSIONAL BANKING

EQUAL HOUSING LENDER

Member FDIC

53 years in Nevada | Over 50 branches statewide | 600 ATMs across the West
nsbank.com | 866.937.2181

Dentistry: Honored Profession, or Self-Serving Trade?

Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD
editornda@nvda.org

Dentistry is currently under sophisticated external assault from low-level technicians that declare they can perform dentistry as well as dental professionals. The American Dental Association (ADA) states that dentistry is a profession and, as emphasized by the 1936 ADA House of Delegates (HOD), an employment of the mind requiring a rigorous education coupled with high ethical standards, particularly with regard to patients.[1] One of the first practical things the profession did in the 1930s to demonstrate that it appreciated the ethical element of compassion for patients was establish as routine the previously controversial use of local anesthesia to relieve pain during procedures.[2] The advent of low-level providers renews the historical controversy regarding which definition, trade or profession, dentistry actually fits. The question has been analyzed historically and considered, as a potentially devolving and self-serving profession, recently.[3,4] Lobbyists and politicians can readily find the ADA listed in directories as a "trade organization."[5]

> ***…dentistry** is a profession and an employment of the mind **requiring a rigorous education** coupled with **high ethical standards**, particularly with regard to patients.*

In both 1837 and 1838, Dr. Chapin A. Harris unsuccessfully petitioned the University of Maryland Medical College to include dentistry within its professional courses. The college refused largely because dentistry was regarded as a trade, not a credible profession. Undeterred, in 1840 Harris helped establish the Baltimore College of Dental Surgery, the first such institution in the world. Still, many viewed the Baltimore College as just another dental trade school, such as had been established to teach dental mechanics in Bainbridge, Ohio in 1828.[6]

But then a momentous discovery (an observation made known) by a dentist, recently ranked the third greatest medical advance after sanitation and antibiotics,[7] changed public perception mightily. In December 1844, Horace Wells realized that certain agents could obtund pain during surgical procedures and introduced the world to the art and science of anesthesiology. Overnight, dentistry began to change from a mechanical exercise to a profession as dentist after dentist expertly relieved pain and suffering during surgery.

Dentists became the leading practitioners of anesthesiology for decades, utilizing more agents and techniques than any sister profession. President Grover Cleveland's 1893 tumor surgery anesthesiologist was Ferdinand Hasbrouck, DDS.[8] Dentists discovered CO_2 absorption[9] and how to liquefy nitrous oxide for practical use.[10] Dentists administered anesthesia for all types of surgical procedures, including the first use of general anesthesia for obstetrics in the United States.[11] A dentist was the President of the American Society of Anesthesiology (ASA) and the International Anesthesia Research Society (IARS).[12] G.V. Black, the father of modern dentistry, lectured on general anesthesia.[13]

Continues ➲

Dr. Orr practices Oral & Maxillofacial Surgery in Las Vegas, is a Clinical Professor of Surgery & Anesthesiology for Dentistry at UNSOM, Professor and Director of OMS at UNLV SDM, and is a member of the California Bar. He can be reached at editornda@nvda.org or 702-383-3711.

Things changed in the 20th century. Medicine, nursing, and veterinary medicine enthusiastically embraced American dentistry's gift to the world and all declared the field a specialty. Later, organized dentistry in parts of the Orient, the Middle East, and Canada did the same. However, in the United States, the growth and development of the science principally transitioned from dentists to others because of the lack of a specialty in dentistry.

Further, in 1950, the ASA rescinded the option for dentists to be unrestricted members.[14] Recognizing the need for a platform to speak about dental anesthesiology, former dental members of the ASA formed the American Dental Society of Anesthesiology (ADSA). The first issue of the *ADSA Newsletter* mentioned, in each of its first three paragraphs, that anesthesiology needed to be a specialty in dentistry in order to foster more training options.[15]

At the 2012 ADA Annual Meeting, the House of Delegates (HOD) had the opportunity to recognize anesthesiology as a specialty and acknowledge dentist anesthesiologists (DAs) the most comprehensively trained dentist anesthesia providers and the front line defenders of anesthesia for both the profession and its patients. This was the fourth time within 20 years the HOD considered the question. Each time, the application was thoroughly vetted and approved by the Council on Dental Education and Licensure, the Committee on Recognition of Specialties and Interest Areas in General Dentistry, and the ADA Board of Trustees. Each time, the HOD voted to not trust DAs, CDEL, the Committee, and, ironically, its own Trustees.

In 2012, DAs reaffirmed that their goals had remained unchanged over the decades, i.e. to increase expertise in anesthesiology by providing more training opportunities for undergraduate and graduate dentists. It was noted that many outside dentistry (health professionals, media, regulatory agencies, etc.) regularly criticize various forms of dental anesthesia.[16] DAs, however, documented their steadfast historical support, both clinically and politically, for all safe methods of anesthesia in dentistry including, but not limited to, local, nitrous oxide in oxygen, per oris protocols, and other techniques of sedation and general anesthesia, including the singularly successful oral and maxillofacial surgery (OMS) team anesthesia niche. Some dental opponents of the application were fearful that if a specialty were to come to fruition, "the rest of us would be left out of the loop."[17,18] In reality, collegial support of the application by the HOD would have done more to ensure a high level defense of dentistry's anesthesia paradigms than any other measure.

DAs also detailed an overwhelming unmet need for anesthesia services by millions of potential patients.[19,20,21,22] Not mentioned at the annual meeting was the ubiquitous popular perception that pain control in dentistry is literally a joke, evidenced by generations of comedians.[23]

During the Council of Dental Accreditation (CODA) session, an antagonist of the application argued against increased studies, stating that there was no reason for dental anesthesia residencies to comprise a minimum of three years of training (as medicine, nursing, and veterinary medicine do). Opposing enhanced education eviscerates the very definition of a health professional.

Further, at the Reference Committee hearing related to the specialty application, opponents with six months or less of anesthesia training stated that DAs in three year programs do not bring any additional expertise to dentistry.

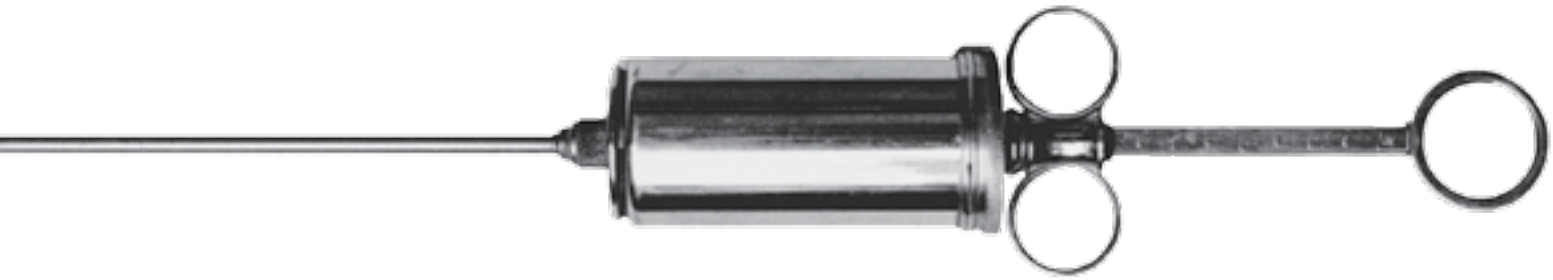
Interestingly, adversaries also questioned the safety of mobile dental anesthesia, wherein DAs transport medications and equipment to facilities to provide anesthesia services. According to closed-claims data, the mobile DA model has a safety record second to none not only in dentistry but also among any other profession's specialty anesthesia providers.[24]

The final vigorous debates on the floor of the HOD were fascinating. The Speaker of the House, a uniformly perceived foe of the application, refused to recuse himself while settling controversial procedural questions. Challengers "mistakenly" crowded behind proponent assigned microphones, usurping time from those who would have spoken in support of the application. Opponent delegates, solemnly charged to altruistically represent the profession and its patients, were overheard voicing base ad hominem attacks at advocates.

An HOD application rival opined that since the word "anesthesiology" is not specifically mentioned in the ADA Definitions of Dentistry, it should not be allowed.[25] Such attitudes could open the door for dentistry's detractors to demand that "dental mechanics" no longer be permitted to dabble in administering any anesthetics whatsoever.

Another uninformed delegate stated that the HOD should not consider the question because anesthesiology is the "practice of medicine," obediently parroting a statement first made at the 1912 ASA national meeting in Niagara Falls. This delegate beguilingly ignored nearly 170 years of historical, practical, regulatory, and adjudicated legal precedent. He also gave dentistry's adversaries evidence that some dentists are willing to cede a portion of what has been established as the practice of dentistry since the very day anesthesia was discovered by Wells.

Controversy regarding the provision of anesthesia is not new. Wells stated that it should be as freely accessible as the air we breathe. Dentist William T.G. Morton, after successfully demonstrating Lethion in 1846, patented his "invention" (ether disguised with perfume) in order to maximize



profits, demonstrating a degree of fiscal selfishness that is anathema to the health professions.[26]

Prior to the 2012 ADA Annual Meeting, The American College of Legal Medicine, an assembly of dentist and physician attorneys, vetted and supported the application.[27]

It would not be surprising if organized dental anesthesia stopped seeking specialty status recognition via the ADA. Other professions have demonstrated that there are additional routes to specialization besides an association. In fact, within dentistry itself, the ADA has not always been the sine qua non to confirm specialty status. For instance, in 1942, prior to the establishment of a national certifying body, four states had their own OMS specialty boards.[28] California, site of the 2012 ADA meeting, already statutorily verifies that DAs are specialists.[29]

Based on the 2012 HOD specialty vote, it is not inconceivable that the ADA may become irrelevant with regard to specialties.

In order for the ADA to remain the voice of dentistry, it must avoid the precedent established by the American Medical Association. Once respected, the AMA is now immaterial, as less than 15% of physicians find membership worthwhile.

As mentioned at the annual meeting, in Esterburg's article, in the *ADA Code of Professional Conduct*, and in the *ADA News*, a learned profession requires commitment to high ethical standards of conduct, including always putting patient interest before self- or special-interest.[1,3,4,30]

Whether dentists continue to be deemed honored health professionals vigorously advocating for patients, including the provision of that most basic obligation of pain relief, or are judged to be a self-serving tradesmen long-overdue for less expensive entry-level mechanics, remains to be seen and is ultimately dependant on the altruistic conduct of dentists themselves. ◆

References

1. O'Loughlin K, Executive Director's Address to the 2012 American Dental Association House of Delegates, 22 October 2012.
2. Driscoll, E, History and Future Trends in Pain Control, Jorgensen Memorial Lecture, Am Dent Soc Anesth Annual Meeting, 27 February 1977.
3. Esterburg JC, "Are dentists losing their status as 'professionals'?," *J Am Dent Assoc*, 142:1084–1085, 2011.
4. Liu, JR, "Specialty Application," *ADA News*, Dec 10, 2012, http://www.ada.org/8038.aspx, accessed 14 December 2012
5. Trade Organizations Washington, http://washington.opendi.us/1433865.html, accessed 04 February 2013.
6. Bainbridge Dental Museum, http://www.bainbridgedentalmuseum.org/, accessed 19 December 2012.
7. Ferriman A, "Greatest Advances in Medicine since 1840," *Brit Med J*, 27 January 2007, 334:111, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1779856/, accessed 16 January 2013.
8. Algeo M, *The President is a Sick Man*, Chicago Review Press, Inc., Chicago, 2011.
9. Coleman A, "Economical Process of Preparing and Administering Nitrous Oxide," *British Med J*, Dec 31, 1831, 1056.
10. Miller AH, "Technical Development of Gas Anesthesia," *Anesthesiology*, 2:4, July 1941.
11. Pittinger CB, "The anesthetization of Fanny Longfellow for childbirth on April 7, 1847 (Letter)." *Anesth Analg*. 1987, 66:368–369.
12. Stebbins, HM, Charles K. Teter, DDS, *J Am Dent Soc Anesthesiology*, January 1958, 5:1, 15–16.
13. Black GV, "Introduction of Bromide of Ethyl as an Anaesthetic for Dental Purposes or any Very Short Operation," *Transactions Illinois State Dental Society*, 1883, 67–70.
14. *American Society of Anesthesiologists Newsletter*, 15:5, May 1951.
15. Kinney, WB, *ADSA Newsmonthly*, April 1954, 1:1.
16. Orr, DL, "Dear 2012 American Dental Association House of Delegates," *Am Assoc Dent Editors*, Summer 2012.
17. Goszkowski, R, "Dental anesthesiology falls short of becoming ADA specialty," Dr. Bicuspid.com, http://www.drbicuspid.com/index.aspx?sec=sup&sub=rst&pag=dis&ItemID=311903, accessed 01 November 2012.
18. Indresano AT, District VI Trustee Report, *The WSOMS Westerner*, 25:2, Fall 2012, 10.
19. University of Sydney, *Dental Phobia*. Sydney.edu.au/news/84.html?newsstoryId=8807, accessed 01 November 2012.
20. Lethbridge-Cejku M, VIckerie J, "Summary health statistics for U.S. adults: national health interview survey, 2003," *Vital Health Stat* 10:225, 104, 2005.
21. National Institute of Dental and Craniofacial Research: Oral health in America: a report of the Surgeon General, Rockville, MD, 1000, U.S. Dept. of Health and Human Services, U.S. Public Health Service.
22. ADA conference, the dentist-patient relationship and the management of fear, anxiety, and pain, 1982.
23. Thiboudeau E, Mentasi L, "Who stole Nemo?," *J Am Dent Assoc*, 138:656–660, 2007.
24. Weaver JM, *Nevada Dent Assn J*, 14:4, 2012.
25. ADA, Definitions, https://www.ada.org/2555.aspx, accessed 19 December 2012.
26. Jackson CT, Morton WTG, "Improvement in Surgical Operations," U.S. Patent Office No. 4848, 12 November 1846.
27. American College of Legal Medicine, Resolution on Dental Anesthesiology, http://www.aclm.org/, accessed 08 November 2012.
28. MacIntosh RB, Kelly JPW, "The American Board of Oral and Maxillofacial Surgery, a History," ABOMS, 2010.
29. Department of Consumer Affairs, Dental Board of California, Regulations Chapter 2, Article 7, Section 1054, http://www.dbc.ca.gov/lawsregs/regulations/ch2_article7.shtml, accessed 08 November 2012.
30. ADA Code of Principles of Ethics and Code of Professional Conduct, http://www.ada.org/194.aspx, accessed 01 November 2012.

