PDC PREVIEW EDITION

Dental Tribune

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

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Be careful whom you kiss!

Is kissing harmful to your health? With just one kiss couples can share more than 500 different types of disease-causing germs and viruses, warns the Academy of General Dentistry (AGD).

"Not knowing who you are kissing could be as dangerous to your health as having multiple sexual partners," says AGD spokesperson Connie White, DDS, FAGD.

Before you pucker up again, White dishes on the most common diseases and viruses that you and your sweetie can transmit to each other while smooching.

Know whom you are kissing, says the AGD. (Photo/Dreamstime.com)

Cold sores

Cold sores are caused by the herpes virus. They appear as tiny, clear, fluid-filled blisters that form around the mouth and lips. The sores are highly contagious, especially if they are leaking fluid. However, even sores that have scabbed over can be contagious.

"A wound near the lips is most often herpes," says White. "A good rule of thumb is that if a person has any visible sores near his or her lips, avoid intimate contact!"

Colds

If you feel a cold or flu virus coming on, White suggests avoiding a make-out session. Common cold and flu viruses can be transmitted very easily through contact with the saliva or nasal secretions of a sick person (Yuck!).

Mononucleosis

Mononucleosis, also known as the "kissing disease," is easily communicated to others through kissing, as well as sharing food, a cup,

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British Columbia awaits ...

The Pacific Dental Conference (PDC) in beautiful Vancouver, British Columbia, Canada, expects some 12,000 attendees, but may very well exceed this figure from last year. The PDC is fast becoming the most recognized dental conference in Canada by attendees, exhibitors and speakers. This year's program boasts 138 speakers, so we'd be willing to bet you'll find a lecture on a topic that interests you.

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Dentists at risk for hearing loss

By Fred Michmershuizen, Online Editor

Everyone knows there are certain jobs that carry a risk for loss of hearing. Rock musicians come immediately to mind. So do construction workers who use jackhammers. And don't forget the people who use those yellow flashlights to direct planes at airports. According to a recent study, dentists can also consider themselves among those at risk for ear trouble.

Most individuals would not consider a dental office to be a place where noise is a problem, but the federal Occupational Safety and Health Administration (OSHA) warns that any workers exposed to noise levels in excess of 85 decibels are at risk.

The exposure to continuous high frequencies from a dental drill can degrade one's hearing. According to the experts, dental professionals should use protective hearing

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‘Smiles Change Lives’

“I love to smile now. It’s just automatic,” exudes Carrie, a recent Smiles Change Lives (SCL) program alumna.

Now a beaming 16-year-old with aspirations of college, sports and a nursing career, Carrie attributes her confidence and positive outlook to a dental transformation that began three years ago.

“I used to shy away from cameras and didn’t smile or raise my hand in class. I really hated showing my crooked teeth, but my family couldn’t afford braces,” she admits.

Carrie’s school counselor noticed she was struggling in school and was developing issues with her self-esteem so she recommended Smiles Change Lives to Carrie’s family.

“It was almost too good to be true. Finally, we found a program that helps working families trying to make ends meet,” shares Shelby, Carrie’s mother. “We applied to the program, found out that Carrie met the Smiles Change Lives guidelines, and got Carrie assigned to a wonderful orthodontist near us for a very reasonable price.”

With more than 900 immediate openings nationwide, SCL is a national nonprofit organization that connects caring orthodontists with children in need.

With nearly 400 orthodontic providers, and more joining each day, SCL is seeking applicants who meet the following criteria:

- Ages 11–18 with good oral hygiene.
- Family income at or below 200 percent of federal poverty level.
- Crooked teeth and/or misaligned jaws.

“We’re not a family that takes handouts, and we’re thankful that we still have our jobs. But with pay-cuts and several kids in the house, we couldn’t afford braces for Carrie. Smiles Change Lives was the miracle we needed to help Carrie find her true smile,” adds Carrie’s mother.

When asked how she would celebrate Valentine’s Day this year, Carrie remarked, “Well, I’ve got a date to the Sweetheart Dance for the first time. I can’t wait to pose for the pictures and show off my perfect teeth!”

Dentists, counselors, nurses and teachers are encouraged to nominate a child for this program.

