



The COMPASS

Official Publication of the California Association of Oral and Maxillofacial Surgeons



Volume VI, Issue 3, Fall/Winter 2004

SO CLOSE, AND YET SO FAR

Well we almost got our Cosmetic Surgery Bill SB 1336 passed this year; but were stymied at the last minute by Governor Schwarzenegger, who requested an occupational analysis of oral and maxillofacial surgery before he would consider such a measure. The Governor wrote:

"I am returning Senate Bill 1336 with out my signature.

This bill authorizes the California Dental Board to issue permits to oral surgeons allowing them to perform certain types of elective cosmetic surgery. I believe this practice needs to be more carefully reviewed and evaluated to fully ensure the safety of California's consumers.

Therefore, I am directing the Department of Consumer Affairs to conduct an occupational analysis of the Oral and Maxillofacial Surgeon (OMS) profession. This analysis will allow the Department of Consumer Affairs to Examine the existing training and education requirements and make an assessment as

to whether the additional permit standards proposed in the bill would enable the OMS to practice safely and competently in the expanded situations allowed for by the bill."

But despite our loss, we should be proud of the tremendous efforts of...the CALAOMS Membership whose grass roots efforts was invaluable

Because this analysis will take longer than the rest of this year's legislative session, SB 1336 is finished for this year.

But despite our loss, we should be proud of the tremendous efforts of the CALAOMS Legislative Committee, our CALAOMS PAC, our CALAOMS Staff, and our Lobbyist. Kudos to the CALAOMS Membership whose grass roots efforts was invaluable. Also critical to our quest was the tremendous partnership effort by the California Dental Association in providing guidance and support as SB 1336 moved through the Senate Business and Professions Committee,

the Senate Appropriations Committee, the California Senate, the Assembly Business and Professions Committee, the Assembly Appropriations Committee, the California Assembly, and then back to the California Senate. In the entire process, we had only three (3) negative votes which were in the California Assembly. This was a tremendous accomplishment for any legislative effort despite the side show

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Editor's Corner



Corrine Cline-Fortunato, DDS
Editor

These are strange days indeed. Tonight I simultaneously watched a full lunar eclipse *and* the Red Sox win the world series, SB1336 was vetoed by our governor after passing the legislature so successfully, and I consulted with three patients last week for bisphosphonate related osteonecrosis. The later might not seem so impressive, but up until now I hadn't seen any patients with this condition; therefore, Dr. Felsenfeld's contribution to this edition of *The Compass* feels a little like kismet. After a discussion with our neighboring oncologist, it appears that referrals for this condition will be increasing as patients in his office taking the combination of Zometa and Aredia are increasingly complaining of oral symptoms.

As this is the last 2004 issue of *The Compass*, I'd like to take this opportunity to publicly thank the members of the Publications Committee for their contributions and hard work, particularly on the last issue of (an unexpected death in the family required me to be out of state for an

extended period of time right as we were to go to publication and the group put out a stellar product). It has been a personal pleasure to work with each of you. And special thanks to the CALAOMS staff, and Steve Krantzman in particular, for your assistance...you rock!

May the rest of you enjoy the upcoming holidays, and have a Happy New Year.

Enjoy,

Corrine Cline-Fortunato, DDS
Editor



YES



NO

SOME PERSPECTIVE ON SB 1336

By,
Gerald Gelfand, DMD.
Vice President, CALAOMS

What disturbs me most about Governor Schwarzenegger's veto of SB 1336 is not just that he vetoed it, though that's certainly disturbing. No, what disturbs me most is that after many hours of testimony in front of the legislature, he discounted their sentiments entirely despite only three nay votes out of 120 members of the Senate and Assembly.

The Governor didn't sit in on all the committee hearings and testimony presented by both sides of this issue. Rather, it is my understanding, that he discounted the vote of the legislature, which heard all the arguments and facts relating to the legislation, and based his veto decision on the sentiments of one individual who clearly had a significant bias against the bill. The Governor elected to exercise his veto power improperly in my estimation.

The right of a chief executive to veto the work of the legislative branch is an important part of our system of checks and balances. However, as with all rights, there is a responsibility and in my estimation, the Governor violated that responsibility by so

inappropriately wielding his veto power in the face of such overwhelming support in the legislature. This wasn't a close one, folks.

