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DENTAL TRIBUNE

The World's Dental Newspaper · U.S. Edition

JANUARY 2012 — VOL. 7, NO. 1

www.dental-tribune.com

NEW DEVICE STRENGTHENS FILLINGS

Prototype plasma brush uses a 'cool flame' to strengthen bond between tooth and filling.

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STAFF MEMBER TOO TATTOOED?

Be prepared for a staff member whose edgy appearance starts going over the edge.

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ALL ABOUT IMPLANTS SUCCESS

The International Congress of Oral Implantologists invites you to the San Diego Bay in February.

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David Harris
Photo/Prosperident

Most dental practices will encounter fraud

An interview with licensed private investigator and Prosperident President David Harris

By Robert Selleck, Managing Editor

The potential for embezzlement and theft is a problem no business is immune to. And research shows that smaller businesses are more likely to experience problems than larger ones. For dental practice owners, it's not just being small that increases risk. The typical dental office management structure is inherently vulnerable to fraud, according to dental-practice fraud expert David Harris. Adding to the challenge, Harris said, detection can be trickier in a dental practice compared with other small businesses. And the bad news continues: Harris, who has 20 years of experience in dental-practice fraud investigation, puts little stock in deterrence. Instead he emphasizes early detection as the only viable defense. He shared those thoughts and more with Dental Tribune.

What is the likelihood of a dental office experiencing fraud?

There have been several studies by the American Dental Association and others. Collectively they suggest that the probability of a dentist being a fraud victim in his or her career is between 50 and 60 percent. However, such statistics are necessarily low because there is an unquantifiable amount of fraud that is never detected or is detected but not disclosed.

Are there any reasons why dental practices would be more likely or less likely than other types of small businesses to experience fraud?

Two main points influence the prevalence of fraud in dentistry. First, the clinical responsibilities carried by dentists effectively reduce them to being absentee owners in their own businesses. Second, the fact that so much of dentistry is paid for by third parties removes one of the most basic controls that businesses depend on.

Is there a difference in potential for fraud in a three- or four-person office compared with a practice with 20 or more?

Intuitively, one would think that a larger practice should be able to have tighter controls through increased separation of duties. But many group practices are essentially several solo practices sharing space, thus offering no particular administrative synergy. When a group practice is run as a single unit, the dentists owning the clinic tend to delegate oversight of the administrative functions to a single dentist. Given that there are many thefts perpetrated against a solo dentist, imagine the fraud possibilities when one dentist is overseeing a much larger business activity.

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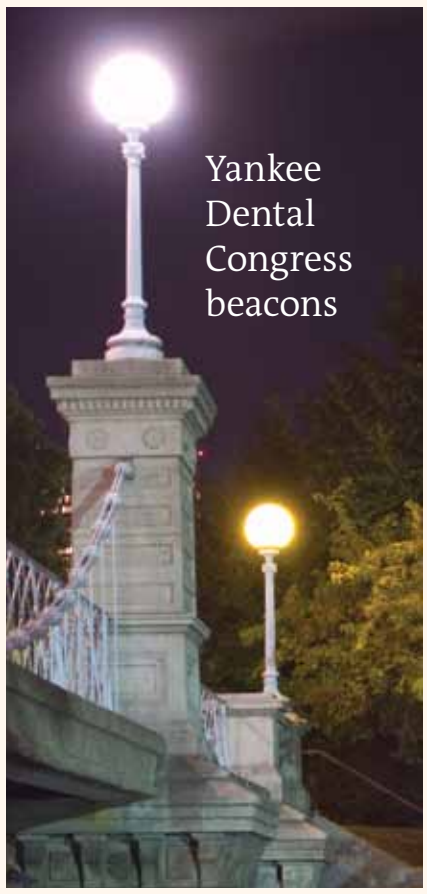

Lagoon Bridge in Public Garden is among the countless Boston attractions awaiting those attending the Yankee Dental Congress, Jan. 25–29, where you'll find nearly 28,000 fellow dental professionals, 450+ exhibitors and 300+ courses, lectures, workshops and live-dentistry sessions. Photo/Brandon Goad, *www.dreamstime.com*

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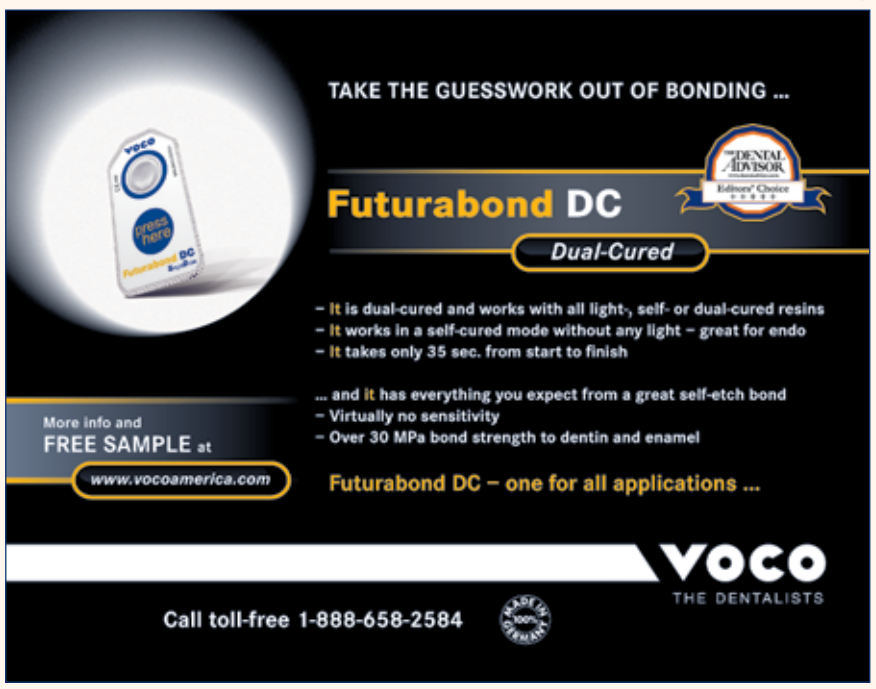

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Do you have statistics for average or median losses to fraud based on various sized dental practices?