Robert H. Talley, DDS, CAE
robert.talleydds@nvda.org

The Legislative Session continues through June 3. Our website has a complete listing of the bills we are supporting, opposing or just monitoring. You will find this under the advocacy tab under current bills.

At the time of the writing of this article, the bill concerning "capping of non-covered services" is being written. It prohibits a dental plan from capping a fee on a service that they do not cover.

In this journal (pages 12 & 13), you will find the meeting and registration information for our annual summer meeting being held at the PlumpJack Squaw Valley Inn on July 4–6, 2013. We have planned some great activities and have secured a great room rate for this wonderful resort. Full breakfast is included with your room and there will be a free welcome Reception Thursday night featuring fresh wood-fired pizza. Your President, Gilbert Trujillo, has promised some special music (his band) for the Friday night dinner. The hotel room deadline is June 4, so please get your reservations soon. The registration and event deadline is June 28 and we are going to be firm on this date as many of the activities will not allow add-ons. Meals are particularly hard to plan when we have last minute additions. The North–South Golf challenge will take place Friday afternoon at Coyote Moon Golf Resort in Truckee. ◆

Affiliate News

Beware of cash-on-the-spot gold buyers

In our world of skyrocketing precious metals prices, we are seeing a proliferation of scrap buyers visiting dental offices nationwide. Some are legitimate representatives of established refiners, but more and more we're seeing the cash-on-the-spot buyer.

Do you really want to lose a large portion of the value of your scrap for the so-called convenience of a quick cash transaction? Selling your scrap to one of the many cash-on-the-spot buyers currently operating is a very risky way to go about selling your valuable precious metal scrap. Here's why:

- They can't accurately assess precious metal purity or composition of your material, such as Palladium alloys.
- They must make very conservative payments in order to protect themselves from potential losses due to poor guesswork in determining your scrap's value.
- The buyers then sell your material for a lot more than they paid you.
- You get no accounting of the contents of your material.

Who are they? Who do they represent? Do they expose you to potential liability issues associated with EPA regulations?

Only a reputable precious metals refiner has the technology and expertise to maximize your return based on precision laboratory analysis of your scrap. One excellent resource is Garfield Refining, a long-established (120 years) refiner headquartered in Philadelphia.

As long as we're on the subject, Garfield has also agreed to an exclusive offer for members of the Nevada Dental Association, as follows:

> In addition to receiving premium returns for your dental scrap, Garfield Refining will contribute an additional 5% of the valuation as a bonus for every submission of scrap from an NDA member.

Member dentists should contact Garfield's Nevada Representative, Tess Mosely, at 702-409-3737 to arrange a pick-up. Tess will need proof that you are a current NDA member and she will tag your lot of dental scrap for the 5% bonus prior to shipping to the refinery. ◆

Save the Date!

NDA Annual Summer Meeting

July 4–6

PlumpJack Squaw Valley Inn, North Lake Tahoe

Visit www.nvda.org
or call 702-255-4211 for details


Why
Compromise?
Experience the Value
of Aurum Ceramic @ LVI!
• A perfect fit with your practice – From advanced smile design to exacting full mouth reconstruction: superbly crafted crown & bridge restorations, dentures and cast partials to leading edge orthodontic appliances.
• Comprehensive Digital Workflow for superb accuracy and fast turnaround.
• Value-priced Aurum-exclusive products: Opalite®, Aurum's Cristal Veneers®, AurumTek® Abutments and much more.
• Innovative implant-based fixed price restoration programs and warranties.
• Proven solutions that simplify the restorative process – from initial impression to final restoration.
• Delivering Continuing Education on all the latest aspects of dentistry – Coast to Coast.
Visit us at www.aurumgroup.com
AURUM CERAMIC @ LVI
Call TOLL FREE for FREE PICK-UP
1-877-254-5334
*Designed and Manufactured in North America

Gilbert A. Trujillo, DDS
gtdds@charter.net

Greetings from Northern Nevada!
Hope this finds you healthy and prosperous.

The Nevada Legislature is in full force and we, the Nevada Dental Association, are actively monitoring all proposed legislation that could impact our members. The NDA is your advocate during these sessions and we are striving to keep abreast of the issues for you.

Dr. Robert Talley has been flying to Reno to attend meetings in Carson City, meeting with legislators and our lobbyist, Chris Ferrari. Mr. Ferrari and his staff are very busy in Carson City representing the NDA. We are pursuing our own legislation with regard to non-covered services and a bill to increase penalties for crimes committed against dental students. There are other issues that the NDA is closely monitoring that could affect our profession and patients. As these issues arise, we are meeting with the Legislative Committee to keep them informed and to strategize. I have also been in Carson City, but have to give kudos to Dr. Talley and Chris Ferrari, who are spending several hours each day for our organization.

By the time this issue of the *Journal* reaches you, we would have had our NDA Legislative Day in Carson City. This was a way to meet with legislators and let them know all the wonderful things our members do for our state. The NDA feels that Nevada dentists are providing the standard of care for the citizens of Nevada and that we are addressing our state's access to care issues. If you are providing pro-bono treatment to patients, please let the NDA, or your local component know so that we may use this data to further our agenda. The more our legislators know of our service to our citizens, the better it is for our profession.

On a lighter note, this year's NDA Summer Meeting, July 4–6, is going to be a wonderful family event. It is in Squaw Valley, California, which is only 35 minutes from Reno. We are holding it at the PlumpJack Resort, which features boutique rooms, beautiful scenery, a wonderful outdoor mall, and many opportunities for family adventure. Your room stay also includes breakfast daily! I chose this location because it is an amazing place for family fun, golf, fishing, zip lining, biking and many other activities.

Again, it is my pleasure to serve as your president. I am honored to serve with all the members of the NDA Executive Committee and all the other committees and members of the NDA. Together, our profession can stay strong if we are all united. Please attend our meetings, mentor a new dentist and keep doing what you have been doing for years…providing the best dental care in the United States. ◆

Oral Health Program Snapshot

December 2012–February 2013

By Monica Ponce, DDS, Board member, State of Nevada Board of Health

Staff Changes

The Oral Health Program Manager, Tim Streeper, is no longer with our program. Please contact the Chronic Disease Section Manager, Kimberly Fahey at 775-684-4253 or kfahey@health.nv.gov, if needed. The Section anticipates recruitment for this vacancy to begin March 11. Current staffing includes the following:

Christina Demopoulos, DDS, MPH, *Nevada Dental Director*, 702-774-2545

Melanie Flores, MSW, *Oral Health Evaluation Coordinator*, 775-684-7509

Aisha Bowen, *Oral Health Educator/Fluoridation Coordinator*, 702-486-9272

Renea Greenlee, *Oral Health Program Administrative Assistant*, 775-687-7525

Sealant Programs

The Oral Health Program is working with Future Smiles, Seal Nevada South, and Health Access Washoe County (formerly St. Mary's) to identify the impact of potential loss of funding previously provided by the Fund for Healthy Nevada. This resource provided funding to help support school-based dental sealant programs in Nevada and is eliminated in the Governor's budget to support other efforts in the next biennium 2014–2015.

Oral Health Summit

The Oral Health Summit was held in conjunction with the Statewide Chronic Disease conference held in January. This combined effort was a huge success. There was a great turnout of various community partners. Conference presentations can be viewed online at www.nevadapublichealthfoundation.org. Community partners were presented with 2013 Silver ACE Awards, to recognize their work in Chronic Disease Prevention and Health Promotion. Three awards were given to Oral Health Community partners for their outstanding work.

2013 Silver ACE Award Winners, Terri Chandler, RDH, Healthy Kids; Christina Demopoulos, DDS, MPH, Seal Nevada South; and Stephen DeLisle, DDS, Positively Kids, pose with Astrid Palmer, CHES, Division of Oral Health, Dept. of Health and Human Services, Centers for Disease Control and Prevention (CDC).

Future Smiles received the Outstanding School Health Promotion award for providing vital oral health care in school based setting to vulnerable children to decrease the incidence of oral disease.

Seal Nevada South received the Outstanding Surveillance/Data (Community) Award for accurate and concise data and surveillance with respect to various oral health indicators that allow comprehensive analysis of oral health disparities in the youth populations.

Stephen DeLisle, DDS received the Outstanding Clinical Linkage (Community) award for working with multiple care organizations. Within his private practice, Dr. DeLisle provides children with simplified access to a dental home and referral systems for treatment and follow up.

For more information on the award ceremony, visit the State Chronic Disease website at http://health.nv.gov/CD_ChronicDisease_Synchronicity.htm. You may also contact Kimberly Fahey at 775-684-4253, kfahey@health.nv.gov.

Head Start Basic Screening Survey (BSS)

On March 8, the 2011–2012 Head Start Basic Screening Survey (BSS) report was published online and presented to the State Advisory Committee of Oral Health. The report is posted on the State Oral Health website at http://health.nv.gov/CC_OralHealth.htm.

Community Activities

Dr. Christina Demopoulos, State Dental Director and Aisha Bowen, State Oral Health Program Educator presented at the Nevada Disability Conference on April 21. ◆

Nevada Oral Health Initiative—http://health.nv.gov/CC_OralHealth.htm

95th Annual Summer Meeting

PlumpJack Squaw Valley Inn • Squaw Valley, CA

July 4–6, 2013

Schedule

THURSDAY, JULY 4

Registration	1–5 PM
Executive Committee Meeting	3–5 PM
Welcome Reception	6–8 PM

FRIDAY, JULY 5

Joel F. Glover Fun Run & Pizza	6 AM Run / 7 AM Breakfast
HOD I—Leadership Training	8–11:30 AM
North–South Golf Tournament	1 PM / Coyote Moon Golf Resort
President's Dinner	7–9 PM

SATURDAY, JULY 6

Pliney Phillips Breakfast	7–8 AM
HOD II	8 AM–12 NOON

Registration Form

NDA 95th Annual Summer Meeting, July 4–6, 2013
PlumpJack Squaw Valley Inn • Squaw Valley, California

Event	Time	Number Attending		Fee (per person)	Total payment
Registration—NDA member/spouse/child		_____		$ 0	
Registration—Non-NDA member (required)		_____	x	$ 300	$_____
Registration—Non-ADA member (required)		_____	x	$ 500	$_____
Thursday, July 4					
Executive Committee Meeting	3–5 PM	_____			
Welcome Reception	6–8 PM	_____		Included in conference cost	
Friday, July 5					
Joel F. Glover Fun Run & Pizza Breakfast	6 AM Run	_____			
Joel F. Glover Fun Run & Pizza Breakfast	7 AM Breakfast	_____		Included in conference cost	
House of Delegates—Session 1	8–11:30 AM	_____			
North–South Golf Tournament	1 PM	_____	x	$ 110	$_____
President's Dinner Adult	7–9 PM	_____	x	$ 110	$_____
President's Dinner Child (5–12)	7–9 PM	_____	x	$ 55	$_____
Saturday, July 6					
Pliney Phillips Breakfast	7–8 AM	_____		Included in conference cost	
House of Delegates—Session 2	8 AM–12 NOON	_____			
				Grand Total	$

Note: Registrations will be accepted until June 28, 2013.
No refunds given past June 28, 2013. Hotel reservations and pricing are only guaranteed through June 4, 2013.

Name _____ ADA Number _____

Guest(s) _____ Email _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Accepted forms of payment are: check (payable to NDA), Visa, MasterCard and AMEX. Please indicate below.