Interested families may view program guidelines and download an application at *www.smileschangelives.org/*apply or by calling (816) 421-4949.

Smiles Change Lives serves families at varying income levels. For more information on financial qualifications, please visit *www.smileschangelives.org/qualify*. DT

(Source: Vocus/PRWEB)

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utensils or straws.

White says that college students are more prone to developing mononucleosis, due to a lowered resistance and living in close quarters with other students.

“People can look as healthy as can be, but you have no idea what kind of diseases they are carrying,” says White. “To protect yourself, know the person you are kissing.”

If you’re still in the mood — and you and your partner are healthy — stealing some smooches may benefit your oral health by increasing saliva production.

Saliva helps to wash away food particles and cavity-causing bacteria. It also protects teeth from decay by neutralizing harmful acids.

Another important consideration when it comes to kissing is how to keep your breath in minty-fresh condition. White shares these tips to get fresh breath:

- Avoid spicy foods, such as onions and garlic, and coffee. These foods and drinks can be detected on a person’s breath for up to 72 hours after digestion.
- Brush and floss your teeth at least twice a day. Remember to brush the tongue, cheeks and the roof of the mouth.
- Chew sugar-free gum after meals to wash away food particles that get stuck between teeth and cause bad odors.

“If these methods don’t alleviate bad breath, members of the public should make an appointment with a general dentist to determine its source,” says White.

“If your dentist believes that the problem is caused internally, such as an infection, the dentist may refer to a family physician or a specialist to help remedy the cause of the problem.”

The AGD has made these and many other oral health tips available on its website for the public, located at *www.KnowYourTeeth.com*. This site is the AGD’s source of consumer information on dental care and oral health.

Its goal is to provide reliable information in a format that is easy to use and navigate, and to provide the tools that will help consumers of all ages to care for their teeth and other aspects of oral care.

The site answers important dental health questions, offers the latest information on current dental treatments and tips for first-rate oral hygiene and can help visitors find qualified dentists near where they live or work. DT

(Source: Academy of General Dentistry)

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devices.

Other professions that carry risk for hearing impairment are aviation, construction and anything that involves the use of firing guns, such as military and law enforcement careers.

According to the National Institute of Deafness, 36 million Americans suffer from hearing loss, and those exposed to loud and high-frequency noises are most at risk.

In most instances, individuals in the workplace do not test their hearing until after damage occurs. Hearing aid technology can help after damage has already occurred, but professionals recommend hearing protection if working in an environment with exposure to loud sounds.

There are many businesses, such as The Tactical Hearing Co., that offer high-performance digital hearing enhancement and protection.

Tactical Hearing Co. uses the latest advanced technologies and offers affordable hearing devices that can be used in the industries of dentistry as well as construction, aviation, military and law enforcement, target shooting and hunting. DT

Tell us what you think!

Do you have general comments or criticism you would like to share? Is there a particular topic you would like to see more articles about? Let us know by e-mailing us at *feedback@dental-tribune.com*. If you would like to make any change to your subscription (name, address or to opt out) please send us an e-mail at *database@dental-tribune.com* and be sure to include which publication you are referring to. Also, please note that subscription changes can take up to 6 weeks to process.

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An invitation to Vancouver for the Pacific Dental Congress

An aerial view of Vancouver, British Columbia, Canada (Photo/Provided by the Pacific Dental Congress)

Visit the 2011 Pacific Dental Conference (PDC) at the Vancouver Convention Centre, in beautiful Vancouver, British Columbia, Canada. This is the second year at this venue and the new home of the PDC has brought the conference to a new level. Last year's attendance exceeded 12,000.

The PDC is fast becoming the most recognized dental conference in Canada by attendees, exhibitors and speakers and the organizers are pleased to offer participants a wide selection of quality continuing education programming.

This year, with 138 speakers presenting and a selection of 205 sessions to choose from, you will find more than enough variety for every member of the dental team. During the three-day conference, you can refine your clinical and practice excellence, participate in personal development courses and, of course, meet with your colleagues in a relaxed environment at one of the social events.