Unfortunately, there isn't any published data specific to practice size. Bill Hiltz, who heads our investigation department, has a hypothesis that frauds typically range between 4 and 7 percent of monthly revenue while the fraud is going on. In its 2007 Survey of Current Issues in Dentistry, the ADA surveyed dentists who had been fraud victims. The average estimated loss was $18,174. Based on our own experience, this number is tremendously low. That's not surprising because in the same survey only 51.3 percent of the dentists who were fraud victims completed a fraud investigation, raising questions on how the remainder determined their losses. We normally find that the amount of fraud that dentists are able to identify without the benefit of professional assistance is far less than the true fraud.

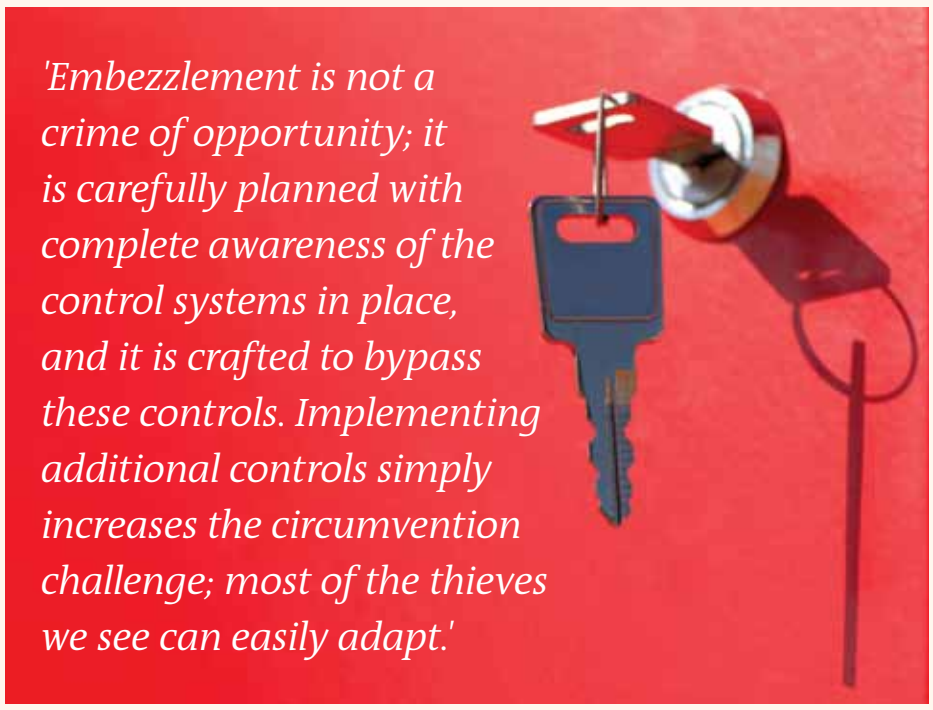
We surveyed our own files several years ago and found an average theft of more than $150,000. This is superficially consistent with the Association of Certified Fraud Examiners number of $200,000 for the average small business loss, but many of its "small businesses" are much bigger than most dental practices. We have seen a number of dental frauds of more than $500,000 and a few exceeding $1 million.

What are the most typical types of fraud cases seen in dental practices?

Most of the fraud that we see is "revenue fraud." Some examples are writing off amounts that were actually collected, deleting treatment that was done so that collections are "off the books" and billing the full amount to two insurance companies when someone has dual coverage.

A second type of fraud that we are seeing involves creation of "phantom" revenue. Insurance companies are billed for work that was never done, with funds either stolen directly or "lapped" (used to pay someone else's balance to cover a stolen payment). Obviously, if discovered by an insurance company, this type of activity can have serious consequences for the innocent dentist.

Most thieves use more than one method of stealing; very few stick to a single methodology. Also, we are continually seeing new variants. For example, we recently saw a thief take advantage of a server crash to decrease some accounts receivable balances. When patients paid the correct balances, they would be paying more than the "official" balance in the practice management software, with the thief pocketing the difference.



Photo/Andriy Solovyov, *www.dreamstime.com*

Is there a type of fraud more prevalent in a dental practice compared with other small or similarly sized businesses?

Since we investigate only dental embezzlement, my knowledge of fraud patterns in other small businesses is limited to what I read. My perception is that much of the fraud committed against other businesses involves expenses: payroll, paying non-existent suppliers, padding expense claims, etc. The majority of embezzlement that we see in dental practices involves revenue.

While we do see a fair number of thieves who will steal revenue and also manipulate their payroll or create a phony supplier, very few will commit expense fraud while concurrently resisting stealing some of the cash that patients hand them daily.

What about fraud that's more indirect, such as questionable workers' compensation claims?

We have seen an astonishingly wide variety of unconventional thefts, everything from stealing the gold that is recovered from old restorations to misappropriating dental supplies and instruments and selling them online. However, embezzlement typically involves larger amounts and takes place undetected for a longer period.

What motivates the typical perpetrator?

We see two types of fraudsters. One type we call "dishonest" — these people typically believe that they should live better than their "official" compensation permits. I immediately think of one thief who rented a private plane with stolen funds for a New York City shopping trip with girlfriends. Funds from another major theft were used to purchase a yacht and the most expensive BMW available. The other group I would characterize as "desperate." These people struggle to meet basic needs. There might be an addiction, an uninsured medical condition, a divorce or an unemployed spouse. In contrast to the dishonest fraudsters, these people have their moral compass altered by their desperation. Many initially plan to repay what they "borrow," but a continuing deficit frustrates this. Interestingly, the desperate thieves have normally worked for more than eight years at their office.

What are the strongest deterrents?