Credit Card Number _____ Expiration Date _____ Security Code _____

Name on card _____

Billing Address _____

Authorized Signature _____

Mail or fax completed form to:
Nevada Dental Association
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147
702-255-4211 • Fax: 702-255-3302

Hotel Reservations: Cutoff for rooms is June 4, 2013
PlumpJack Squaw Valley Inn • Squaw Valley, CA
1-800-323-7666
Group name: Nevada Dental Association
Rates start at $185 and include full breakfast

Hypnosis in Dentistry

By Yasaman Yasini, BS, RDH

Abstract

Dental phobia is one of the most overlooked phenomena in dentistry.[1] While many dentists may be most aware of the clinical excellence of their work, some tend to forget about the experience it leaves behind for the apprehensive patient. An anxious patient is less inclined to complete his/her routine dental visits which can lead to an increase in the incidence of oral pathology such as periodontal diseases. Clinical hypnosis is known to be a powerful technique in treating phobic patients. The objective of this study is to explore the applications of hypnotherapy in dental offices as well as its effectiveness as supplemental treatment when dealing with phobic patients. The subjects of the study were 50 individuals from two dental offices with varying dental treatment plans. Data collected from the questionnaire revealed that patients used hypnotherapy for treatment of orofacial pain disorders, parafunctional/maladaptive oral habits, dental phobia, and for analgesia. It should be noted that the effect of hypnotherapy varies from patient to patient and it cannot be consistently used on everyone.

Introduction

Clinical hypnosis is a form of psychotherapy which involves the induction of a trance-like state in an individual resulting in a state of hyper-suggestibility. In this state, the conscious mind relaxes or becomes dormant through distractions while supplanted by the subconscious mind. The mechanism of hypnosis is yet to be understood but one fact most would agree with is that hypnosis involves a system of bypassing the critical and skeptical nature of the conscious mind with a heightened receptivity to suggestion to achieve a therapeutic outcome.[2] In this process, the therapist or the clinician acts as a guide, shifting the patient's consciousness to a state of hypnotic trance. A trance has a sleep-like quality and is associated with many physiologic changes such as relaxing of facial muscles, decrease in orienting movements, immobility, decreased blinking and swallowing, catalepsy in limbs, increased autonomous motor behavior, decreased respiratory rate and pulse, fixed gaze, faraway look, changed voice quality, time lag in volitional responses, literalism, dissociation, amnesia, and time distortion.[3]

Clinical hypnosis has a long history of application. The technique dates back to the Ebers papyrus in Egypt and Aesclepius' sleep healing temples in ancient Greece.[2] There are various accounts of hypnosis found in the Bible and the Hindu Vedas dating back to 1500 B.C.[4] In 1775, Franz Antoine Mesmer developed a healing procedure known as "animal magnetism" or mesmerism which was later renamed hypnosis.[5] Modern clinical hypnosis has grown to have a wide range of applications in the dental, medical, and mental health fields.

In the field of dentistry, the use of hypnosis began in 1763 when Oudet, a French dentist, used hypnoanesthesia to complete a dental extraction.[4] Today's research uncovers various applications of clinical hypnosis in patient dental care. While undergoing dental treatment, many patients experience a high level of physical stress. Close physical proximity of the patient and the doctor can cause additional stress. Statistics show that only 20–30% of the patients presenting for their dental appointment are anxiety-free, while international studies reveal that 46–59% of all patients are apprehensive of dental treatment and up to 27% are extremely anxious.[4] Patients with severe dental phobia or anxiety tend to avoid dental treatment, which in turn aggravates their oral health, most often leading to more dental disease.[6] Dental fear can manifest itself in various forms such as fear of injection, pain, smell, sound, gagging, or the dental operatory overall. Clinical hypnosis, as an alternative approach, helps reduce stress and anxiety in fearful and phobic patients through distracting them with suggested imagery and stories.[7]

Hypnoanesthesia is another aspect of clinical hypnosis that plays a vital role in restorative dentistry. Studies[3] suggest that employing hypnosis for dental analgesia is more beneficial compared to chemical numbness in a sense that the numbing effect does not last for hours; there are no chemical risk factors, and it requires no injection. Hypnosis combined with

standard sedatives can also provide a mean of sedation for drug-dependant patients who have developed tolerance to standard sedative agents.[8]

Moreover, hypnotic interventions have been used for treating patients with smoking,[9] parafunctional oral habits such as bruxism and clenching, as well as those suffering from orofacial pains such as temporomandibular disorder syndrome.

Methods

The data for this study was collected from a questionnaire (*Appendix 1*) that was previously structured and later distributed between dental patients of two dental offices. The doctors agreed to participate on the condition of anonymity.

The questionnaire contained queries about the age and the sex of the patient, the patient's medical or dental conditions, any fear or anxiety the patient experiences before or during dental treatment has affected the regularity of these visits. Patients were also asked about any existing oral para/malfunctional conditions and as well as their opinions on the effectiveness of the hypnotherapy used.

The total number of individuals involved in this study was 50—27 from one office (office X) and 23 from another (office Y). Patients were encouraged to partake in the survey, but participation was completely on voluntary basis.

Results

From the total of 50 participants who completed the survey, 15 out of 27 from office X were female and 12 were male. Data collected from office Y yielded 17 out of 23 females and 6 males. Of the patients, 23% claimed to be completely anxiety-free when visiting the dentist, while the rest reported mild to high levels of anxiety. The self claimed anxious patients reported lower frequency of dental visits due to their phobia (46% answered yes when asked whether their anxiety affects their dental visits). Moreover, the data collected revealed that 28% of the subjects used hypnosis for dental analgesia (86% for restorative dental work and 14% due to drug dependence); 20% for orofacial pain, more specifically for temporomandibular pain disorder (70% of the patients answered yes to being recalcitrant to conservative medications); 40% for management of dental fear and anxiety (gag reflex, fear of injection, pain), and 12% for treatment of parafunctional or maladaptive oral habits such as bruxism and clenching (*Figure 1*). When asked about the reason as to why the respondents chose hypnotherapy over other traditional dental treatment, 45% chose hypnosis due to its cost efficient and non-invasive nature while 55% of the participants preferred hypnosis due to the fact that it gives them a chance to be in control throughout the process, hence reducing the level of their anxiety (*Figure 2*). Figures 1 and 2 summarize these findings. Moreover, 72% of the respondents answered positive to practicing self-hypnosis pre- and post dental office hypnosis sessions.

Continues ➲

FIGURE 1

Clinical hypnosis application among 50 dental patients in two dental offices: 40% used hypnosis for phobia management, 28% for dental analgesia, 20% for orofacial pain and 12% for maladaptive/parafunctional oral habits.

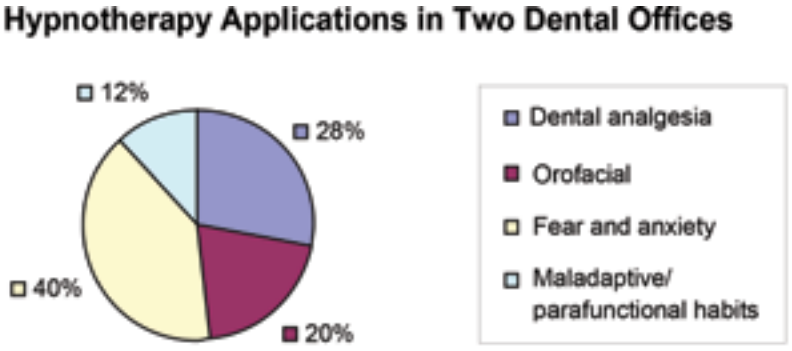
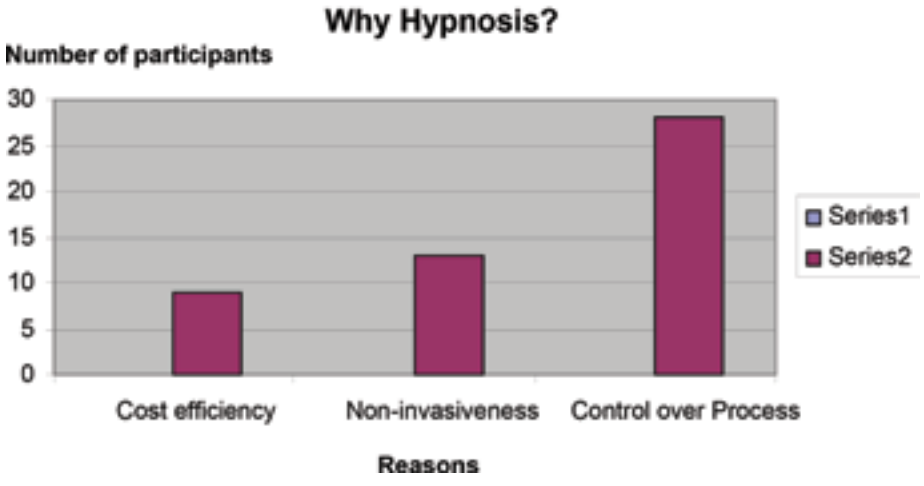


FIGURE 2

The number of participants preferring clinical hypnotherapy over traditional dental treatments. 18% preferred the cost efficiency of hypnosis, 26% favored its non-invasive nature, and 56% appreciated the control they held during dental procedures.



Discussion

Clinical hypnosis, alone or in conjunction with other dental anxiety treatment modalities, plays an effective role in different aspects of dentistry. The survey results from the study demonstrated a diverse spectrum of clinical hypnotherapy applications, the most prevalent being the use of hypnosis for the management of anxiety. International studies have found that up to 11% of all dental patients suffer from a dental phobia that renders them incapable of attending dentist visits and affecting their personality enough to cause severe psychic reactions.[4] Hypnosis affects the patient by utilizing suggestions which modify the conscious state of the patient during the hypnotic trance. This trance dissociates the patient from the source of his/her anxiety through "physical and mental relaxation, distortion of time, and anxiolysis."[4] Ghoneim et. al. revealed in a study that patients who practiced self hypnosis pre- and post-molar tooth extraction experienced less anxiety and pain pre- and postoperative procedure compared to their control group.[10]

The survey results also found the gag reflex as another hindering problem in attaining regular dental care among patients. A severe gag reflex can be elicited by the dentist's fingers or instruments contacting the oral mucosa or even by nontactile stimuli.[11] This experience tends to be very stressful for both patients and doctors. The clinical hypnosis approach to this problem is to minimize the level of anxiety and stress through engaging the patient with a distracting activity or visual imagery suggestions. Using hypnotic suggestions combined with acupuncture also help the patient manage the gag reflex.[12]

Employment of hypnosis in conjunction with, or in replacement of, chemical anesthesia, analgesia or sedation was the second most popular technique among the study population. The majority of the respondents utilized hypnoanesthesia/analgesia for restorative dental work while there was a small percentage that employed this technique due to drug dependency problems. Through a simple hypnotic induction and suggestion of numbness and relaxation, a first point of numbness in the patient's index finger is produced. The finger is then placed on the gums and teeth gradually extend the numbness panorally.[4]

Patients with drug dependency problems tend to build up tolerance towards standard sedative agents. Since higher doses of sedatives result in respiratory or circulatory compromise, a combination of hypnosis and sedation can create the favorable hypnosedation technique in these patients. However, it should be noted that the hypnosedation procedure is highly dependant on the choice of sedative regimen and the patient's nature of drug dependency.

Also listed on the survey was the use of hypnosis for treatment of orofacial pain disorders. In treatment of orofacial pain disorders and most specifically temporomandibular disorder (TMD), hypnosis tends to be the treatment of choice. In patients who have been shown to be recalcitrant to conservative treatments, hypnotherapy has led to significant decrease in the intensity, duration and frequency of TMD pain. The effectiveness of the hypnotic treatment modality can be explained through the unconscious nature of the behaviors responsible for the pain symptoms (i.e. grinding and clenching) which happens often during sleep.[3] What hypnosis does is provide the patient with posthypnotic suggestions "that muscle tension, pain, and discomfort are the cues for the muscle to automatically relax whether during sleep or when awake." A study by Simon et. al. successfully demonstrated that their subject studies exhibited a significant decrease in their TMD pain ratings after 3–6 session of hypnosis treatment.[3]

Bruxism and clenching were also included as some of the para-functional/maladaptive activities that the participants listed for which they sought hypnotherapy. Hypnosis triggers continuous muscular relaxation with the emphasis on the muscles of mastication[4] which consequently helps overcome the problems of clenching and bruxism.

Aside from the fact that almost all participants found hypnotherapy to be cost efficient, non-invasive, and more patient-centric, successful hypnosis treatment results vary from patient to patient. It should be noted that all hypnosis is self-hypnosis and the therapist or the clinician only act as

guides. The effect of hypnosis is dependant on the interaction of the patient and the clinician and mental openness of the patient undergoing trance and therefore is not equally effective in each individual.

Conclusion

Clinical hypnosis creates a trance like state with the use of visual imagery suggestions as well as mind distracting methods to help the patient relax physically and mentally. This technique is extremely helpful in the field of dentistry while dealing with anxious patients. However, induction of hypnosis depends not only on the therapist but on the patient's willingness to accept a trance. Therefore, hypnosis treatments tend to have varying effects in different individuals. Current studies support that clinical hypnosis is a viable adjuvant for traditional dental treatments.[4] In order to be more widely utilized in dentistry, more studies should be carried out on the practicality and effectiveness of hypnotherapy. ◆

Yasaman Yasini, BS, RDH is a practicing educator and dental hygienist at the University of the Pacific Dental Hygiene. She has been accepted for matriculation into dental school in 2013.

Editor's Note: The free dental CE options listed on page 16 include an article from Wiley Publications' CA, A Cancer Journal for Clinicians *titled "Hypnosis for Cancer Care." CA also offers a free CE article titled "Oral Complications of Cancer and Cancer Therapy."*

APPENDIX 1

Survey on Applications of Hypnotherapy

Sex: Age:

1. Do you experience dental phobia or anxiety pre/post/during treatment?
   A) Yes B) No

   If so, does this anxiety affect your regular dental visits?
   A) Yes B) No

   Please write down the reason for which you are undergoing hypnosis treatments. (Possible options: Dental analgesia, Orofacial pain disorder, Dental phobia or anxiety, Maladaptive/parafunctional oral habits, drug dependency). Feel free to elaborate.