The roster of speakers from Canada, the United States and outside North America will be presenting topics ranging from clinical dentistry to team building and other important facets of dental practice. Speakers include Gordon J. Christensen, Joe Blaes, Anthony Cardoza, Ray Padilla, Michael Koceja, Robert Edwab and Mariano Rocabado to name a few.

Increasing the Saturday programming has been a main focus for organizers of the PDC. This year they have planned a full day of sessions and are kick-starting the day with some good old Canadian entertainment as Corner Gas star and creator Brent Butt takes the stage at 8:30 a.m. for the inaugural Saturday morning breakfast session.

Due to popular demand, organizers have brought back the "So You Think You Can Speak? Series;" be sure to include one or two of these sessions in your Saturday schedule in support of these new budding speakers.

Once again, the exhibit hall continues to grow and 2011 will be the largest ever. With more than 267 exhibitors occupying 540 booths, you will be sure to find the latest and best range of products and services for your practice.

The exhibit hall provides an excellent opportunity for you to compare products and services from the leading companies in the dental industry.

Please be sure to stop by the Live Dentistry stage while you are visiting the exhibit hall and check out the live demonstrations by Clayton A. Chan, Elliot Mechanic and Dwayne Karateew on both Thursday and Friday.

Be sure to take some time to visit Vancouver's arts, culture, fine dining, sights and a wide range of attractions, including spring skiing at world famous Whistler Mountain.

Visit *www.pdconf.com* for registration, hotel and conference program information. The organizers of the PDC look forward to seeing you in Vancouver. DT

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Pacific Dental Conference

March 10–12, 2011 Vancouver, BC

Make Vancouver your spring destination for CE learning and vacation experience!

- Earn up to 15 hours of CE credits during three days of lectures and hands-on courses
- 138 speakers, 168 open sessions and 50 hands-on courses to choose from
- Enjoy the largest two day dental tradeshow in Western Canada featuring all the newest equipment and products at over 500 exhibitor booths in the spacious PDC Exhibit Hall
- Lunches and Exhibit Hall Receptions included in the registration fee
- Online hotel reservations now available
- Shopping, hotels, restaurants and breath-taking Stanley Park are all within blocks of the spectacular Vancouver Convention Centre
- Scenic two hour drive to world famous Whistler Mountain for spring skiing and snowboarding

Join your colleagues for an exciting and fun experience at the Pacific Dental Conference this spring!

Gordon J. Christensen Materials/Techniques
Joe Blaes Lasers
Anthony (Rick) Cardoza Forensics

Other featured speakers of interest to Dentists include:
Robert Edwab, Jim Grisdale, Ben Johnson, Michael Koceja
James Kohner, John Molinari, Cindy Novotny, Mark Olesen
Ray Padilla, Ken Reed, Chris Scappatura, Nader Sharifi

Easy online registration and program information at...
www.pdconf.com

Dental malpractice prevention

Some simple guidelines to help you reduce the risk to you and your practice

By Stuart Oberman, Esq.

Dental malpractice litigation is on the rise. Now more than ever, dentists need to practice risk management in order to avoid malpractice actions.

Accurate records should be kept, patients should be completely informed and patients should be actively involved in their treatment process.

Following these easy guidelines will greatly reduce the risk of a dental malpractice claim.

Legal terminology

Dentists must have a basic understanding of certain legal terminology in order to reduce the likelihood of a malpractice action brought against them.

Negligence is a common claim brought against a dentist in a malpractice action. In order to prove negligence against a dentist, the patient must allege and prove four components.

First, the patient must prove that the dentist owed a duty of care to the patient.

Once that is established, in the second component the patient must prove that the dentist breached that duty of care.

Third, there must be an injury to the patient.

Finally, the injury must be proximately caused by the breach of the dentist's duty of care.

Most dentists are aware that they have a duty to comply with the "standard of care." Many lawsuits simply allege that a dentist has not met the applicable standard of care.

The standard of care for a dentist is the level of care that is expected of a reasonably competent dentist acting in similar circumstances.

It is important to note that the standard of care is based on that of the average dentist, not on specialists or on the top percentage of dentists nationally. The standard of care is based on the level at which an ordinary, prudent dentist with the same training and experience would practice in similar circumstances.