Deterrence is effective with crimes of opportunity or where thieves can choose their target. Embezzlement is not a crime of opportunity; it is carefully planned with complete awareness of the control systems in place, and it is crafted to bypass these controls. Adding more controls

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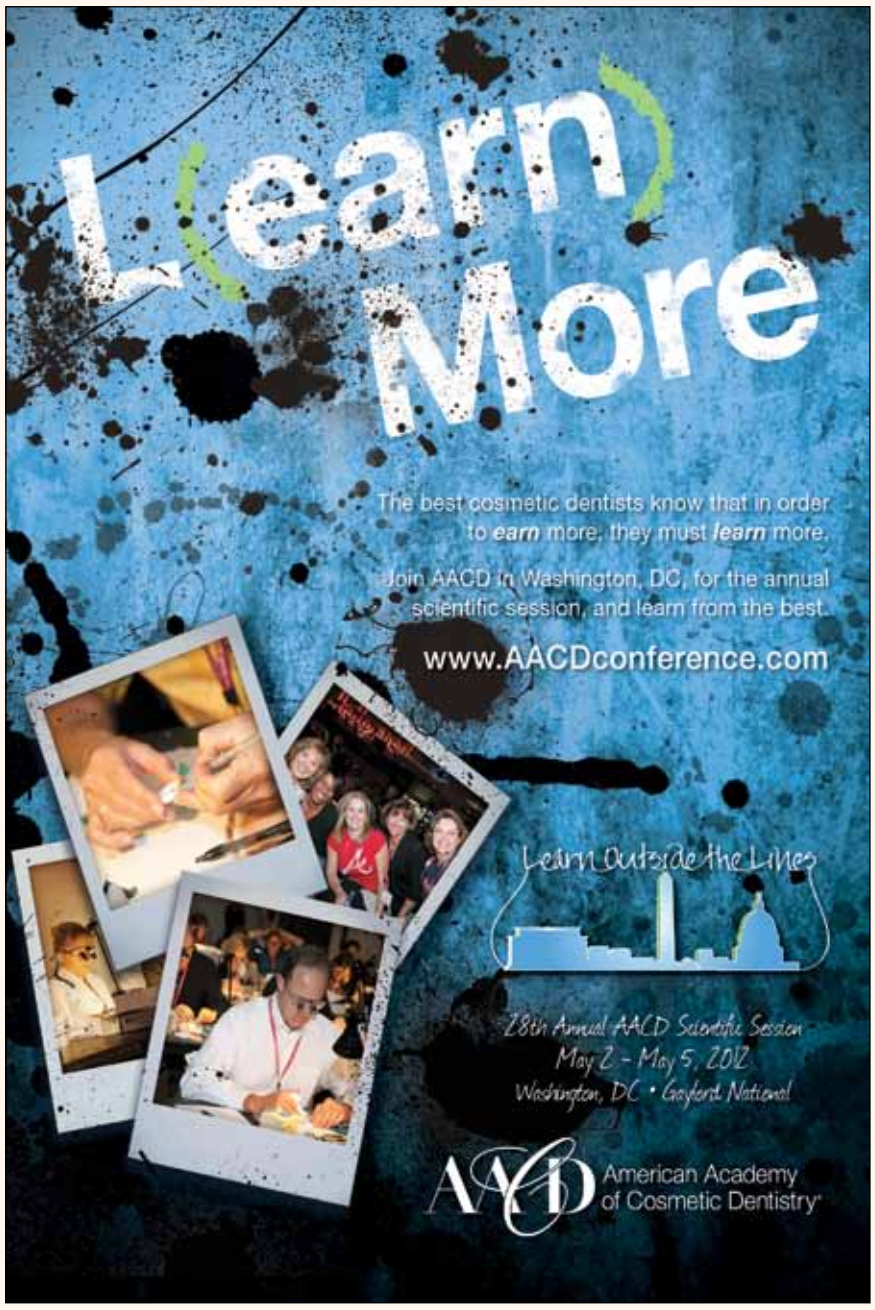

Classmates fund scholarship

David Moghadam is the first student at the New Jersey Dental School to earn the William R. Cinotti Endowed Scholarship. Photo/New Jersey Dental School

To honor a professor who profoundly influenced their lives, four graduates from the New Jersey Dental School class of 1989 have established an endowed scholarship in his name.

"We have all been influenced by people as we travel through life. Sometimes one special person makes all the difference," said Dr. George Bambara, 1989 class president. "Dr. William Cinotti was the one special person who made that difference for each of us."

The graduates, Bambara, Dr. Michael Donato, Dr. Phil Echo and Dr. William Ranucci, were the four class of 1989 officers. Twenty years after graduation, reflections of their experience with Cinotti spurred their generous pledge of $25,000 to establish the William R. Cinotti Endowed Scholarship.

"Through Dr. Cinotti I learned life lessons while becoming a dentist," said Donato, class secretary." He taught me to give back to the community, to look out for my colleagues by helping them and to reach my goals through hard work."

The scholarship is awarded to a dental student at the University of Medicine and Dentistry of New Jersey who

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DENTAL TRIBUNE
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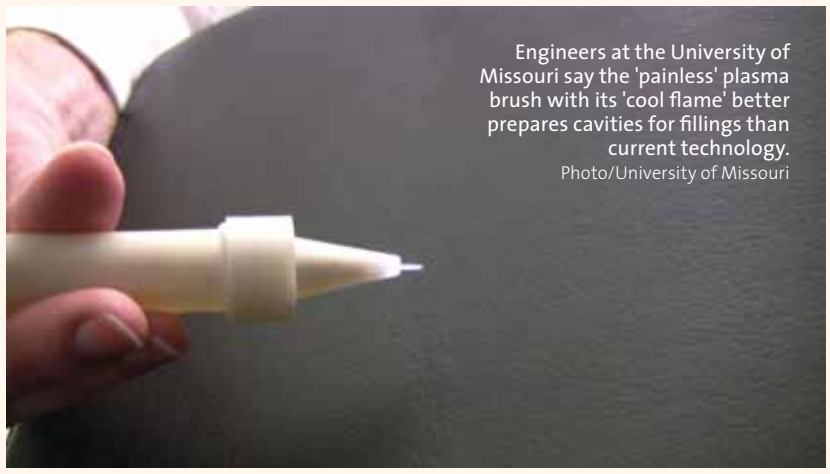
Prototype tool uses 'cool flame' to improve fillings

Researchers say 'painless' plasma brush creates sturdier, longer-lasting bond between tooth and filling

By Robert Selleck, Managing Editor



Engineers at the University of Missouri say the 'painless' plasma brush with its 'cool flame' better prepares cavities for fillings than current technology.
Photo/University of Missouri

A "painless" cavity-cleaning dental instrument is moving closer to market reality after lab results showed it reduces the cost of restorations while increasing the strength and potential lifespan of fillings.