2. If you have been diagnosed with Temporomandibular Disorder (TMD), have you been treated with conventional medications?

   If yes, why are you choosing to undergo hypnotherapy?

3. Why have you chosen hypnosis over traditional dental treatment?
   A) Cost efficiency
   B) Non invasiveness
   C) Having the control over the procedure

4. Has the hypnotherapy been effective?
   A) Yes B) No

5. Do you comply with pre- and post- hypnotic suggestions?
   A) Yes B) No

6. Do you practice self-hypnosis?
   A) Yes B) No

References:

1. University of Sydney, "Dental Phobia." sydney.edu.au/news/84.html?newsstoryid=8807. Accessed February 14 2013
2. Gurgevich, S. "Clinical Hypnosis and Surgery." *Alternative Medicine Alert.* October 2003, vol (6), 109–120
3. Ericson MH, Rossi EL, Rossi SI. *Hypnotic realities: the induction of clinical hypnosis and forms of indirect suggestion*. New York: Irvington Publishers; 1976.
4. Rauch C, Panek H. "Hypnosis in Daily Dental Practice." *Dental and Medical Problems*. 2008, 45, 3, 301–306.
5. Wobst A.H.: "Hypnosis and surgery: past, present, and future." *Anesthesia and Analgesia*. 2007, 104, 1199–1208.
6. Lethbridge-Cejku M, Vickerie J, "Summary health statistics for U.S. adults: national health interview survey, 2003," *Vital Health Stat* 10:225, 104, 2005.
7. Peltier B. "Psychological treatment of fearful and phobic special needs patients." *Special Care in Dentistry*. 2009, 29, 1, 51–57.
8. Morse D.R., Cohen B.B., "Desensitization Using Meditation-Hypnosis to Control "Needle" Phobia in Two Dental Patients." *Anesthesia Progress*. May/June 1983, 30(3), 83–85
9. Montgomery GH, Schnur JB, Kravits K, "Hypnosis for Cancer Care: Over 200 Years Young." *CA Cancer J Clin* 2013;63:31–44, Jan/Feb 2013.
10. Ghoneim M.M., Block R.I., Sarasin D.S., Davis C.S., Marchman J.N. "Tape-Recorded Hypnosis Instructions as Adjuvant in the Care of Patients Scheduled for Third Molar Surgery." *Anesthesia and Analgesia*. 2000 Jan, 90(1), 64–8.
11. Bassi G.S., Humphris G.M., Longman L.P. "The etiology and management of gagging: A review of the literature." *The Journal of Prosthetic Dentistry*. 2004, 91, 459–67.
12. Eitner S., Wichmann M., Holst S. "Hypopuncture—a dental-emergency treatment concept for patients with a distinctive gag reflex." *The International Journal of Clinical and Experimental Hypnosis*. 2005, 53, 60–73.

Oral Squamous Cell Carcinoma

By Nadim M. Guirguis, DMD; Jonathan C. McCabe, BS, DMD; Victoria L. Woo, DDS

Case Report

A 62-year-old Caucasian female presented to the emergency clinic at the University of Nevada, Las Vegas School of Dental Medicine (UNLV SDM) complaining of a "cut" on the left mandibular ridge and increasing pain radiating to her left ear. The patient reported that the area of concern had been present for several months but was not healing. She reported wearing a mandibular removable partial denture which was contributing to her discomfort. Further questioning revealed a 47-pack year history of smoking cigarettes (i.e. one 20-cigarette pack per day for 47 years) and social alcohol use. The patient also related that her brother, a heavy smoker and drinker, had been previously diagnosed with oral cancer.

The patient's past medical history was significant for osteoporosis, hypothyroidism, and hypercholesterolemia. The patient reported a known allergy to sulfa drugs. Her medications on presentation included alendronate, fenofibric acid, levothyroxine, and vitamin D supplements.

Extraoral examination revealed no lymphadenopathy, no trismus, and no masses or swellings of the exposed facial and cervical skin. Visual and tactile examination of the temporomandibular joints showed no abnormalities, with no limitation or pain upon movement. On intraoral examination, a red-white mass with a thick, verrucous surface was identified involving the left ventral tongue and floor of mouth (*Figure 1*). The lesion measured approximately 3.0 x 2.0 cm and was markedly indurated. Further examination revealed a white, papillary lesion involving the left posterior lateral tongue (*Figure 2*). This second lesion was distinctly separate from the first mass and measured approximately 0.4 x 0.4 cm. The remainder of the intraoral examination was within normal limits.

Given the clinical appearance of the ventral tongue-floor of mouth lesion and the patient's extensive smoking history, we strongly favored the diagnosis of squamous cell carcinoma (SCC) for the first lesion. Our differential diagnosis for the second, posterior lateral tongue lesion was broader and included verrucous epithelial dysplasia versus SCC versus squamous papilloma. To establish a definitive diagnosis, two biopsies were performed, the first specimen from the ventral tongue-floor of mouth mass and the second from the left posterior lateral tongue lesion. The biopsies were sent to an oral and maxillofacial pathologist. Both specimens showed dysplastic stratified squamous epithelium with overlying hyperkeratosis in a prominent papillary pattern. Islands of squamous cells were identified

FIGURE 1

Red-white, verrucous mass involving left ventral tongue and floor of mouth.

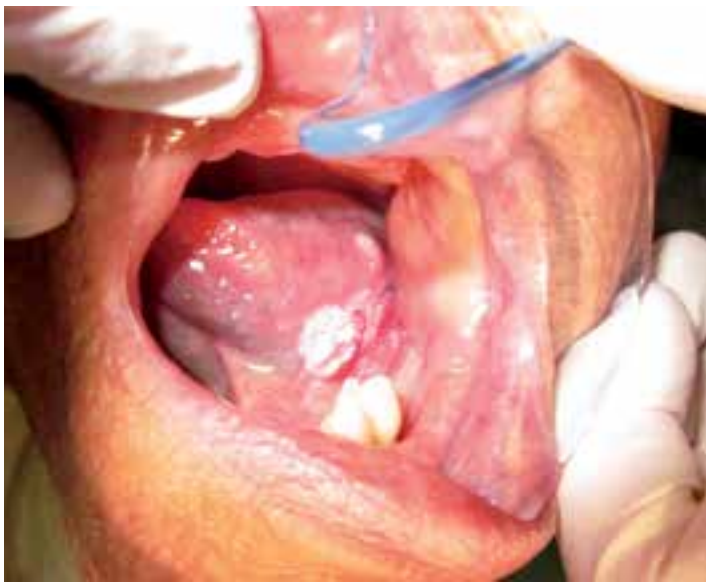
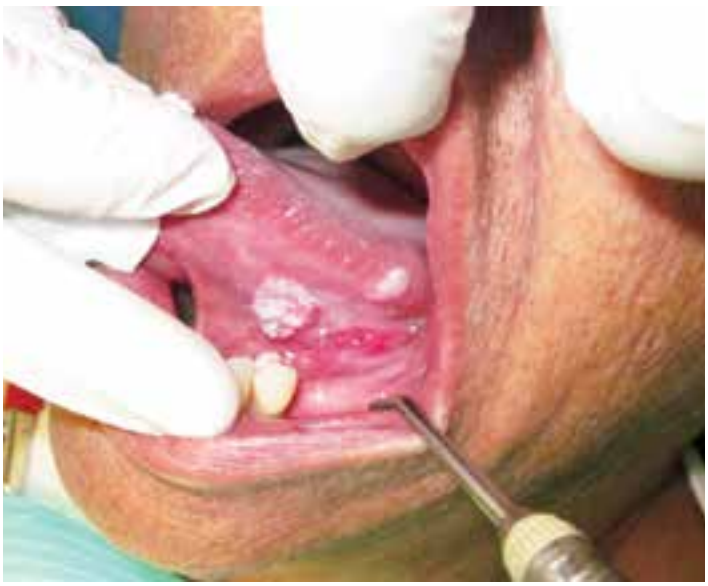


FIGURE 2

White, papillary mass involving left posterior lateral tongue.



infiltrating the underlying connective tissues (*Figure 3*). The squamous cells exhibited mildly atypical features, including increased nuclear-cytoplasmic ratios and mitotic figures (*Figure 4*). Keratin pearls were also observed throughout the invasive squamous islands. The diagnosis rendered for both specimens was well-differentiated SCC.

Following discussion of the diagnosis with the patient, she was provided with a surgical referral for further imaging and management of her tumor.

Discussion

Oral cancer accounts for nearly 3% of all cancers worldwide.[1-3] Of the 615,000 new cases of oral cancer reported worldwide in 2000, 300,000 were primary oral SCC.[1,4] In the United States alone, an estimated 28,900 new cases of oral SCC will be identified each year and 7,400 deaths will be attributable to this diagnosis annually.[5,6] In the past, oral SCC was typically associated with men of age 60 years and older who were regular consumers of tobacco and alcohol products. Similarly high incidence rates are seen in middle-aged black males.[1,2] However, the patient demographic has shown a shift in recent years with an increase in oral SCC noted in patients younger than 40 years and women who do not smoke or drink .[3,7]

Etiology

Oral SCC is a condition that is associated with a wide array of causative agents and factors. Two risk factors of notable importance in the etiology of oral SCC are tobacco use and alcohol consumption, which contribute to approximately two thirds of all cases.[4] Recently, the role of viruses in the development of oral SCC has received much attention. Human papilloma virus (HPV) subtypes 16, 18, and 31 are of interest as subtypes 16 and 18 are found in 22% and 14% of oropharyngeal tumors, respectively.[4] These HPV subtypes have been shown to increase the risk of oral SCC development by 3- to 5-fold.[8-10]

Clinical and microscopic features

Clinically, the majority of oral SCCs are preceded by a precancerous clinical findings such as a leukoplakia, erythroplakia, or submucous fibrosis, a condition seen in patients who use the carcinogenic compound betel quid. Upon progression to oral SCC, the tumor can present as an exophytic or endophytic red, white or mixed red-white mass. It may exhibit an irregular papillary or verruciform surface and may demonstrate tumor-related ulceration and necrosis. Firmness and induration are often noted on clinical palpation. The most common locations for oral SCC are the ventral and lateral borders of the tongue (40%) and the floor of the mouth (30%).[2,6] Other sites of involvement include the retromolar trigone, buccal mucosa, and gingiva. Although all patients with a history of oral or oropharyngeal carcinoma are at risk for developing a second primary malignancy, patients with floor of mouth involvement are at particularly high risk.[1] This risk is further increased in patients who continue to smoke or abuse alcohol following treatment of their initial lesion.[1]

Microscopically, oral SCC is characterized by atypical squamous cells that invade the underlying lamina propria and connective tissues. The individual tumor cells may present with variable features of cytologic atypia, including enlarged and darkened nuclei, prominent nucleoli, and

Continues ➲

FIGURE 3

Microscopic view of first biopsy showing invasive islands of squamous cells and keratin pearl formation (hematoxylin-eosin, x 40 magnification).

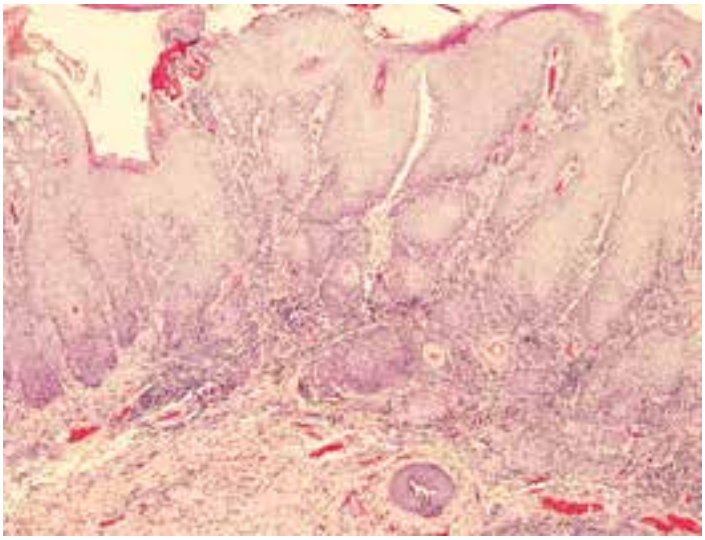
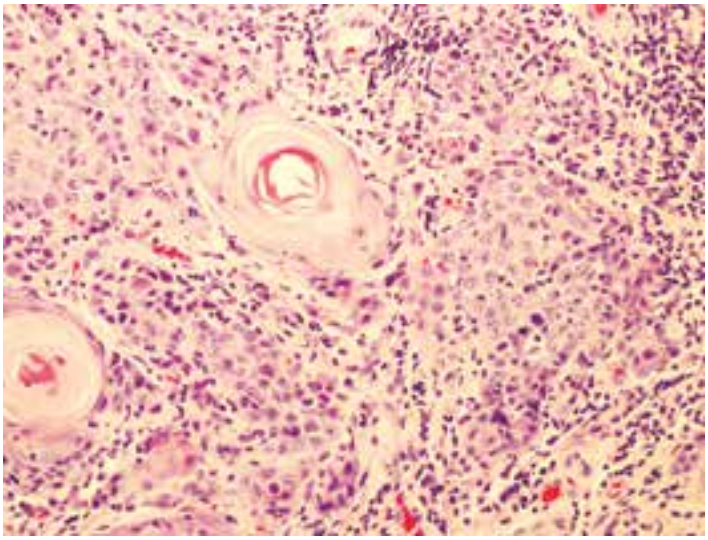


FIGURE 4

High-power microscopic view of first biopsy showing squamous cells with enlarged, darkened nuclei and mitotic figures (hematoxylin-eosin, x 200 magnification).



increased and atypical mitotic activity. Abnormal architectural features such as loss of normal maturation and keratin pearl formation may also be observed. A strong inflammatory reaction is often seen in response to the invasive cells. Focal or diffuse areas of necrosis may also be present. Histologically, oral SCC will often be classified as well-differentiated, moderately differentiated or poorly differentiated depending on the maturity and degree of cytologic atypia exhibited by the tumor cells. Tumors composed predominantly of squamous cells that are mature and bland-appearing and that retain their ability to produce keratin are labeled as "well-differentiated." In contrast, tumors comprised of primitive, pleomorphic cells with little resemblance to squamous cells and with no evidence of keratin production are labeled as "poorly differentiated" and have a correspondingly poorer prognosis. To date, histopathologic examination remains the gold standard in confirming the diagnosis of oral SCC.