For many of us at CALAOMS and CDA it was truly a punch in the stomach when we heard the news. After so many years of strategizing and hard work on the part of many people, the veto was, to say the least, deflating and disheartening. But don't underestimate the resolve of those of us who have fought for this legislation on behalf of our specialty.

Our detractors no doubt hope we will just walk away feeling that we fought the good fight and lost. Ain't gonna happen. They don't understand the mentality of the average oral and maxillofacial surgeon. Defeat is not in our vocabulary. We will go through the hoops put before us by the Governor and we will be back until we are justly rewarded in our quest. It's easy to battle on when you know you're right.



If the Governor can be swayed by one biased voice, maybe he needs to be vetoed.

Continued from page 1

media frenzy and the opposition's misinformation campaign about the Bill and the education, training and competence of Oral and Maxillofacial Surgeons.

Out of this unsuccessful effort have come many positives, which we can build on for the future of CALAOMS and the specialty of OMS. These include:

- 1.) An improved relationship and mutual trust with CDA and an understanding that we can be beneficial to each other on a multitude of issues important to Dentistry and Oral and Maxillofacial Surgery.
- 2.) Activation of our Legislative Committee and establishment of a grass roots network of members, which we can hopefully expand for future efforts.
- 3.) An expanded contact with legislators and an opportunity to educate them about our specialty and the things we do.
- 4.) Recognition by the CALAOMS Membership of the importance of financial support of our Political Action Committee (PAC) so that relationships with legislators can be solidified and our specialty better understood by those who are involved in regulatory issues effecting OMS. It is important for all of you to continue to contribute to CALAOM-

SPAC to replenish the funds expended this year and to allow us to continue fostering relationships with present legislators and the new legislators who are replacing those who are termed out this year. This is an ongoing process and we need to continue our political presence in Sacramento.

Also on a positive note, SB 1546, the Dental Assistant's Scope of Practice Bill was passed by the Legislature and signed by the Governor in late September 2004. This Bill is a direct result of CDA's efforts and they were fully open to CALAOMS' request for the establishment of the category of Registered Surgery Assistant. This category will enable our surgery assistants to legally place dressings, remove IV lines, and push IV drugs under the direct and immediate supervision of the surgeon as of 2007. Assistants, will have to complete, within 120 days of hire, courses in infection control/California law, radiation safety, basic CPR and also be required to complete an educational track specific for the dental surgical specialty they choose (OMS vs. Perio.).

We are carefully assessing our future options regarding our OMS scope of practice and will keep you posted, as we know where we are. Thanks to everyone who worked so hard this year, it was quite a ride!

P. Thomas Hiser DDS, MS
President, CALAOMS

AAOMS Annual Meeting in Review

Oral and Maxillofacial Surgeons from California were active as always in the 2004 AAOMS Annual Meeting in San Francisco. As we all know for this year, Dr. Elgan Stamper has been the President of the American Association of Oral and Maxillofacial Surgeons, and has set the highest standards for the office. Members on the Committee on Continuing Education and Professional Development from California include Drs. Peter Moy, Michael Cadra, and M. Anthony Pogrel. Dr. Larry J. Moore is the chairman on the Committee on Practice Management.

During the dedication and at the Opening Ceremony and Awards Presentation at the 2004 AAOMS meeting, Dr. Alan H. Kaye was given the Presidential Achievement Award and Senator (Dr.) Samuel M. Aanestad was given the Outstanding Legislator of the Year Award. Congratulations to California Oral and Maxillofacial Surgeons.

Unique for this year at the meeting was the use of interactive hand units in which the presenters could poll the audience for responses as to various aspects of clinical

practice related to the topic presented. This allowed for immediate feedback and enhanced the discussion.

OMS from California involved in the program at the 2004 AAOMS meeting included: Dennis-Duke Yamashita, Bach T. Le, Brian L. Schmidt, R. Bryan Bell, Suzanne U. Stucki-McCormick, Richard C. Robert and Lester Machado in surgical mini-lectures of various topics.

Participants in symposia included: Alan L. Felsenfeld, Laurence R. Rifkin, and David H. Perrott.

Presentors in the Surgical Clinics were Edmond Bedrossian, Dennis G. Smiler, Jeffrey J. Moses, and Alan S. Herford.

Clinical Interest Group participants were represented by M. Anthony Pogrel.