According to the lab results, in less than 30 seconds, the plasma brush uses chemical reactions to disinfect and clean out cavities for fillings. In addition to the bacteria-killing properties, the "cool flame" from the plasma brush forms a better bond for cavity fillings. The chemical reactions involved with the plasma brush change the surface of the tooth to create a substantially stronger bond with the filling material than occurs without use of the device.

The effort to bring the plasma brush technology to market is backed by the National Institutes of Health Small Business Innovation Research (SBIR) program and the National Science Foundation, both of whom have contributed funding.

The university researchers who created the device believe that results from human clinical trials now under way will support efforts to secure investor funding and enable the next steps needed to place the product on the market. If the studies go well and the U.S. Food and Drug Administration clears the use, the researchers' time line suggests the plasma brush could be available to dentists as early as the end of 2013. The university researchers behind the plasma brush have formed the company Nanova to bring the technology to market.

"There have been no side effects reported during the lab trials, and we expect the human trials to help us improve the prototype," said Qingsong Yu, associate professor of mechanical and aerospace engineering at the University of Missouri, Columbia. The University of Missouri, where much of the initial research was conducted, holds a co-patent for the plasma brush with Nanova. The university has a policy of sharing patents with its researchers and supporting efforts that turn such research into viable businesses.

The researchers said that more than 200 million tooth restorations are performed every year in the United States at an estimated cost of $50 billion to patients and insurers.

The team's statistics also indicate that replacement fillings comprise 75 percent of a dentist's work. "The plasma brush would help reduce those costs," said Hao Li, associate professor of mechanical and aerospace engineering in the University of Missouri College of Engineering. "In addition, a tooth can only support two or three restorations before it must be pulled. Our studies indicate that fillings are 60 percent stronger with the plasma brush, which would increase the filling lifespan. This would be a big benefit to the patient, as well as dentists and insurance companies."

Li, along with Yu and Meng Chen, formed Nanova, with Chen serving as chief scientist and leading the plasma brush device development through the SBIR program. The research and development team also includes Yong Wang from the School of Dentistry at the University of Missouri, Kansas City, and Liang Hong from the School of Dentistry at the University of Tennessee, Memphis.

Human clinical trials are expected to begin in early this year at the University of Tennessee, Memphis.

(Sources: University of Missouri, Nanova)

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demonstrates leadership, outstanding character and exemplary academic performance. The scholarship just awarded money to its first recipient, David Moghadam.

"We selected our criteria based on what we learned from Dr. Cinotti," said Echo, class vice president. "It is because I hold Dr. Cinotti in such high regard that I decided to help establish this scholarship in his name."

Ranucci, class treasurer, agreed. "Not only was Dr. Cinotti my Little League baseball coach, but as I grew up he turned out to be a major guiding force in my life," he said. "We all thank him for making such a wonderful difference for us."

If you would like to contribute to the William R. Cinotti Endowed Scholarship, or learn how to establish a scholarship, contact Andrea West, New Jersey Dental School director of development, at (973) 972-1039 or at *westan@umdnj.edu*.

ADA updates its guide to creating employee manual

The American Dental Association (ADA) has updated its Practical Guide to Creating an Employee Office Manual, which assists dental practices in creating customized employee office manuals.

Written and reviewed by a team of ADA professionals, the book addresses many common employment issues and contains sample forms, checklists, policies and procedures. These documents are included in Microsoft Word format on the book's accompanying CD-ROM for quick and easy customizing for each dental practice's unique needs.

New and updated features include: updated sample job descriptions and interview questions; new sample policies on using cell phones, electronic communications and social media — on and off the clock; new chapter on patient management; updated sections on the Health Insurance Portability and Accountability Act and Occupational Safety and Health Administration policies; new performance evaluation forms; and expanded section on natural disaster preparation

The ADA Practical Guide to Creating an Employee Office Manual is available electronically and in hard-copy by calling (800) 947-4746 or through the ADA Catalog online at *www.adacatalog.org*.

The hard-copy book with CD-ROM is $89.95 for ADA members and $134.95 for non-member dentists.

The guide is also available as an e-book on the Barnes and Noble Nook in its entirety or in individual chapter downloads on *www.adacatalog.org*.

HR 101: Tees and tats causing a stir

SALLY MCKENZIE is CEO of McKenzie Management, which provides success-proven management solutions to dental practitioners nationwide. She is editor of The Dentist's Network Newsletter at *www.thedentistsnetwork.net*, the e-Management Newsletter at *www.mckenziemgmt.com* and The New Dentist™ magazine at *www.thenewdentist.net*. She can be reached at *sallymck@mckenziemgmt.com* or (877) 777-6151.

Too often dentists look at human resources polices as an expense rather than a necessary investment

By Sally McKenzie, CEO McKenzie Management

Amber is an assistant in Dr. D's office. She's what you picture when you think "free spirited." She likes to color her hair a new shade every month: bleach blond, jet black, fiery red, etc. She has a few ear piercings. It's a somewhat edgy style but not offensive ... until recently. Her latest dye job is pink and green. She's now sporting a large circular ring in her nose, a bar in her eyebrow, sleeve tattoos wind their way up both forearms and the letters J-A-M-E-S are now tattooed on her knuckles.

Dr. D. is about to drop dead. His practice is in Manhattan ... Manhattan, Kansas, that is, in the heart of the Midwest. Even in this college town, it's fair to say that there is a somewhat conservative view of individual style. Dr. D has been in practice for 25 years and has many aging boomers who've long since forgotten the concept of free spirit and the psychedelic revolution.