The last-clear-chance doctrine provides that if the dentist has information from another health care provider that the dentist knows, or should know, is incorrect, the dentist is liable if he/she relies on that incorrect information and the patient is harmed, as the dentist had the last chance to save the patient from harm.

Most dentists are familiar with informed consent. Informed consent is a required element of patient care, but it is also a simple element.

Dentists may not wish to load patients with too much information assuming that if the patients are interested in understanding more, they will ask questions. Patients may also tell their dentist that they trust the practitioner to perform the procedure that is in their best interest and do not need to discuss the treatment.

However, these patients can still fall back on the lack of informed consent and start a legal action against the dentist. Patients must be informed as to the proposed treatment and its benefits, the risks of the proposed treatment, alternative treatments, the patient's prognosis and the cost of the proposed treatment.

In order to give consent to a proposed treatment, the patient must be completely informed. Patient relations will be improved through informed consent, as the patient will realistically know what to expect from a given procedure.

Practicing risk management

It is well known that dentists should keep accurate and complete records on every patient as well as documentation of each patient's consent and understanding of a proposed treatment.

Once a malpractice action is commenced, dentists will have a better legal defense if these steps are followed. However, dentists need to do more in the office to prevent these malpractice claims from arising.

Patients want to make their own decisions regarding their health. Dentists who include patients in the

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planning process will have happier patients who will be less likely to instigate a malpractice action.

By involving patients in the treatment planning process, dentists are informing their patients of the available treatments and the benefits of each, and letting the patients choose the treatment that best suits their needs.

It is often claimed that the most important factor in preventing a malpractice suit is trust in the practitioner. Trust is especially vital in the dentist-patient relationship. Patients should view their dentists as trustworthy, knowledgeable and skilled professionals.

Dentists may gain this trust through involving their patients in the treatment planning process. Patients are much less likely to sue a dentist whom they know and trust.

It is also important for dentists to understand the needs of their patients. The patients' best interests should be kept in mind at all times. Patients may have special health needs or may be concerned about financing. The dentist may suggest providing dental care in phases in order to best serve the patients' needs or to make payments more affordable. This, in turn, will allow the dentist to gain the patients' trust.

It is important to market your services to patients; however, "puffery" should always be avoided. Puffery is a promotional statement that expresses subjective rather than objective viewpoints. Typically, puffery is a statement that no reasonable person would take literally.

When discussing the expected outcome of a dental procedure, statements such as, "this root canal will be easy," "this treatment will be relatively pain free" or "your teeth will be beautiful after this procedure" should be avoided.

This may cause the patient to build up high (maybe even unreasonable) expectations that may lead to disappointment and, potentially, to a lawsuit.

In addition, after performing an invasive procedure on a patient, it is a good idea for a dentist to follow up with the patient through a phone call.

This not only builds trust and improves the quality of care the dentist provides, but also alerts the dentist if the patient is experiencing unexpected problems that the dentist may be able to remedy.

If the problems are left unaddressed, however, the potential for a lawsuit becomes much greater.

With a more thorough understanding of malpractice actions and by following these simple tips for handling patient relations in the dental office, dentists will be more likely to avoid costly malpractice actions.

In addition, by involving patients in decisions regarding their dental care, the dentist will gain each patient's trust. This, in turn, will also reduce the risk of malpractice actions — protecting both you and your practice. DT