Abstract Sessions as moderators or participants included: Brian Bast, Milan J. Jugan, Brian Schmidt, Janice Lee, Arthur H. Friedlander, Radhika Cigurupati, Douglas K. Doran, and Angelle M. Casagrande.

By Vince Farhood, DDS

What's Happening at the Central Office

If you attended CALAOMS' Annual Meeting this year in Monterey, you had the chance to meet the Staff of CALAOMS. If you attended the Banquet in Monterey you got to know even more that you have a GREAT staff working for your Association. I would venture to say since you all work with staff, you would agree with me that staff can make or break your office. Even one person can be the straw that can bring down even the best in office camaraderie. Having had some of those straws in the office, I feel that I can take a few minutes to introduce to you a great addition to the CALAOMS Central Office Staff. Teri Mandella started with us 3 months ago and

the entire staff and members that have met her agree that she is a wonderful employee and team player. Steve Krantzman, Debi Cuttler, Barbara Holt and Teri Mandella along with myself, make up the Central Office. I feel that I can speak for all of us when I say that we appreciate the opportunities afforded us by working at CALAOMS, and enjoy the camaraderie with our staff and the members of the Association. When you call the office, please thank the staff for their efforts, because each one is an integral part of the success of CALAOMS. Thank you.

*Pamela Congdon
Executive Director*

New ABOMS Diplomates



Congratulations to the following OMS from California who are new 2004 Diplomates to the American Board of Oral and Maxillofacial Surgery. The list includes:

Arsalan Ahani	San Francisco	Jone Kim	Anaheim
Simona Arcan	Redondo Beach	Mark Kuo	Selma
Gabriel Aslanian	Tarzana	Janice Lee	San Francisco
Steven Barney	Rolling Hills Estates	Andrew Lee	Chino Hills
Radhika Chigurupati	San Francisco	Alex McDonald	San Francisco
Harold Cox	Redding	Robert Mower	Castaic
David Ehsan	San Francisco	Michael Newton	Thousand Oaks
Scott Fross	Palo Alto	D. Allen Pulsipher	Murrieta
Jose Garri	Santa Monica	Andrew Rahn	Fresno
Gregory Hailey	Citrus Heights	Jamsheed Shamloo	Tarzana
Holly Hatt	San Diego	Gregory Thomas	Burlingame
Peyman Hedayati	Santa Rosa	William Tom	Healdsburg
Keith Kealey	San Diego	Ramtin Vahadi	Oak Park
		Joy Wang	Mountain View

Certification by the ABOMS is the “crowning achievement in the educational process because it indicates that an individual who has attained this recognition cares about defining and improving their level of knowledge,” stated ABOMS President Dr. Edward Ellis III.

CALAOMS OMS appointed to the 2004-2005 ABOMS Examination Committee

Dr. Alan Felsendfeld from UCLA and Dr. Vincent Farhood from Vacaville were appointed to the examination committee of the American Board of Oral and Maxillofacial Surgery for the 2004-2005 years. They were two of ten OMS appointed to the position

of board examiner. The oral examination will be given (as usual) in Chicago the week of Feb 13. The examination committee will be active from Feb 12 to Feb 19. Service on the committee requires long hours and dedication to the quality of the certifying process. Congratulations to OMS selected and to Drs. Felsendfeld and Farhood.

Oral and Maxillofacial Surgery Alert

The Tip of the Iceberg!

Alan L. Felsenfeld, DDS
Professor of Clinical Dentistry
Oral and Maxillofacial Surgery
UCLA School of Dentistry



Originally published in the Western Los Angeles Dental Society's newsletter WESTVIEWS, and reprinted here with the permission of Dr. Felsenfeld

This is not a scientific article. Nor is it supported with any significant research, laboratory studies or extensive literature reviews. I am writing it in the first person rather than the traditional third person appropriate for publication since this is more of an opinion-editorial piece (something that you will be seeing more of from me in the future) rather than an article meant to contribute something scientific to our body of knowledge.

So what am I trying to do in this space? I have a growing concern about a medical problem that we have been seeing at UCLA that is supported, despite my earlier comments, by some articles and observations by other clinicians.^{1,2} It is my hope that I can share my experiences with my colleagues with what I believe to be an escalating problem.

By way of background, there are a number of radiographic lesions of the jaws that are associated with systemic conditions. Within this group are metastatic tumors from distant malignancies as well as osteoporosis. Specifically, multiple myeloma, metastatic breast cancer and metastatic prostate cancer create radiolucent or sometimes mixed lesions that can be seen in the jaws.