The dentist is hoping appropriate dress is covered in the employee policies and procedures manual. There's just one problem: He never actually got around to finishing and distributing the manual. There is no policy on appropriate dress or anything else. Truth be told, the dentist never really thought he would need the manual until, of course, he needed it.

Too often dentists look at human resources polices as an expense rather than a necessary investment in protecting the practice from potentially costly litigation. In other cases, a dentist may purchase a practice that has an existing manual and then simply assume that it is OK, that everything that should be addressed is ... until the dentist discovers otherwise.

Lawsuits on the rise

When the economy tanked in 2008, the number of discrimination and wrongful termination lawsuits skyrocketed. When the economy is good and people can find jobs quickly, they don't bother pursuing litigation. In this environment, it is much more likely that an unhappy employee will sue or file a complaint than it was five years ago. It's essential that employers have policies and procedures in place.

Certainly, dress and appearance are big issues in today's workplace. Dentists need a dress code and a policy. You can say that everyone is going to wear scrubs. You can say no jeans are allowed. You don't have to tolerate offensive or off-color attire, T-shirts with inappropriate sayings, crazy hair, etc., but it's essential to have policies in place. However, dentists do need to be aware that if the clothing, such as a head scarf, is worn because of the employee's religious practice, it is protected.

McKenzie Management's HR Solutions division encourages dentists to work with a professional to create a "policies and procedures manual" that is specific to the individual needs of the practice. The manual may cover as many or as few issues as the dentist chooses, but would probably serve its purpose most effectively if it included key practice policies, including those listed below:

Equal opportunity statement: This states that the employee's religion, age, sex or race will not influence hiring, promotion, pay or benefits in any way.

Definition of the work schedule: This indicates that all employees are to be at assigned work areas and ready to provide care for patients at a certain time.

Salary/payment policies: This details when the employee can expect to be paid, how wage increases are handled, overtime, etc.

Professional code of conduct: This section clarifies the practice's expectations regarding employee dress, punctuality, use of tobacco, alcohol and drugs, as well as policies regarding personal phone calls, Internet usage and personal visits.

Time-off policies: This section explains policies on vacation, parental/maternity leave, illness, military, funeral, personal, jury duty, holidays, personal days, etc.

Performance review policy: This section explains exactly how and when employee performance is evaluated, including samples of performance evaluation forms. It may also spell out the practice's policy on progressive discipline and unsatisfactory performance. And it may list those infractions that could result in termination of employment.

Terminating an employee is something that many dentists will go to great lengths

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simply increases the circumvention challenge. Most of the thieves we see can easily adapt.

Because shoplifting is a crime of opportunity, control systems such as video cameras and radio-frequency identification tags on merchandise are effective at helping to prevent pilferage; however, such deterrence is unlikely to work in a dental practice.

The other point I will make is that fear of punishment seems to be virtually ineffective in deterrence. Embezzlers we see are well aware of the consequences of their actions, which include loss of livelihood and potentially, loss of liberty. Because of the needs of each group, we should not expect punishment to deter either the dishonest or the desperate fraudsters.

Are there any effective deterrents?

My suggestion is that deterrence strategies that provide no collateral benefit (i.e., are done only to discourage fraud) are a waste of resources; instead dentists should focus on early detection of fraud.

I will again disagree with much of the collective "wisdom" that exists on dental embezzlement when I say that for a dentist or advisors to try to confirm fraud by some form of audit or analysis is unproductive and possibly dangerous. Because there are many possible ways to steal from a dentist, without considerable knowledge and some specialized software, this activity is looking for a needle in a field of haystacks.

Fortunately for dentists, even though there are myriad ways to steal, the behavior of embezzlers is remarkably consistent. With the right knowledge, identifying embezzlement through behavioral analysis is painless and reliable.

We have a behavioral assessment questionnaire requiring less than five minutes to complete, which dentists can request from our website.

How does an economic downturn affect dental-practice fraud?

Difficult economic times create more of these desperate people I mentioned earlier, which creates more fraud. We did notice a much larger incidence of fraud in the Detroit area after the auto industry downsizing a few years ago.

What are the first critical steps a dental practice owner should take if he or she suspects internal fraud is occurring?

Unfortunately, intuitive steps are not always the right ones at this point. Dentists try to conduct their own investigation, bring their CPA into the office, or call the police. Doing any of these will likely alert a perceptive thief to your suspicions.

The overarching objective is not to telegraph your suspicion to the suspect. When fraudsters think they are about to be discovered, their strong urge is to destroy evidence. This invariably causes collateral damage. Destruction might consist of wiping the computer's hard drive and destroying all backup media.

In one spectacular case, the victims did not engage us but began their own (clumsy) investigation. The thief, once alerted, burned down the office!

This is really the point where expert guidance is needed. We have an "immediate action checklist" for dentists who suspect fraud in their office. They can request the checklist from our website.

Our investigative process is completely stealthy. I promise never to send a nerdy-looking investigator to your office. This helps ensure that evidence is protected, and also that working relationships are not destroyed in the event that suspicions are groundless.

What is the most unusual fraud case you have encountered?

About once a month we see something innovative. The alteration of receivable balances after the server crash is one I think of — we suspect that the thief caused the server to crash. By placing a magnet inside one of our lab computers, we could replicate the crash quite easily.

Is there specific insurance owners can buy to protect their business against loss to fraud? Is such insurance worth getting?

This insurance is either included in the basic insurance package that offices already have or an "employee dishonesty" rider can be added. I don't have cost details, but understand that it is quite inexpensive. Based on what I said about the probability of fraud in offices, I think everyone should have this coverage.

How much of a problem is external fraud involving customers, vendors, suppliers or other business relationships compared with internal fraud?

It certainly happens. We see a fair amount of identity theft from people trying to make use of someone else's insurance coverage or to obtain prescription medication. However, the financial and other damage that this type of activity normally causes pales in comparison to the damage caused by embezzlement.