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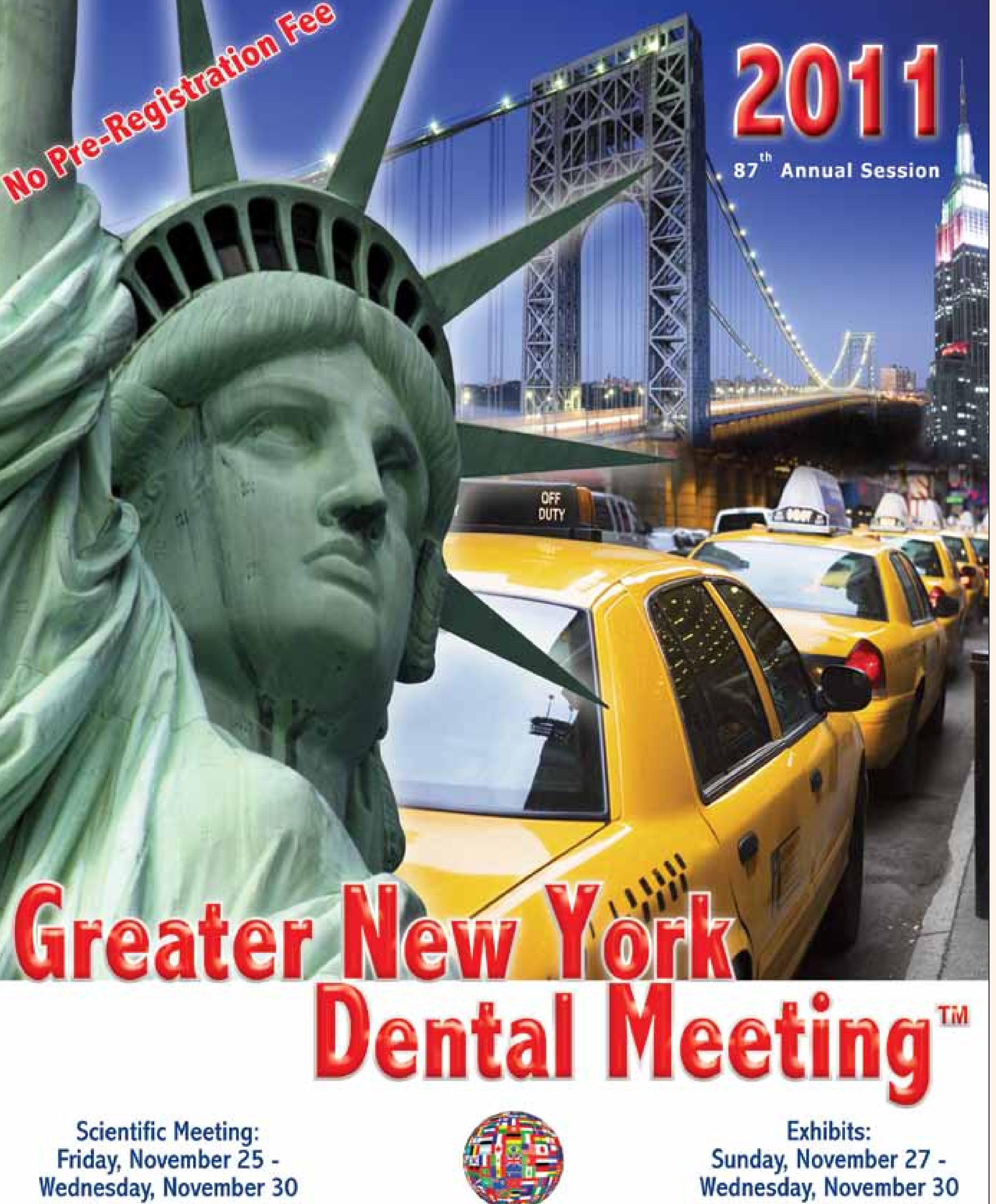

About the author

Stuart J. Oberman, Esq., has extensive experience in representing dentists during dental partnership agreements, partnership buy-ins, dental MSOs, commercial leasing, entity formation (professional corporations, limited liability companies), real estate transactions, employment law, dental board defense, estate planning, and other business transactions that a dentist will face during his or her career.

For questions or comments regarding this article, visit *www.gadentalattorney.com.*

Prevent fraud in the dental office

Stuart J. Oberman, Esq., has been invited to lecture at Boston University Henry M. Goldman School of Dental Medicine. Oberman will be one of the featured speakers at a continuing education course titled "How to Prevent Fraud in the Dental Office" on June 27.

For more information on Stuart J. Oberman, please visit *www.GaDentalAttorney.com,* or go to the corporate website at *www.ObermanLaw.com.*

Maxillofacial prosthesis: it can happen to anyone

By Dov M. Almog, DMD, Stephen F. Bergen, DDS, and Giselle Yap, DMD

Craniofacial reconstruction has been recorded throughout recorded history. Human beings have found the need to reconstruct missing or defective maxillofacial parts — such as eyes, ears, noses, maxilla, mandible and teeth — with artificial substitutes.