Tumor staging

The staging of oral SCC is critical in determining appropriate treatment and in predicting prognosis. Tumors are currently staged according to the TNM classification system which involves assessment of tumor size, regional lymph node metastasis, and distant metastasis (Table 1).[11]

TABLE 1

TNM staging for oral carcinoma

Primary tumor size (T)

- T0: No evidence of primary tumor
- T1: Primary tumor <2 cm
- T2: Primary tumor 2-4 cm
- T3: Primary tumor >4 cm
- T4: Invasion of tumor into adjacent structures (e.g. muscle, skin, bones, nerves)

Regional lymph node status (N)

- N0: No regional lymph node metastasis
- N1: Metastasis to a single ipsilateral lymph node (<3 cm)
- N2a: Metastasis to a single ipsilateral lymph node (3-6 cm)
- N2b: Metastasis to multiple ipsilateral lymph nodes (<6 cm)
- N2c: Metastasis to bilateral or contralateral lymph nodes (<6 cm)
- N3: Metastasis to any lymph node (> 6 cm)

Distant metastasis (M)

- Mx: Cannot be assessed
- M0: No distant metastasis
- M1: Distant metastasis

Staging

- **Stage 1:** T1N0M0
- **Stage 2:** T2N0M0
- **Stage 3:** T3N0M0, T1N1M0, T2N1M0, T3N1M0
- **Stage 4:** Any T4 lesion, any N2 or N3 lesion, any M1 lesion

Adapted from: Tumor-node-metastasis (TNM) staging system for oral carcinoma. In: Greene FL, Page DK, Fleming ID et al, editors. *AJCC cancer staging manual, ed 4.* New York, 2002, Springer.[11]

Management and prognosis

The mainstay treatment oral SCC is wide surgical resection with or without dissection of the cervical lymph nodes (neck dissection). Neck dissection is indicated in patients with suspected regional lymph node metastasis and/or in patients with tumors showing greater than 4mm depth of invasion histologically.[4,12] Planning the surgical management of a patient with oral SCC is a complex process that must take into account tumor stage as well as a patient's functional status and co-morbidities. Because the oral cavity is particularly critical for speech, deglutition, and mastication, ablative surgical resection risks severe compromise of these essential physiologic functions. Quality of life studies have shown that the most important functional outcomes for oral SCC are the preservation of speech and swallowing.[13,14] With the introduction of microvascular free-tissue grafting, there has been significant improvement in quality of life indices of patients undergoing ablative surgery for oral SCC.[4]

Radiation therapy is one of the most common post-operative (adjuvant) therapies given for patients with oral SCC. Conventional 2- or 3-dimensional radiation therapy or intensity-modulated radiation therapy (IMRT) is indicated for lesions involving the oropharynx and presence of close or positive resection margins, regional metastasis, and high-grade histologic features.[1] Chemotherapeutic may also be given in some cases before and/or after surgical resection and to reduce symptoms in incurable cases.[1]

The recurrence rates for oral SCC remain fairly high, reportedly ranging from 25 to 48%.[15,16] Recurrences are typically attributed to positive margins, or presence of tumor cells at the borders of the resected tissues.[17] Prognostically, initial stage at diagnosis appears to be a powerful predictor of survival in patients with oral SCC. Survival rates for stage I tumors approach 80%, whereas survival rates associated with tumors diagnosed in more advanced stages (stages 3 or 4) falls dramatically to 21%.[6] Distant metastasis of oral SCC is observed rarely and most commonly affects the lung. Unfortunately, the outlook for patients with distant metastasis is poor, with mean survival times reportedly as low as 8.9 months.[18]

Early detection and treatment are of utmost importance in the overall survival of patients with oral SCC. As such, vigilance on the part of practicing dentists in performing thorough intraoral examinations and recognizing the features of pre-malignant and malignant epithelial pathology may lead to early identification of such lesions and ultimately, a more favorable outcome for affected patients. ◆

References

1. Neville BW, Damm, DD, Allen CM, Bouquot JE. "Epithelial pathology." In : Neville BW, Damm, DD, Allen Cm, Bouquot JE, editors. *Oral & Maxillofacial Pathology*, 3rd ed. St. Louis: W.B. Saunders: 2009; p. 409–21.
2. Silverman S, Jr. "Demographics and occurrence of oral and pharyngeal cancers: the outcomes, the trends, the challenge." *J Am Dent Assoc* 2001;132(suppl):7S–11S.
3. Llewellyn CD, Johnson NW, Warnakulasuriya KA. "Risk factors for squamous cell carcinoma of the oral cavity in young people: a comprehensive literature review." *Oral Oncol* 2001;37:401–418.
4. Kademani D. "Oral cancer." *Mayo Clin Proc* 2007;82, 878–887.
5. Jemal A, Tiwari RC, Murray T, et al. "American Cancer Society. Cancer statistics, 2004." *CA Cancer J Clin* 2004;54:8–29.
6. Ries LAG, Harkins D, Krapcho M, et al, editors. SEER Cancer Statistics Review, 1975–2003. Bethesda, Md: National Cancer Institute. Available at: http://seer.cancer.gov/csr/1975_2003/, based on November 2005 SEER data submission, posted to the SEER Web site, 2006.
7. Schantz SP, Yu GP. "Head and neck cancer incidence trends in young Americans, 1973-1997, with a special analysis for tongue cancer." *Arch Otolaryngol Head Neck Surg* 2002;128:268–274.
8. Mork J, Lie AK, Glattre E, et al. "Human papillomavirus infection as a risk factor for squamous-cell carcinoma of the head and neck." *N Engl J Med* 2001;344:1125–1131.
9. Gillison ML, Shah KV. "Human papillomavirus-associated head and neck squamous cell carcinoma: mounting evidence for an etiologic role for human papillomavirus in a subset of head and neck cancers." *Curr Opin Oncol* 2001;13:183–188.
10. Miller CS, White DK. "Human papillomavirus expression in oral mucosa, premalignant conditions, and squamous cell carcinoma: a retrospective review of the literature." *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 1996;82:57–68.
11. Greene FL, Page DK, Fleming ID, et al. "Tumor-node-metastasis (TNM) staging system for oral carcinoma." In: Greene FL, Page DK, Fleming ID, et al, editors. *AJCC cancer staging manual*, ed 4. New York: Springer: 2002.
12. Spiro RH, Huvos AG, Wong GY, Spiro JD, Gnecco CA, Strong EW. "Predictive value of tumor thickness in squamous carcinoma confined to the tongue and floor of the mouth." *Am J Surg* 1986;152:345–350.
13. Chandu A, Smith AC, Rogers SN. "Health-related quality of life in oral cancer: a review." *J Oral Maxillofac Surg* 2006;64:495–502.
14. Woolley E, Magennis P, Shokar P, et al. "The correlation between indices of deprivation and health-related quality of life in patients with oral and oropharyngeal squamous cell carcinoma." *Br J Oral Maxillofac Surg* 2006;44:177–186. Epub 2005 Aug 18.
15. Pearlman NW. "Treatment outcome in recurrent head and neck cancer." *Arch Surg* 1979;114:39-42.
16. Nathanson A, Agren K, Biorlund A, et al. "Evaluation of some prognostic factors in small squamous cell carcinoma of the mobile tongue: a multicenter study in Sweden." *Head Neck* 1989;11:387–92.
17. Van Es RJ, van Nieuw Amerongen N, Slootweg PJ, et al. "Resection margin as a predictor of recurrence at the primary site for T1 and T2 oral cancers: evaluation of histopathologic variables." *Arch Otolaryngol Head Neck Surg* 1996;122:521–525.
18. Younes RN, Gross JL, Silva JF, et al. "Surgical treatment of lung metastases of head and neck tumors." *Am J Surg* 1997;174:499–502.

About the authors

Nadim M. Guirguis, DMD
UNLV SDM, is a resident in Orthodontics at the University of the Pacific

Jonathan C. McCabe, BS, DMD
UNLV SDM, is a resident in Oral and Maxillofacial Surgery at the University of Florida-Jacksonville

Victoria L. Woo, DDS,
is an Associate Professor of Biomedical Sciences at UNLV SDM

What if?

By Lawrence B. Hundley, Jr., DDS

The day began as any other day in Dr. Jerry's professional life. He had awakened to the sun's rays glistening against the glass window of his bedroom. The sun was tracking its way up from the east, following its usual course. Dr. Jerry followed his same jogging trail around the park, speaking as he went to the same faces he greeted on each of his other early morning runs.

Later, the dew was still damp on the windshield of his sports car when he popped in, snapped his seat belt and sped off to his office.

At 8:10 a.m., he drops his briefcase behind his desk and slips into his office attire. The staff of ten is now ready for the same routine. The appointment book is full of names of scheduled patients. Six patients are waiting for their 8:15 a.m. treatment. No one knows who, or how many patients, will "walk-in" with complaints of an acute problem of some kind. But based on the previous days, the staff will expect 6–10 people to walk-in to balance the no-shows for the day.

The day proceeds without a hitch. Dr. Jeremy is rushed from exam room #1 to procedure rooms #2, 3, 4 and 5. There is no time for greetings or small talk with patients. "Got to be sure that the lady in room #4 gets her denture," he mutters as he hurries on to the next managed care approved procedure.

Even if, and often when, other procedures would be beneficial, there is no time to discuss these options. Covered procedures, under this plan, are the only procedures considered in this busy office. Those time consuming changes on treatment plans have to be forgotten. Long-term treatment gives way to shorter treatments. The same routine is repeated day after day.

BUT, WHAT IF?

What if, on one tomorrow, the same routine begins the day, but when Dr. Jerry reaches his office, there is only one car in the previously full parking lot. The office is pregnant with silence; the schedule is greatly decreased with many unfilled spaces.

WHAT HAS HAPPENED? Has managed care given way to private pay, indemnity insurance or direct reimbursement? What could this young dentist have done to protect him from this dilemma?

Dr. Jerry squandered many opportunities in the process of building his practice of dentistry. The third-party carriers marketed this practice. He depended on these sources for his total success. His patients did not know his name. The office was chosen by the insurance plan. In today's marketplace, many patients leave after treatment without knowing the name of the individual who treated them. We have moved away from using our names on our doors and windows. Many dental offices use generic names, such as "Jacksonville City Dental Office" or "County-Line Family Dental Clinic." Patients never become acquainted with the treating doctor. Thus, if the plan ever changes or the patient drops the present insurance, even if they

preferred the previous dentist, there is no name to seek.

One solution to this problem is to have your personal cards available for your patients. Give one to every patient you treat. Be sure that your patient knows you by your name. The lines from Shakespeare's *Romeo and Juliet*: "What's in a name? That which we call a rose by any other name would smell as sweet," is not apropos in the practice of dentistry.

> ***"…parent your practice; nurture and bond to your patients. Familiarity breeds success."***

Another missed opportunity involves doctor/patient discussion of alternative treatment plans for their problems. The opportunity to explain the various options should never be omitted. This issue should never be left in the hands of a clerical associate. Never assume that the patient doesn't want, or worse yet, can't afford, a procedure other than the one chosen by a particular plan.

It is a proven fact that satisfied patients don't change loyalties, even though plans may change providers.

The development of a practice is similar to the development of a child. It's your baby. It will require tender loving care, nurturing, communication and bonding to thrive. In child development, a day care center can be an option, but it can never do the job of a parent. In other words, parent your practice; nurture and bond to your patients. Familiarity breeds success. ◆

Reprinted from a 1998 issue of the TCDS Bulletin, *the publication of the Tri-County Dental Society, Riverside, CA. Dr. Lawrence B. Hundley, Jr., is currently a professor in OMS at the UNLV SDM.*

SNDS Executive Director's Message

Robert Anderson
s_nds@hotmail.com

After the lull of the holiday season, and with Spring coming on, there is so much going on in southern Nevada.