DAVID HARRIS has had the pleasure of hearing many cell doors slam shut on thieves he has caught. He is president of Prosperident, the only company in North America specializing in the detection and investigation of embezzlements committed against dentists. He is a member of the Academy of Dental Management Consultants and has been called the "The Dental Fraud Guru." Learn more at *www.prosperident.com*.

The reviews are in!

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Christopher Esposito, DMD
Medford, NJ

Dental PRODUCT SHOPPER RECOMMENDED 2011

Oxford Zircore NANO: The blockbuster core build-up material of 2011.

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Internal root resorption rules out restoration

Permanent maxillary central incisor replaced with removable partial denture

By Dov M. Almog, DMD, and Odalys Hector, DMD

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For decades, case reports and scientific studies have described the condition of internal root resorption. A recent web search related to internal root resorption revealed 247 results in PubMed and more than 1 million results in Google. According to many of the studies, internal root resorption is infrequently detected in clinical or radiographic examinations of teeth, but is a frequent finding in teeth with pulp inflammation or necrosis.

Case report

Many of the published works on internal root resorption condition are in the form of case reports similar to this one. Some, though, are scientific studies that examine the histological and biological aspects of the condition.[1]

A recent scientific study revealed that teeth with healthy pulps did not exhibit the condition of internal root resorption. By comparison, half of the teeth with pulpitis, and the majority of the teeth with necrotic pulps, had internal resorption.[2] Inflammation was shown to be an important etiologic factor of internal resorption.

In our case, a 42-year-old African American male, a U.S. armed services veteran, presented for the first time to the Veterans Affairs New Jersey Health Care System Dental Service at East Orange, N.J., seeking dental care. The patient's primary reason for coming to the Dental Service was for a complete dental exam.

This case report describes the condition of a permanent maxillary central incisor affected by internal root resorption. While the etiology of this pathology is unknown, most commonly it is associated with trauma or seen postoperatively following a large resin restoration. According to the literature, this type of progressive internal root resorption can be stimulated by ongoing inflammation from infection.[3]

A comprehensive oral and maxillofacial examination included an intraoral and extraoral exam with cancer screening, full-mouth X-rays and a panoramic radiograph.

Among other things, the examination revealed extensive internal root resorption condition in tooth #8, coupled with a buccal fistula draining purulent discharge (Fig. 1).

After careful assessment of all the available diagnostic information, and upon further exploration of the feasibility of different treatment options to restore the patient's tooth, the case was discussed and explained to the patient.

While root canal treatment has been the treatment of choice for this pathologic condition to date,[1] after reassessing the extent of the internal resorption and describing the condition to the patient, including the potential associated postoperative ramifications, it was collectively decided to extract the tooth followed by socket preservation.

At the same visit, an immediate acrylic removable partial denture (RPD) was delivered.

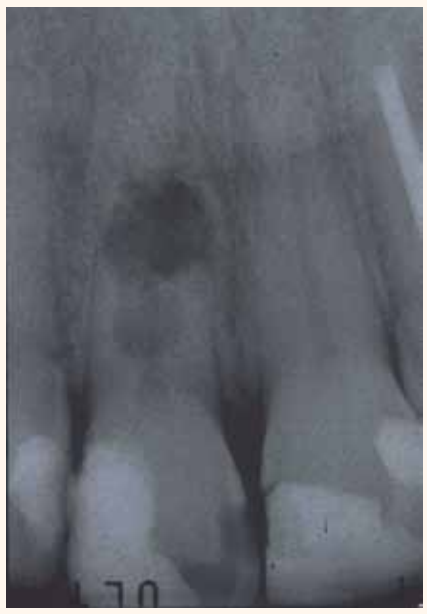

Fig 1
Based on clinical and radiographic diagnosis with conventional two-dimensional periapical radiographs, tooth #8 appears to have a large internal radiolucency in the middle of the pulp canal defined as an internal root resorption.

Photo by Dr. Dov Almog

Consequently, all restorative, periodontal and prosthetic needs were addressed, including a cast RPD replacing tooth #8 and other already missing bilateral teeth.

Conclusion

As described in this case report, for decades it has been determined that internal resorption is seen frequently in teeth associated with pulp inflammation or necrosis. Following suggested course of action in the literature, when internal root resorption condition has progressed to involve an external communication with the periodontal ligament space, this condition should not be restored and maintained.[4]

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Photo/Shae Cardenas, *www.dreamstime.com*

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to avoid — at great harm to the practice. Consider this all too familiar scenario. The new employee, "Rita," comes on board. She is bright and enthusiastic. Her responsibilities increase over the years. She has her way of doing things, which is fine with the dentist because he doesn't have to worry about things getting done. Before you know it, she's been with the office 15 years and knows the practice better than the dentist does.

The problem: That once bright, young, enthusiastic employee has become stubborn and controlling. She challenges the dentist and staff regularly. She's negative, difficult, and regularly refuses to comply with routine requests. She has become the proverbial "employee from Hell."

The dentist has finally had enough. He spent the better part of the last two years — yes, two years — making excuses for her to the remaining staff who actually didn't quit in disgust. "She's going through a difficult time." "She really is a good employee; you just have to look past her shortcomings." "You have to admit, she's very good with the schedule."

As McKenzie Management HR Solutions division has found, this situation is a common scenario in dental practices.

The dentist hands over so much responsibility to a key employee that the individual becomes central to the continued operation of the practice. This person changes over the course of weeks, months or years and issues surface.

In the case above, the dentist wanted to dismiss the employee. Somehow Rita learned of the dentist's desire to terminate her and threatened to sue him for 15 years of back pay and overtime.

The dentist was terrified. Sadly, he spent months paralyzed from fear and trying to convince himself he could just live with her disruptive behavior. He couldn't. This one employee was running his practice into the ground.

Eventually, he sought legal counsel and learned that he lived in a state where an individual had only one year to sue for back wages. But even at that, it was still far more than the dentist wanted to pay. Moreover, the entire ugly situation could have been avoided if the dentist had established office policies and procedures in place. He didn't think he needed them until he needed them.