These maxillofacial deformities may be due to congenital defects such as cleft palates, acquired disfigurements of the face from accidents, war trauma, cancer or other diseases. Evidence of the making of such prostheses has been found in archeological digs dating back to the Egyptian Dynasty (pre-2500 B.C.).[1]

Maxillofacial defects can cause not only functional difficulties, but also some serious psychological struggles that could cause the individual to avoid social contact all together.

In view of the significance placed upon facial appearance, especially in today's society, accolades should be given to those creative professionals involved in the development and improvement of various facial and ocular prosthetic restorations, materials and treatment modalities.[2–5]

There are several synthetic polymeric materials, such as rubber, silicone or acrylic, that are currently used for facial prostheses. These require color and texture blending and matching with that of the patient to achieve a realistic and seamless appearance.

Long-term success of these facial prostheses depends mainly on their material stability, strength and facial retention. For many years, retention of the synthetic polymeric craniofacial prosthetic restoration was obtained by inferior mechanical factors, such as tissue undercuts or skin adhesives.

The retentive abilities were somewhat proven to be unpredictable, with the potential of prompting some very delicate psychological circumstances.[3–5]

It was only after the introduction of extraoral osseointegrated implants, with retention bars, clips, magnets and other attachment mechanisms for anchoring the prostheses, that the area of maxillofacial reconstruction gained the needed support, security and the anchorage that patients required for confidence in the treatment of their complex reconstructive prostheses.[2,6,7]

One exception to this was patients who have received radiation therapy. Those should be selected cautiously because overall success rates in this category were found to be low.[8]

Case report

In 1950, Dr. V. Eskenazi, the subject of this case report — a general dentist who served his mandatory term in the Israeli Defense Force (IDF) — sustained a shattering facial injury.

In addition, the location of the injury involved a facial birthmark that was compounded by basal cell carcinoma. As a result, for the following 10 years, he ended up having numerous surgical and radiation procedures.

Interestingly enough, Eskenazi originally practiced dentistry in Bucharest, the largest city and capital of Romania. Shortly after he was discharged from the IDF, he re-established a dental office and resumed his career as a dentist.

Unfortunately, the basal cell carcinoma turned out to be a "rodent ulcer" type, a persistent basal cell carcinoma condition. As a result, the affected site increased in size following each surgical excision. Ultimately, about 10 years after his injury, his right eye and surrounding socket were removed as well.

His medical records defined this procedure as an "orbital exenteration and radical maxillary resection." The defect encompassed the right orbit, midface and right maxilla. It