First of all, thank you to everyone who helped make our 11th annual Give Kids A Smile a success. The UNLV School of Dental Medicine and Roseman University's Orthodontic Residency were wonderful hosts, and really went out of their way to make it happen. Families were recruited and screened by Helping Kids and Keller Elementary, and treatment was delivered by volunteers from the UNLV dental students and Roseman residents, hygienists from the Southern Nevada Dental Hygienists' Association and students from the CSN Hygiene School. Residents from the UNLV Pediatric and General Practice Residencies, along with dentists, assistants and residents from the 99th Dental Squadron at Nellis AFB were there with us, and we were helped out by volunteers from United Way. Henry Schein worked magic, along with Pact One, while TREW Financial Group provided breakfast and lunch for everyone. When GKAS 2013 was over, 190 children had been treated, with treatment valued at an estimated $140,000. Thank you to everyone who helped make a difference for these young people.

We met up with the 99th Dental Squadron when they hosted us for our annual February Nellis meeting. Our gracious hosts reserved the Officers' Club for us, their residents provided table topics, we had a great speaker, and an excellent evening. While there, we also learned that our contributions to the families on the base, through our holiday Dental Elf Program, once again more than matched the donations made by all other sources combined.

We've also been calling members to remind them that the deadline for paying membership dues is fast approaching. Our reminders can help avoid paying the late fee, so we hope that everyone responds promptly.

Our program season is winding down, as well, with our CE Café series having just two more installments. Watch for the details on date and location in upcoming Prezfaxes. These popular after work seminars are available only for SNDS members and are free! Each provides 2 CEUs.

Our mainline CE Series offers two installments as well. On **April 26**, we'll host Dr. Robert Winter, who will be speaking on "**An Interdisciplinary Approach to Treatment Planning, Clinical Procedures and Esthetic Dentistry."** On **May 17,** Cathy Jameson will be presenting "**It Costs Too Much! Overcoming The Fear of Cost In Dentistry."** Both seminars are held at the Gold Coast Hotel, from 9:00 am to 4:00 pm and offers 6 CEUs. This is always the time when it's a good idea to check your CEUs before you renew your license.

We're now working to put next year's CE series together. In fact, we're even working ahead into the year after next, in order to lock in some of the more sought after speakers and bring them to southern Nevada. As it is, our seminar series attracts dentists from out of state, as far away as New York or Alaska, and even Canada, so we hope to keep that trend going with dynamic presenters and relevant topics.

Also new this year, we will be adding a member dinner meeting in May. In past years, we didn't have a meeting in May and held our installation of officers instead. This year, we thought we'd combine the two, and add another event for our members at no charge. This will be held Tuesday, May 14 at the Gold Coast. Watch for details to come. ◆

Brendan Johnson, DDS
docbgj@cox.net

Welcome to spring in southern Nevada! Along with the pleasant weather and longer days, there is much happening in the dental community.

Probably of most interest is the Nevada Dental Association's legislative progress. The NDA gives us a constant presence in Carson City, both to promote the issues important to us all, as well as watch over legislation that's introduced that might affect how we care for our patients. I encourage you to check the NDA website for updates and keep in touch with just how they're working for us where it counts!

As part of their presence, they are spreading the word about our work in Clark County, especially Give Kids A Smile. This year, our 11th, almost 200 children were treated. Anytime we can be a catalyst for bringing almost 200 volunteers together to treat underprivileged children who need oral health care, it should be news in Carson City. Once again, we drew together many organizations and partners, from UNLV's School of Dental Medicine, to the Orthodontic Residency at Roseman University, to United Way and CSN, even Nellis Air Force Base. Thank you all, for helping us put a smile on southern Nevada.

Just as I find myself halfway through a year as your president, so, too, are we half way through our program year. Our Peer Review Committee is functioning as always, with a dedicated group of volunteers providing this important benefit or us all, as members. Elsewhere in the *Journal* you can find information on our remaining seminars and events, but I do want to pass along how important it is, especially in this legislative season, to participate and be involved. There are always new things to learn, news of the day, and a myriad of networking opportunities, large and small, that benefit each of us in our practice. We also have a few meetings and seminars to invite non-member colleagues to attend, to check us out, and see for themselves that as dentists, each of our individual practices is stronger when we all unite and work together. So invite a friend, and let them know the value of belonging, the value of being a part of organized dentistry. The fellowship and friends aren't bad, either. So invite a colleague to join you, to join us.

In working with the officers, planning for next year has already begun. We are looking ahead at new opportunities, new media and ways to get the word out. The word out to you about what's going on inside the SNDS, and the word out to the greater Las Vegas community about just what dentists contribute to southern Nevada. We've all done pro bono work, or volunteered at a clinic. We're working on ways to track and tabulate all of these efforts, but we need you to contact the NDA or SNDS to let them know.

We're also working on bringing in some top names for our CE series, even locking them in well in advance because they are so in demand. Watch for the news as it develops. We'll also have our slate of speakers and topics laid out for our dinner meetings, and the CE Café well in advance. I'm also happy to see our CE On Demand taking hold, with members and even visitors taking advantage of the opportunity to view CE seminars on dvd in our SNDS office. With license renewal upon us, the SNDS has more opportunities than ever to help you meet that CE requirement.

Finally, I want to thank you, the members, for stepping up and making things work. From Give Kids A Smile to our dinner meetings, there's a great dynamic when good people come together in a common interest, a common cause. My contribution, as President, has been to learn just how true it is that by working together, we're putting a smile on southern Nevada. ◆

SNDS Annual Report

By Emily Ishkanian, DMD

This year, the SNDS has grown to a significant group; increasing participation and broadening our scope of events to incorporate community service, as well as continuing education.

- We kicked off 2012 with a happy hour sponsored by the Southern Nevada Dental Society.
- We were represented at Give Kids A Smile, and also worked with Henry Schein to provide lunch for UNLV Dental Students during their ADEX examination.
- With the generosity and support of Dr. Brendan Johnson, Dr. John Holtzen of Nevada Oral and Facial Surgery, and Mr. Michael Martinek with Nobel Biocare, we offered 17 complimentary implant continuing education credit hours to participants.
- At the ADA's New Dentist Meeting in Washington D.C., District 14 was represented by Northern/Southern Nevada committee chairs: Dr. David White and Dr. Emily Ishkanian.
- The ADA Annual Session in San Francisco hosted a New Dentist Happy Hour which served as our final event of the year.

The new year brings additional plans for continuing education, partnerships with UNLV School of Dental Medicine to aid students with their transition into practice. We also have a goal to increase representation of SNDS members at the ADA 27th New Dentist Conference, "Climbing to New Heights" in Denver, Colorado on July 18–20. ◆

For more information on the ADA 27th New Dentist Conference, visit their site online at: www.ada.org/newdentistconf.aspx.

NDA Past Presidents

1922 George H. Marvin	1968 James F. Archer
1923 John V. Ducey	1969 Philip J. Youngblood
1924 Thomas H. Suffol	1970 Carl M. Hererra
1925 George A. Carr	1971 George P. Rasqui
1926 Samuel T. Spann	1972 William H. Schaefer
1927 Bruce Saulter	1973 Robert L. Morrison
1928 Frederick H. Phillips	1974 John S. McCulloch
1929 Frederick J. Rulison	1975 James M. Jones
1930 William H. Cavell	1976 Harry P. Massoth
1931 Harold E. Cafferata	1977 Leeland M. Lovaas
1932 Louis M. Nelson	1978 Blaine R. Dunn
1933 Carlton E. Rhodes	1979 Louis J. Hendrickson
1934 Pliney H. Phillips	1980 Duane E. Christian
1935 Harold R. McNeil	1981 Dwight Meierhenry
1936 Lawrence D. Sullivan	1982 Clair F. Earl
1937 Alexander A. Cozzalio	1983 R. D. Hargrave
1938 Charles A. Cozzalio	1984 James L. Davis
1939 George A. Carr	1985 N. Richard Frei
1940 George A. Steinmiller	1986 Lloyd Diedrichsen
1941 George A. Steinmiller	1987 Gerald Hanson
1942 Omar M. Seifert	1988 Gerald C. Jackson
1943 Stephen W. Comish	1989 James C. Evans
1944 Quannah S. McCall	1990 Whit B. Hackstaff
1945 Oliver M. Wallace	1991 William E. Ursick
1946 Gilbert Eklund	1992 Dennis J. Arch
1947 Robert H. Gatewood	1993 A. Ted Twesme
1948 E. Ross Whitehead	1994 Bruce Pendelton
1949 Howard W. Woodbury	1995 J. Gordon Kinard
1950 Roy P. Rheuben	1996 Joel F. Glover
1951 Leonard G. Jacob	1997 Rick Thiriot
1952 Clifford A. Paice	1998 Jade Miller
1953 Walter R. Bell	1999 Patricia Craddock
1954 Raymond J. LaFond	2000 William C. McCalla
1955 Jack E. Ahlstrom	2001 Robert H. Talley
1956 J. D. Smith	2002 Susan Jancar
1957 Kern S. Karrash	2003 Dwyte Brooks
1958 Vincent J. Sanner	2004 Peter DiGrazia
1959 Wallaxe S. Calder	2005 Robert Thalgott
1960 John B. Hirsh	2006 Arnie Pitts
1961 David W. Melarkey	2007 George Rosenbaum
1962 David W. Melarkey	2008 Joel T. Glover
1963 Fae T. Ahlstrom	2009 Peter Balle
1964 Morris F. Gallagher	2010 John C. DiGrazia
1965 Wayne L. Zeiger	2011 Michael Banks
1966 Mario E. Gildone	2012 Gilbert A. Trujillo
1967 William D. Berry	

NNDS Executive Director's Message

Lori Benvin
nnds@nndental.org

TABLE 1
Reported pro-bono dentistry in Nevada for 2012

Name of event/program		Amount	Patients	Additional notes
Dentist reports	$	271,923.68		
Donated dental program	$	78,726.00		
Give Kids A Smile – South	$	140,000.00	190	
No. NV Dental Health Program	$	407,173.00	453	$2,460,862 YTD since '08
UNLV SDM clinic	$	327,274.00		
Give Kids A Smile – North	$	118,766.00	305	
Dental Care International	$	51,655.00	91	
Adopt a Vet – North	$	679,665.00	111	Over 200 vets on waiting list
Dentistry from the Heart	$	71,773.00	120	Over 470 patients since '09
TOTALS		**$2,146,955.68**		

Spring into action northern Nevada! Be sure you watch for any legislative requests sent to you by our state office; the NDA. Advocacy is a crucial member benefit and our NDA Executive Director Bob Talley, NDA President Gilbert Trujillo, Legislative Committee, and NDA Lobbyist Chris Ferrari are working tirelessly to be sure Nevada dentists are well represented in Carson City.

On March 14, we hosted our inaugural "NDA Oral Health Awareness Day" at the Nevada legislature building in Carson City. Our purpose was to cultivate relationships with our legislators and demonstrate the incredible generosity of our dentists to our citizens. We proudly presented information to our legislators that recapped the total reported pro-bono dentistry for 2012 (*see Table 1 above*). Our hats off to all members that participated in programs throughout Nevada—for those who give to the less fortunate in their own practices, and to the volunteers and donors who contribute their time and money.

As our 2012–13 general membership dinner meeting calendar comes to a close, we hope you will join us for the following great events:

On **Thursday, April 25** we will honor two amazing dentists at the **10th Annual Mario Gildone Lifetime Achievement Award Night.** We are overjoyed to recognize **Dr. Bruce Pendleton** and **Dr. Pete DiGrazia** for their outstanding achievements to dentistry and leadership over the years. Our MGLAA Chair, Dr. Tom Pitts, and your fellow colleagues will celebrate these two great individuals. Bruce and Pete are truly worthy to be in the company of our past recipients; Drs. Mario Gildone 2003, Carl Herrera 2004, Harry Massoth 2004, Gerald Jackson 2005, Stephen Vaughn 2006, Lloyd Diedrichsen 2007, Dave Melarkey 2008, Morris F. Gallagher 2009, Joel F. Glover 2010, Jim Davis 2011, and Walter R. Bell 2011.

Don't forget: NNDS has lowered the cost for all dinner meetings and continuing education courses. Our executive board lowered meeting costs as a way to thank our members for supporting NNDS events. Members can attend general membership dinner meetings for $35.

On **Friday, May 10,** we offer our annual **Infection Control and OSHA Update** at the El Dorado Hotel Casino in Reno. This continuing education course will fulfill your licensing requirement of CDC Infection Control. Our courses are always pre-approved by the Nevada State Board of Dental Examiners.

Do you have plans for the 4th of July? Come to Squaw Valley and join us for a wonderful weekend at the PlumpJack Resort. The **Nevada Dental Association's annual Summer Meeting** will be **July 4–6** in Squaw Valley. It will include our House of Delegates, but will also include fun for the whole family. Watch for more information, or check the NDA website at www.nvda.org!