When faced with situations in which an employee must be terminated, first and foremost, practices must have established policies and procedures. Second is to seriously consider offering severance agreements. Severance agreements in which employees give up all rights to sue are valid in every state. Offer a severance agreement with a modest amount of money to put the issue to bed and send the employee on his/her way.

The amount of severance awarded will vary based on the employee's position in the practice and how long he/she has been there. It could be three-five months salary, but when you've been dealing with a seriously poisonous staff member, most dentists will do just about anything to be rid of this person. And most agree that a few months' salary is well worth it. Rita was eventually sent on her way with six months' pay.

Additionally, the agreement should assure that the employee will not disclose confidential practice information or trade secrets. This can be taken care of up front when the employee is hired.

There should be a confidentiality provision in the handbook and the employee must be required to sign off that he/she is aware of it and agrees to follow it.

The key is preparation. Waiting until employee behaviors are so problematic that they are damaging the practice make the dentist and practice highly vulnerable to litigation.

As annual congress nears, courses already filling up

Even free courses at Yankee Dental Congress, Jan. 25–29, now require preregistration

The Yankee Dental Congress has everything dental professionals need to be informed, inspired and entertained, all packed into five days in Boston. Photo/Cpenler, *www.dreamstime.com*

A late-December visit to the 2012 Yankee Dental Congress (YDC) website showed more than 30 of the event's 300-plus lectures, workshops and hands-on courses filled up more than a month before opening day of the five-day meeting.

A new policy requires preregistration for all no-charge courses, except the High-Tech Playground, student table clinics, student lecture and social/cultural programs. Registrant's seats will be held for 10 minutes after the start of the course. When the room is filled, no additional people will be admitted and no standing is allowed per order of the fire marshal.

Diverse educational offerings

This year's educational highlights include: presenters from the Scottsdale Center for Dentistry; the team leader of the first ever partial face transplantation; the Las Vegas energy of the Madow brothers; management tips from Disney Institute; and an actual head and neck dissection course.

The exhibit floor will once again feature exciting programs in the Live Dentistry Pavilion as well as no-cost presentations in the High-Tech Playground and the new Nutrition Nook.

The YDC has everything dental professionals need, all packed into five days in January that will inform, inspire and entertain. Nearly 28,000 dental professionals are expected at the Boston Convention and Exhibition Center for the 37th annual congress, Jan. 25–29.

Also during the congress, more than 450 of the hottest companies in the dental industry will showcase their newest products and services on the exhibit hall floor, with all of the exhibitors eager to do business and many of them offering show specials.

Two complimentary live dentistry sessions added

Two complimentary live dentistry courses were recently added to the exhibit floor educational offerings courtesy of company sponsorships.

Sponsored by MegaGen USA, the first newly added course features Samuel Lee, DDS, inventor of the "crestal window sinus technique," presenting a sinus bone grafting diagnosis and treatment. The live-patient demonstration will include a detailed explanation of computed tomography evaluation, flap design, lateral window location, membrane elevation and implant insertion.

▸ Continue on page *A10*

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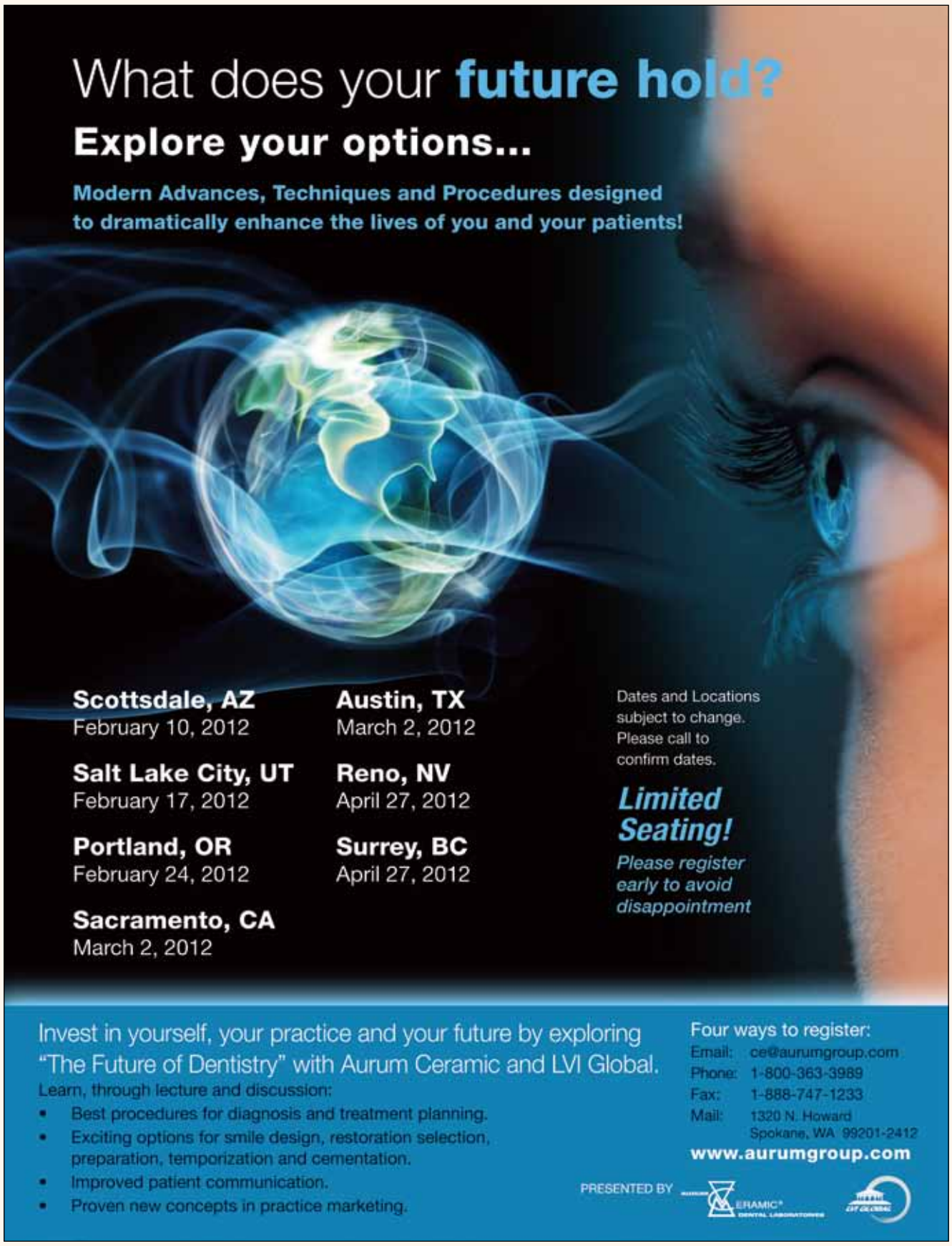