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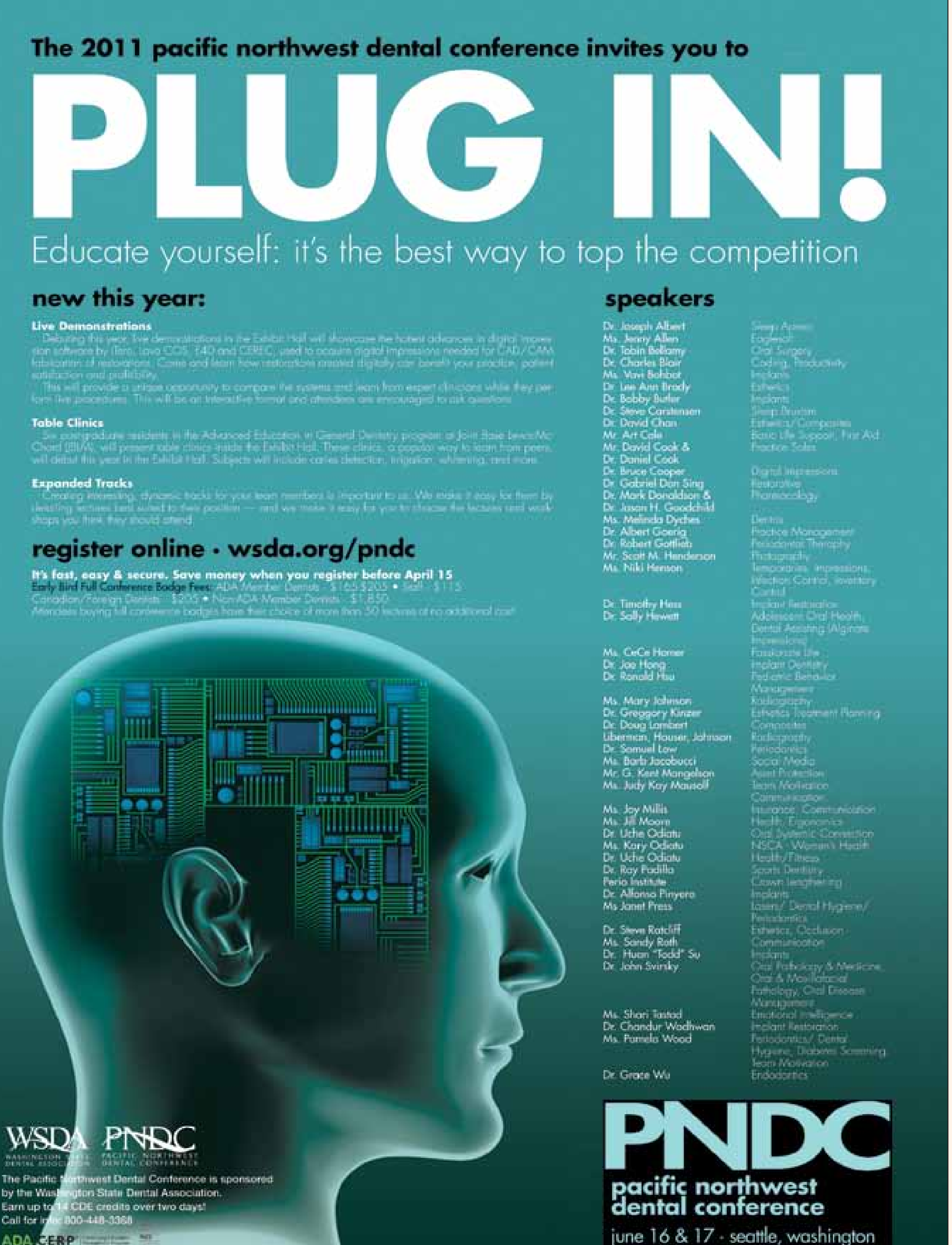

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was closed with a skin graft, taken primarily from his thighs and shoulders regions. Each surgical procedure also left permanent scars at the donor sites.

In 1975, he was diagnosed again with clinical evidence of recurrence of basal cell carcinoma in the deep portion of the facial defect. According to his medical records, this recurrence infiltrated his sinuses near the margins of the existing skin grafts.

At this point, the Organization of Disabled IDF Veterans decided to seek international expertise, and sent him to the head and neck service at Memorial Sloan-Kettering Cancer Center in New York City.

In July 1975, Eskenazi was operated on at Memorial Sloan-Kettering. According to his medical records, the disease was indeed evident bilaterally in the posterior sphenoid sinuses. While most of the diseased tissue was removed, there were no satisfactory margins that were completely clean of the disease.

Surgeons further extended the resection to include the midface and the entire maxilla. The surgical site extended from above his right eyebrow onto his forehead, crossed the midline and included a large segment of the nose and a total maxillectomy, thus significantly increasing the size of the defect (Fig. 1a).

Craniofacial prosthesis incident

Before returning to Israel, Eskenazi was referred to the Burn Institute in Galveston, Texas, where a special maxillofacial prosthesis was fabricated.

Composed of a silicone rubber, a facemask with one glass eye, eyebrow, cheek and nose was designed for him by a medical sculptor. This was in addition to a maxillary obturator prosthesis restoring the roof of his mouth.