Lastly, save the date for the **11th Annual Northern Nevada Dental Health Program/Joel F. Glover Charity Golf Tournament** to be held on **Friday, September 27** at LakeRidge Golf Club. We are changing it up this year and will have a morning tee-time with breakfast and a BBQ lunch at the conclusion of our event. We are earmarking all proceeds for this tournament to benefit our local veterans through the Adopt-a-Vet Dental Program. Our veterans have sacrificed to serve our country, our participating volunteer dentists and dental labs need recognition, and this program needs funding. They currently have over 200 veterans waiting for dental care. Mark your calendars and come out to support Veterans. Thank you. ◆

The year of 2013 is proceeding forward at a hasty pace bringing our ongoing responsibilities of licensure and dues. Members of the NNDS continue to support their local division in award winning numbers and gain from their membership. When Dr. Rick Dragon attended the American Dental Association annual Membership Recruitment and Retention meeting in Chicago last year, he did not expect to bring home three awards to the state of Nevada. Those awards are based on the ongoing support of the NNDS membership.

I would like to thank the membership of the NNDS for their continued support in attending our various functions. Monthly dinner meeting attendance continues to rise as well as the attendance for continuing education events. The NNDS executive board strives to bring quality education classes and to make them affordable for the members.

There are some new events to look forward to in the coming months. The New Dentist Committee has organized a social prior to every monthly dinner meeting where everyone is welcome to visit with the newer faces in town. On May 10, we bring you our annual OSHA and Infection Control CE with presenter Dr. William Carpenter of the University of the Pacific at the Eldorado in Reno. We hope to see everyone there and again thank you for your support. ◆

Jason Ferguson, DDS
jasfergus@gmail.com

Welcome New NNDS MEMBERS

Moni Ahmadian, DMD – General Dentistry

Trevor Basta, DMD – General Dentistry

Jesse Cardenas, DDS – General Dentistry

Ben Salar, DMD – Pediatric Dentistry

By Karen P. West, Dean, UNLV SDM

Greetings from the UNLV School of Dental Medicine!

Faculty grants/awards

Dr. Christina Demopoulos received a $15,000 award from Oral Health America to fund the Clark County Dental Initiative (CCDI). CCDI is a collaboration between the UNLV SDM/Seal Nevada South program and Future Smiles. Seal Nevada South received the 2013 Silver ACE Award for outstanding surveillance/data for a community. Future Smiles received the 2013 Silver ACE Award for outstanding school health promotion.

Dr. Demopoulos was appointed as the State Dental Director for the Nevada State Health Division Oral Health Program. Funding for the position is awarded as a grant through UNLV.

New faculty

Randy Phillips, DDS, is a 1979 graduate of USC with extensive CAD/CAM experience. He has published in *Dental Products Report* and *ADEA*, and has presented and obtained past funding for CAD/CAM usage. Dr. Phillips is a fellow and member of Pierre Fauchard Academy, fellow and member of the International College of Dentists (ICD), and a member of Omicron Kappa Upsilon (OKU). He joins SDM from his faculty position of 12 years at USC.

Michael Scherer, DMD, MS, Board Certified in Prosthodontics, received his graduate degree from Ohio State in 2012, and his DMD from Nova Southeastern University. Dr. Scherer has published in *JPD, JAPMA* and is also a member of OKU.

Kristina Kuprienko, DMD, is an alum of the first dental class of the UNLV SDM. After attending an AEGD program in Washington State, Dr. Kuprienko practiced privately in Las Vegas for several years. She returns to SDM as a visiting professor.

Davin Faulkner, DMD, is an alumnus and valedictorian of the first class of the UNLV SDM. Dr. Faulkner returns to us as a visiting professor from private practice in Cedar City, Utah.

Foeng Tham, DDS, JD, transitioned from private practice and an extended part time educational commitment at UNLV to a visiting professor. He has practiced dentistry in Nevada since 1991.

We are also pleased to welcome the following new part time and volunteer faculty: **Dr. Steve Hall, Dr. Richard Schoen, Dr. Oahn Le, Dr. John Cope, Dr. Ghassan Khalaf, Dr. Ron Laux, Dr. Ronald Marshall, Dr. George Rosenbaum, Catherine Carreiro, RDH,** and **Natalia Hill, RDH**.

Community service report

Students and residents continue to provide preventive services in community-based, underserved settings in Clark and Nye Counties. Since July 1, 2011, SDM has secured funding from Oral Health America to implement the CCDI in Title 1 schools in Clark County. This funding has enabled Seal Nevada South to be fully implemented in elementary schools and provided a sub award to Future Smiles. Seal Nevada South will be expanding to 15 schools next year while Future Smiles will expand into some middle schools.

From January 2012–December 2012, an estimated $127,000 (SDM fees) in donated services has been offered in school- and community-based events.

Third year dental students and Pediatric Residents continue to provide screenings, education and fluoride varnish applications to uninsured at-risk children in Southern Nevada.

Funding in the amount of $80,000 was obtained through Dignity Health, a California nonprofit public benefit corporation (dba St. Rose Dominican Hospitals) in which at-risk children will receive restorative dental treatment at the UNLV SDM Pediatric Clinic.

During the 2013 Spring Semester, first-year dental students will present oral hygiene and nutrition education information to approximately 12,000 K–5th grade students in 45 at-risk schools in the Clark County School District. Dental students will also hand out toothbrushes, toothpaste and instructions on how to brush and floss.

During the 2012 Fall Semester, second-year dental students visited 25 assisted living centers in Nevada where they performed oral cancer screenings on senior residents. The students presented information on oral hygiene, oral cancer and denture care to over 700 assisted living center residents. Residents were also given toothbrushes, toothpaste and floss or denture kits.

UNLV SDM Office of Research

On March 4, Office of Research and Continuing Education hosted the Dean's Symposium and Student Research Day. Dean Leon A. Assael, University of Minnesota, was the keynote speaker and, along with Drs. Steven Saxe and Michael D. Scherer, assisted with judging the Research Day. Sixteen students competed to attend the national Student Clinician ADA Dentsply competition to be held in October in New Orleans, Louisiana.

Admissions & Student Affairs

The Office of Admissions and Student Affairs received 2,082 applications for the 2012–13 cycle. A total of 451 applicants were invited for interviews and 339 were interviewed. Currently, the class size is 69; acceptances will continue to be sent out until the class is filled with 80 students.

Kudos to **Kelcey Loveland** and **Gustavo Hernandez**, second-year students, for receiving the ADA Foundation Scholarship Award for 2012–13. They will each receive $2,500 to help defray the cost of professional educational expenses.

Preliminary results for acceptances to a specialty/residency for the Class of 2013 are as follows:

Oral and Maxillofacial Surgery	4
Pediatric Residency	7
GPR/AEGD	10
Orthodontics	2
Periodontics	1
Prosthodontics	1
Anesthesiology	1
Military AEGD	5
Military OMFS	1

Alumni activities

William Dahlke, DMD, was named the inaugural UNLV School of Dental Medicine Alumnus of the Year. Dr. Dahlke graduated Summa Cum Laude and in 2012 completed a Pediatric Dental Graduate Certificate at UNLV SDM. He has participated in every Give Kids A Smile event since 2006 and volunteers at our monthly Saturday Clinic. Dr. Dahlke is one of our most active alumni and a driving force in creating an Alumni Chapter. He is an embodiment of UNLV's mission to public service and educational goals. He has been active in enriching the life of the school and, as a past faculty member, he is one of our brightest stars and one alumnus can be proud to call their own. ◆

2013 continuing education courses

May
- Las Vegas Implant Immersion Program (Module 2)

June
- TruDenta/Dental Resource Systems

July
- Surgical Cadaver Bone Grafting
- Las Vegas Implant Immersion Program (Module 3)

August
- Dental Resource Systems Occlusion
- TruDenta/Dental Resource Systems

September
- The ULTIMATE Surgical and Restorative Esthetic Implant
- Advanced Conquering the Esthetic Zone with Surgical Precision!

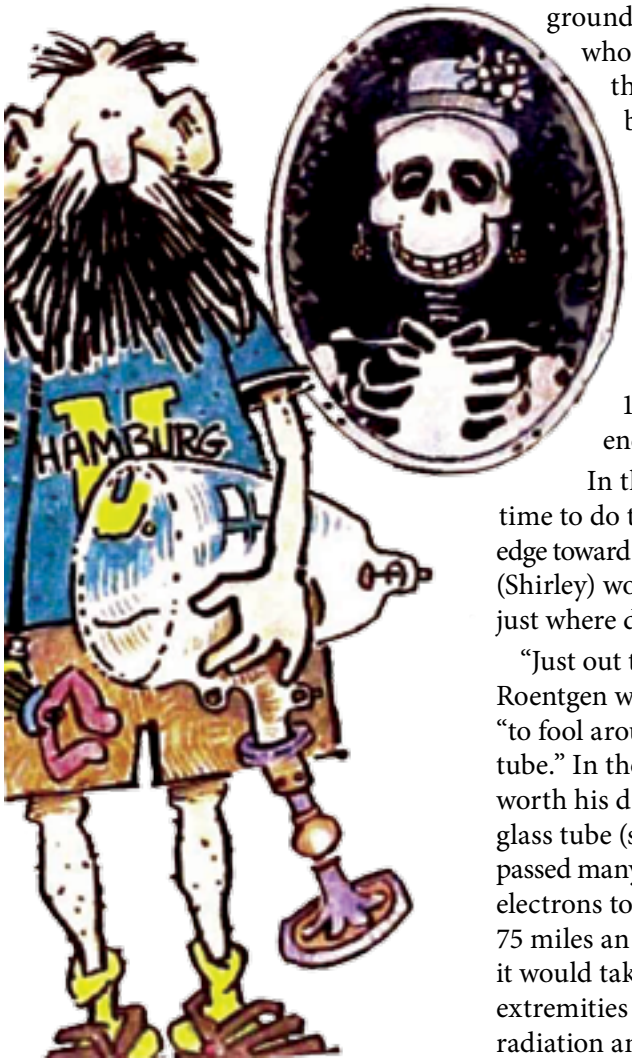
October
- TruDenta/Dental Resource Systems
- Real World Endo® seminar

November
- Advanced Orthodontic Concepts (Brazilian Orthodontists)

Elementary Radiology

By Robert E. Horseman, DDS

If it weren't for Wilhelm Conrad Roentgen, I wouldn't be in the pickle I'm in today. In a few hours, I have to put on some Old Spice, attempt a Windsor knot and go before my granddaughter's 4th grade class to tell them everything I know about x-rays. Once again I have been dragooned into displaying my inability to verbally fence with these over-achievers. Kids brought up on Kryptonite and death ray lasers, with which many of them have personally annihilated hordes of invading mutant aliens at their neighborhood 7–11, do not constitute an uncritical audience.



What am I going to tell them—that I pop this little bit of film in somebody's mouth, point a machine at him and push a button? That by some magic jiggery-pokery I can't explain, invisible rays zap out and go right through his cheek and teeth resulting in a picture on this soggy bit of plastic? Shall I confess that as far as I know, the rays are still in the guy's mouth since they didn't come out the other side, or at least I don't think they did? Maybe he swallowed them and they are finally grounded by infusions of Maalox, who knows? And why aren't the pictures in color, somebody is sure to ask. It's a tough room.

So you can see that on that day in 1895 when Wilhelm Roentgen went out into his garage to fool around with his Crookes tube (see Sir William, 1832–1919), he initiated no end of trouble for me.

In the evening when it came time to do the dishes, Wilhelm would edge toward the door and Mrs. Roentgen (Shirley) would yell after him, "Willie, just where do you think you're going?"

"Just out the back, Schweetie," Roentgen would respond hurriedly, "to fool around with my Crookes tube." In those days, any physicist worth his diploma had an evacuated glass tube (see Crookes) with which he passed many pleasant hours accelerating electrons to speeds upwards of 75 miles an hour just to see how long it would take before one of his extremities received a fatal dose of radiation and fell off.

Dangerous as they might be, it is well to note that if these tubes were ever outlawed, as Charlton Heston has pointed out, only crooks would have Crookes. In any event, it beat sitting around the house with his hands held up before him while Shirley draped a skein of yarn between them. It was something to do while waiting for Sony to come up with big screen television.

One night when he was 50 years old, Wilhelm got to thinking there must be more in life than messing with electrons, angstroms and atoms, none of which he had actually seen. Wondering idly if there was any significance in his being named after the Kaiser, he noticed that a dish of barium platinocyanide he had left out for the cat was fluorescing clear across the room from his Crookes tube. This understandably intrigued him since he had never heard of the word "fluoresce" and had to go look it up. What he was doing with this controlled substance, Class IV, triple prescription stuff has never been satisfactorily explained, at least not to the cat.

"Well, looky here," he exclaimed (in German), "this stuff lights up like a pair of day-glo lederhosen!" Fearing at first that the goop had gone off just because Charles "Ice-Cube" Kelvinator had yet to invent the refrigerator, he soon realized that he had discovered a previously unknown radiation of very short wavelengths.

"How short *were* they?" some of the kids who stay up way too late at night are bound to ask me. I think, "Short enough so you could cram 50 quintillion of them in your pencil box" ought to hold them.

Wilhelm called his new discovery "Roentgen rays" because he liked the

sound of the alliteration and because it gave rise to so many derivative words like roentgenology, the roentgen, roentgenogram, roentgenoscope, roentgenography and "Deutschland uber Alles." His peers, however, complained so much that nobody could spell these things, let alone pronounce them, that he said the hell with it and rechristened them "x"-rays because all the previously discovered rays (Aldo, Johnny and Martha) had already used up the best letters.