Live dentistry stage returns to Pacific Dental Conference

Online registration for March event open at www.pdconf.com

The Pacific Dental Conference, combines all the excitement of Vancouver, named the world's 'Most Liveable City' in 2011 by the Economist Intelligence Unit, with adventurous educational opportunities for the entire dental team. Photo/Michael Iwasaki, *www.dreamstime.com*

The 2012 conference, March 8–10 in Vancouver, British Columbia, features timely C.E. programming, open sessions, hands-on courses and other educational opportunities for the entire dental team. Attendees can earn up to 15 C.E. credits.

Top speakers include: Marcus Abboud, Scott Benjamin, Jeff Brucia, Teresa Gonzales, Derek Hein, Jim Grisdale, David Clark, Jeff Coil, Shirley Gutkowski, David Hornbrook, Sam Kratchman, John Olmstead, Kate O'Hanlan, Ray Padilla, Mark Piper, Rob Roda, Stewart Rosenberg, Geza Terezhalmy, Neil Warshawsky and Daniel Haas.

You can browse through the speaker biographies and presentation descriptions at *www.pdconf.com*.

Live Dentistry Stage returns

The Live Dentistry Stage is back on the exhibit hall floor, with demonstrations on Thursday and Friday. The conference's ever-expanding exhibit hall will keep you as busy as ever this year, with more than 250 companies in 540 booths.

The hours for the exhibit hall are: Thursday, March 8, 8:30 a.m. to 6 p.m. and Friday, March 9, 8:30 a.m. to 5:30 p.m.

Dentists and staff attending the PDC can take advantage of special hotel rates.

Book early to avoid disappointment. Reservations can be made directly with conference hotels by following the links at *www.pdconf.com*.

(Source: Pacific Dental Conference)

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Academy offers five days of implant training in Jamaica

The American Academy of Implant Prosthodontics (AAIP) will join with its affiliates, Atlantic Dental Implant Seminars (ADIS) and the Linkow Implant Institute, to present five-day comprehensive implant training courses in Kingston, Jamaica, March 12–16 and July 3–7.

The courses include lectures, hands-on participation, surgical and prosthodontic demonstrations, diagnosis and treatment planning of implant cases, the construction of surgical templates, diagnostic wax-ups, the insertion of two to six implants and sinus lifts under course faculty supervision.

Upon completion of the one-week comprehensive implant training program, the clinician will be able to: identify cases suitable for dental implants; diagnose and plan treatment for preservation and restoration of edentulous and partially edentulous arches; demonstrate competency in the placement of single-tooth implants, soft tissue management, and bone augmentation; obtain an ideal implant occlusion; work as part of an implant team with other professionals; and incorporate implant treatment into private practice with quality results, cost effectiveness and profitability.

A dental degree is required for participants. Patients will be provided, and malpractice insurance will not be necessary. The course is tax deductible and 35 hours of continuing education credits will be awarded upon completion. Patient treatment is provided in a Jamaican dental school with personalized training in small groups. The course is a cooperative effort of the Jamaican Ministry of Health and the American Academy of Implant Prosthodontics.

Dr. Mike Shulman is course coordinator; Dr. Leonard I. Linkow is course director; and Dr. Sheldon Winkler is course advisor. Additional course faculty include Drs. Robert Braun, Ira L. Eisenstein, E. Richard Hughes, Charles S. Mandell, Harold F. Morris, Peter A. Neff, Robert Russo and Robert E. Weiner.

Dental laboratory support is provided by DCA Laboratory, Citrus Heights, Calif., Dani Dental Studio, Tempe, Ariz., and Dutton Dental Concepts, Bolivar, Ohio.

Founded by Dr. Maurice J. Fagan, Jr., in 1982 at the School of Dentistry, Medical College of Georgia, the Academy of Implant Prosthodontics supports and fosters the practice of implant prosthodontics as an integral component of dentistry.

The academy supports component and affiliate associations around the world, including Egypt, France, Italy, Israel, Jamaica, Jordan, Kazakhstan, Paraguay, Peru and Thailand. It has published two textbooks, "The Dental Implant" in 1985 and "Implant Prosthodontics" in 1990. The Journal of Oral Implantology is its official publication. The academy also publishes a newsletter.

The academy holds an annual convention and international meetings in cooperation with its affiliate and component societies. It offers continuing education courses and sponsors a network of study clubs in the United States. The AAIP is designated as an approved program for C.E. (PACE) provider by the Academy of General Dentistry (AGD). These C.E. programs are accepted by AGD for fellowship, mastership and membership maintenance credit.

Details on the AAIP/ADIS Jamaica implant programs, including tuition, faculty lectures, transportation and hotels, can be obtained from the course website, *www.adiseminars.com*; or call (551) 655-1909. AAIP membership information can be obtained from AAIP headquarters at 8672 East Eagle Claw Drive, Scottsdale, Ariz., 85266-1058; (480) 588-8062; *swinkdent@cox.net*. The AAIP website is *www.aaipusa.com*.

Dr. Mike Shulman instructs Kazakhstan dentists during AAIP/ADIS-sponsored training program in Montego Bay, Jamaica. Upcoming implant courses are scheduled for March 12–16 and July 3–7. Photo/AAIP

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