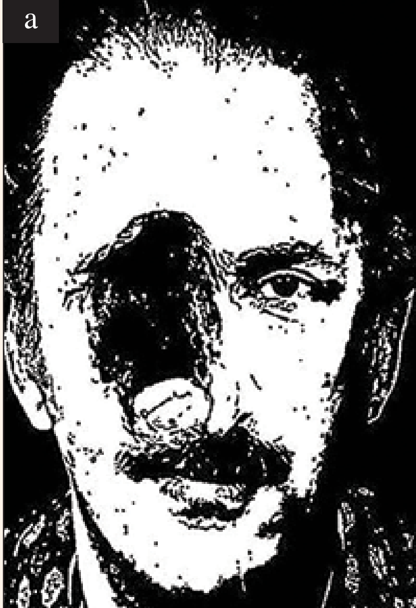
Once the maxillofacial prosthesis was shaped, hand painted and dyed to visually match his face shape and skin color, it was given to him and he returned to Israel. Shortly after, despite his somewhat unusual looking face and slurred speech, he regained his strength and returned to the practice dentistry.

Although his silicone maxillofacial prosthesis was custom made, it had limited retention. As mentioned earlier, back in the '70s the success of the majority of these large facial prostheses depended on retention primarily derived from mechanical undercuts and medical grade skin adhesives.

Due to the size, extent and weight of his prosthesis, these forms of retention were insufficient.

After wearing the extraoral prosthesis for some time, Eskenazi finally refused to wear the prosthesis. Apparently, one day while working in his dental office, due to the combination of the weight, size and high temperature, the prosthesis dislodged. Surprised and horrified at the sight, his patient jumped out of the dental chair while pointing at his face.

As a result, from that time forward and most likely due to insecurity, Eskenazi no longer wore his maxillofacial prosthesis. Instead, he carefully packed the defect in his face with gauze pads and then covered it externally with a large piece of gauze, a ritual, he repeated each morning



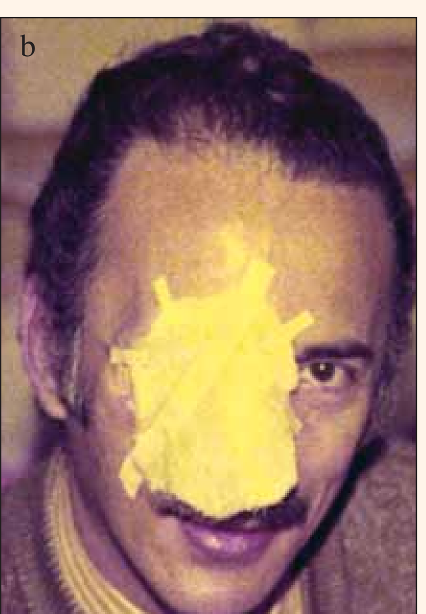


Fig. 1: a) Following radical head and facial surgeries in 1975 and 1977, Dr. Eskenazi ended up with a large gaping defect in his face. His tongue and throat could be seen through the defect. b) To his satisfaction, the surgeons left a sliver of his upper right side of his lip and mustache, concealing somewhat the bottom section of the defect below the gauze. (Photos/Provided by Dr. Almog)

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before he went to work (Fig. 1b).

In 1977, following another recurrence of his disease coupled with spontaneous bleeding and aggravation in his speech impairment, the IDF decided to once again send him back to Memorial Sloan-Kettering in New York City, where he was operated on for a second time.

This time they had to remove additional surrounding bone and tissue, resulting in an even greater disfigurement. In 1979, Eskenazi succumbed to his devastating condition.

Phantom sensations

According to medical literature, there is an illusion of connectivity between our physical body parts and our brain. Following an amputation of a body part, an individual continues to feel the missing part and experience sensations such as body touch, pain, pressure and temperature.[9]

These sensations are called "phantom limb sensations" and Eskenazi experienced them on a regular basis.

According to family records, family members were curious to see him scratch the area that used to be his right eye. When he was asked why he was scratching the gauze on his face, he replied that he "got an itch in his eye." When his family members tried to argue that he lost his eye, he tried to explain that it felt like he had sand in his eye, and shrugged his shoulders.

Conclusion

Injuries to the head and face seem to fascinate the public more than other injuries. Over the years, we have learned about many cases similar to Eskenazi's where someone "lost his or her face." While some are related to devastating illnesses,[10] others are war-, accident- or birth-related.

Facial appearance affects a person's ability to communicate and clearly embodies one's self-esteem and character.

Just think about having to look at oneself in the mirror daily. Loss of facial appearance brings with it difficult psychological effects, which makes re-entering life both at work and home very difficult.[11] DT

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