"But how does it work, Mr. Smarty Pants Know-It-All Doctor?" I hear the childish 4th grade voices demand with thinly disguised contempt.

"Quantum theory explains it," I'll tell them, "as a result of transitions between the unbound states of the electron. Because unbound energy states are continuous rather than discrete, the emitted x-radiation in the form of a photon may have any energy less than the initial energy of the electron; hence the spectrum is continuous and equals the sum of the square of the other two sides. Which, of course, explains why I am on the other side of a lead wall 10 feet away and you're not."

For a long time after that, all folks did with the x-ray was to fluoresce barium platinocyanide. People with nothing better to do on weekends while they were sitting around waiting for World War I to start would say, "Let's go over to Wilhelm and Shirley's and fluoresce some platinocyanide." They would break out ein sechs-pack of schnapps, pop in a record of Wagner's "Kaiser Roll" and fluoresce like crazy until somebody would exclaim, "Gott in Himmel, gelooken at der Zeit!"

X-rays didn't really catch on until 1913 when William D. Coolidge developed the first efficient x-ray tube. It was so successful, we named the 30th president of the U.S. after it. Shortly after that (Friday afternoon), the bitewing, the periapical, the Panorex and 4 x 6 double-print 1-hour service were invented, for which we can all be grateful, especially Eastman Kodak.

Even more appreciative are all of us who realize that had Roentgen's next door neighbor and fellow experimenter, Ludwig von Krautzmeyer, not been off in Munich getting lathered at the Oktoberfest, the discovery of the x-ray might have been another story. We might then have been saddled with the von Krautzmeyerograph, von Krautzmeyerology and that international unit of x-radiation which is equal the amount of radiation that produces in one cubic centimeter of dry air at 0 degrees Centigrade and standard atmospheric pressure

Continues ➲

ionization of either sign equal to one electrostatic unit of charge, ta da—the von Krautzmeyer.

More than a century has passed since Roentgen's discovery. I am reminded each time I hold a roentgenograph up to the light and squint at the underexposed, over-developed, cone-cut, overlapped results muttering, "What the heck is that?" that we've come a long way, baby.

Nearly forgotten in all the hoopla over Roentgen, is the person who first put the dimple on the film to differentiate right from left. He shall remain anonymous at his own request until the ongoing debate over whether it is logical to view the film as if standing in front of the patient, or observed from the point of view of the tongue. The contention of many is that it best not to confuse the issue since it really makes little diagnostic difference anyway until the moment of application of forceps or bur.

So that's what I plan to tell the 4th grade. If they want anything more detailed, the honorarium will have to be upgraded from the traditional lanyard without a whistle made of recycled noodles from the school cafeteria. ◆

CONGRATS OHIO STATE UNIVERSITY FOOTBALL

By NDA Journal FBS/D-1 Championship Committee

NDAJ BCS Era Champions:

2002	Ohio State	14–0
2003	USC	12–1
2004	USC	13–0
	Utah	12–0
2005	Texas	13–0
2006	Boise State	13–0
2007	USC	11–2
2008	Utah	13–0
2009	Boise State	14–0
	Alabama	14–0
2010	TCU	13–0
	Auburn	14–0
2011	Oklahoma State	12–1
2012	Ohio State	12–0

It is well accepted that dentists are among the most trusted professionals in society.[1] The honorable precepts of the ADA's Professional Code of Conduct are second to none,[2] and the Code mandates that dentists put the welfare of society ahead of self-interest. Dentists are highly educated individuals who understand the concepts of logical and ethical cerebration.[3]

These attributes are absent in a program affiliated with higher education today, the BCS, the faction that selects its Football Bowl Subdivision (Division I) champion primarily on the basis of maximizing remuneration for BCS member entities and individuals,[4,5] ignoring well-established, logical, and time-proven options (playoffs) to reward achievers in America.[6]

For these reasons, and without apology to other FBS/D-1 teams jockeying for second place:

The Nevada Dental Association Journal FBS Championship Committee is pleased to announce its selection for college football's 2012 National Champion, the only undefeated team in the nation:

The Ohio State University Buckeyes (12–0)

Endnotes

1. Harris Pole #37, Most Trusted Professionals, May 2006
2. www.ada.org/194.aspx, Accessed Jan 2011
3. American College of Dentists, *Ethics Handbook for Dentists*, 2010
4. Wetzel D, Peter J, Passan J, *Death to the BCS, The Definitive Case Against the Bowl Championship Series*, Gotham Books, 2010
5. Bennett D, "The Arizona Republic takes on the corruption of the BCS," Sep 26, 2011
6. Wetzel's Playoff Plan, http://rivals.yahoo.com/ncaa/football/news?slug=dw-playoff120208&prov=yhoo&type=lgns, Accessed Jan 2011

NDA Calendar of Events

APRIL – JUNE 2013

APRIL			
Tue 9	SNDS Member Dinner Meeting	5:30 PM	Gold Coast Hotel & Casino, Las Vegas
Tue 9	NNDS Executive Committee Meeting	5:45 PM	161 Country Estates Circle, #1B, Reno
Wed 17	*SNDS presents:* CE Café	6:30 PM	Nevada State Bank 1501 W. Warm Springs Rd., Las Vegas
Sat 20	Joel Bowl—Joel F. Glover Memorial Scholarship Fundraiser	5 PM	Grand Sierra Resort, Reno
Thu 25	SNDS Peer Review Committee Meeting	8 AM	To be determined
Thu 25	*NNDS presents:* Mario Gildone Lifetime Achievement Award Dinner	6 PM	The Grove at SouthCreek, Reno
Fri 26	*SNDS presents:* CE Seminar, Dr. Robert R. Winter	9 AM – 4 PM	Gold Coast Hotel & Casino, Las Vegas
MAY			
Tue 7	NNDS Executive Committee Meeting	5:45 PM	161 Country Estates Circle, #1B, Reno
Fri 10	*NNDS presents:* OSHA, Infection Control & CDC CE Course w/ Dr. Bill Carpenter	7:30 AM	El Dorado Hotel Casino, Reno
Tue 14	SNDS Member Dinner Meeting	5:30 PM	Gold Coast Hotel & Casino, Las Vegas
Thu 16	SNDS Peer Review Committee Meeting	5 PM	Grand Sierra Resort, Reno
Fri 17	*SNDS presents:* CE Seminar, Cathy Jameson	9 AM – 4 PM	Gold Coast Hotel & Casino, Las Vegas
JUNE			
Tue 11	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Circle, #1B, Reno
Thu 20	SNDS Peer Review Committee Meeting	7:30 AM	El Dorado Hotel Casino, Reno
Tue 25	SNDS Executive Committee Meeting	6:30 PM	SNDS Office

Classified Ads

Practices for Sale

DENTISTS SERVING DENTISTS—Western Practice Sales invites you to visit our website, **westernpracticesales.com** to view all of our practices for sale and to see why we are the broker of choice for Sellers throughout Nevada, California & Arizona. Because we are owned by dentists, we know the profession well and understand your unique needs. **800-641-4179**.

NDA-Affiliated Products

These companies are NDA-affiliated products. These products have been evaluated and are recommended for use in running your practice. Let us know if you have any feedback or would like to recommend a product or service for affiliation.

For a weblink to each company, go to www.nvda.org/affiliatedproducts.shtml.

Bank of America Practice Solutions
Professional practice finance
800-497-6076 code 1D7F3
www.bankofamerica.com

Best Card, LLC
Credit card processing
877-739-3952
www.bestcardteam.com

CareCredit
Patient financing
800-300-3046 x4519
www.carecredit.com

citifinancial auto
Auto financing
888-248-4325
www.citifinancialauto.com

citimortgage
Real estate assistance
888-466-3232
www.citimortgage.com/ada

Collegiate Funding Services
Student financing
866-312-7227
www.cfsloans.com/ada

CoreVault
Offsite data backup
405-391-8123
www.corevault.com/nda

EBSCO
Subscription service
800-527-5901 x1652
www.ebsco.com/errss

FedEx
Shipping services
800-636-2377
www.1800members.com/nda

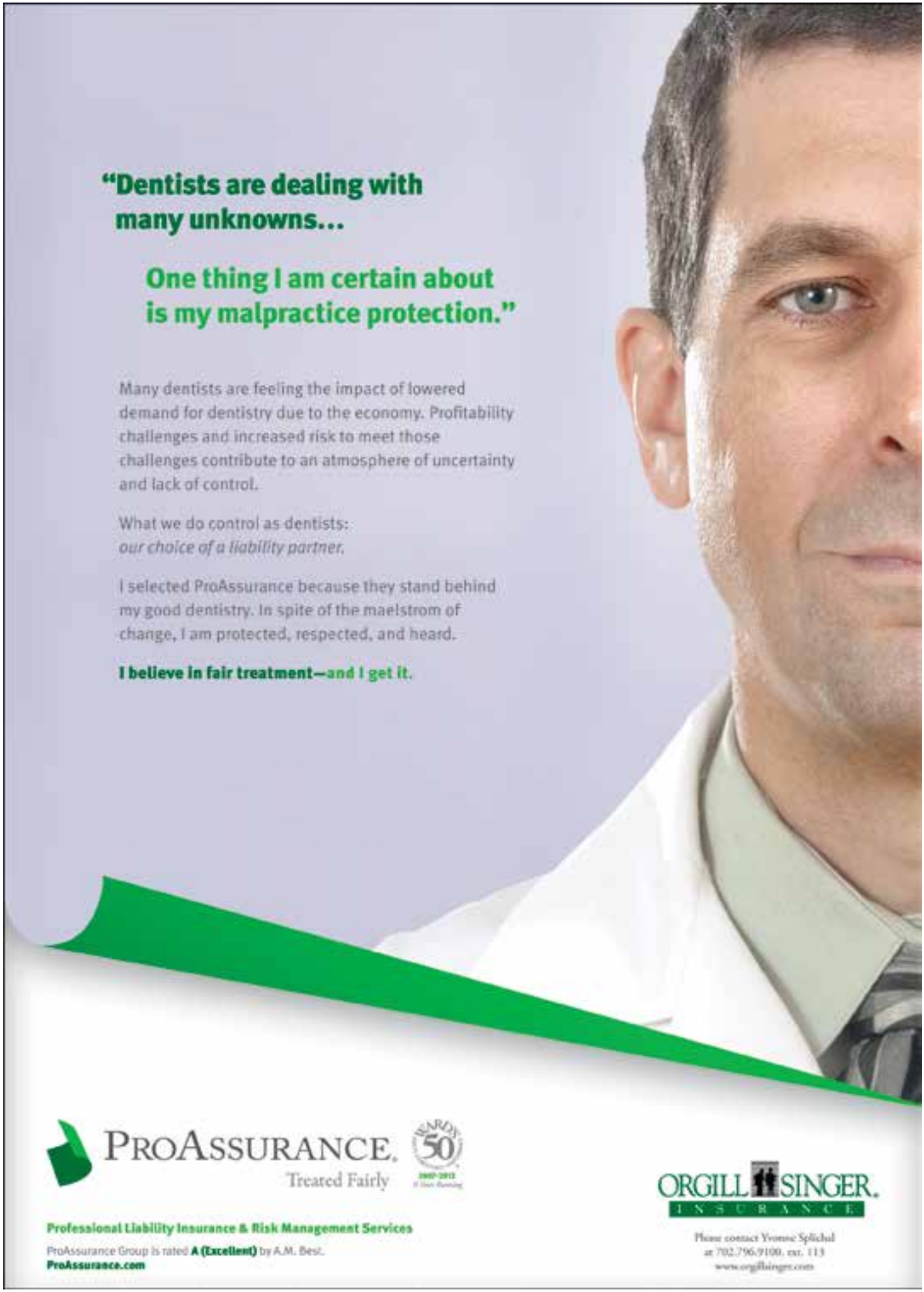
IC System
Collection service
800-279-3511
www.icsystem.com/nda.htm

Office Max
Office supplies
702-647-8662
www.officemax.com

TDIC
Professional liability
800-733-0633
www.tdicsolutions.com

Tel-A-Patient
Appointment reminders/Message on hold
800-553-7373
www.telapatient.com

UNLV School of Dental Medicine
Hands-on continuing education
702-774-2400
www.dentalschool.unlv.edu


"Dentists are dealing with many unknowns...
One thing I am certain about is my malpractice protection."
Many dentists are feeling the impact of lowered demand for dentistry due to the economy. Profitability challenges and increased risk to meet those challenges contribute to an atmosphere of uncertainty and lack of control.
What we do control as dentists:
our choice of a liability partner.
I selected ProAssurance because they stand behind my good dentistry. In spite of the maelstrom of change, I am protected, respected, and heard.
I believe in fair treatment—and I get it.
PROASSURANCE.
Treated Fairly
Professional Liability Insurance & Risk Management Services
ProAssurance Group is rated **A (Excellent)** by A.M. Best.
ProAssurance.com
ORGILL SINGER.
INSURANCE
Please contact Yvonne Splichal
at 702.796.9100, ext. 113
www.orgillsinger.com

NEVADA DENTAL ASSOCIATION
8863 W FLAMINGO RD, STE 102
LAS VEGAS, NV 89147-8718

CHANGE SERVICE REQUESTED

PRSRT STD
U.S. POSTAGE
PAID
SALEM OR
PERMIT NO. 526