Treatment of these diseases is complex with many modalities and therapeutic agents being used. Some of the more commonly accepted and increasingly popular agents in these and other tumor management protocols are bisphosphonates. Bisphosphonates are used to inhibit osteoclastic activity and thereby limiting the spread of the disease within the bone. These drugs, such as zoledronate (Zomeda®) and pamidronate (Aredia®) are given intravenously once a month. Alendronate (Fosamax®) is an oral form of the drug used in the treatment of osteoporosis usually in the post-menopausal female.

One of the apparent, but not scientifically well documented, side effects of these drugs is altered bone metabolism resulting in what has been termed bisphosphonate associated osteonecrosis. This is a condition where the bone in the jaws necroses spontaneously or more frequently as a result of a dental intervention such as extraction or an ill-fitting prosthesis.

Patients will present to dental offices complaining of pain, possible purulent drainage, with an overlying infection, loose teeth or exposed bone in their mouths. Examination will reveal a variety of findings. In some patients there may be little that is noted to be abnormal when the mouth is examined. In others it is obvious that there is large or small amounts of exposed, necrotic appearing bone. These are the extreme presentations with a host of possibilities in between.

Radiographically, and usually paralleling the clinical findings, there may be no obvious bone pathology to extremes of radiolucent areas within the jaws. Frequently, there appears to be a mottled, dysplastic bone present in the area of the symptomatic teeth. Poorly healing extraction sites in the effected area are common. Rarely is a specific sequestrum identifiable and on some occasions spontaneous fracture of the mandible can be noted.

This condition needs to be differentiated from acute or chronic osteomyelitis as well as osteoradionecrosis.

Osteomyelitis is a pure infection of the cancellous and cortical portions of the bone that generally is of bacterial origin. There are acute phases with swelling, purulent drainage and constitutional signs and symptoms such as leukocytosis, shifts to the left, increased C-reactive protein and elevated sedimentation rates. Fever, lethargy and paresthesia may accompany these forms of the disease. Radiographic findings include the presence of sequestra, involucrum and mottled bone.

Chronic osteomyelitis is a more insidious condition with chronic pain and paresthesias. Radiographs will show altered bone patterns with varying degrees of increased radiodensity or radiolucency.

In both forms, bone scans will show increased uptake in the infected areas.

Osteoradionecrosis is a condition where the bone in a field that has had significant radiation loses vascularity with ultimate necrosis and possible exposure of the bone.

Radiographic changes similar to chronic osteomyelitis and pathologic fracture are possible as the process progresses.

Bisphosphonate associated osteonecrosis has some of the characteristics of each of these conditions but is neither. There is not an obvious infectious cause and the patient has not had radiation.

The dental tendency in these patients is to perform endodontic procedures on many of the teeth in the area that are symptomatic for lack of a better diagnosis. This is extremely unlikely to be successful since the origin of the problem is not dental rather from the necrotic bone. Subsequent to endodontics, apicoectomy or extractions are done. All of this results in a potential acceleration of the problem. It has been seen that the damage done to the patient as a result of these procedures produces additional necrotic bone.

We are left with the question of how do we treat them? Philosophically, as dentists, we are taught to 'do' for our patients. I think for this group of patients 'doing' may be more deleterious than not doing. While it is sometimes difficult to take a cognitive approach with dental patients, less is certainly thought to be more. The first rule of medicine is to do no harm. My philosophy of treatment for bisphosphonate associated osteonecrosis is to counsel the patient and advise them of the nature of their problem complete with the long-term poor prognosis for healing. I tend to put the complication into perspective relative to the control of the malignancy that is offered by bisphosphonates. My interaction with the primary care hematologists and oncologists has supported this mode of management.

In my experience, I make every attempt not to do any invasive procedures unless absolutely indicated. When a patient is acutely infected with purulent discharge noted, culture and sensitivities (although likely they will grow oral flora) are indicated as well as topical antibacterial rinses and irrigation. Systemic antibiotics that are appropriate for the oral flora are prescribed as well.

For the patient with chronic exposed bone, it has been my finding that no treatment is a good method of preventing further harm. When spicules of bone are loose certainly limited debridement is helpful to the patient. Rough edges can be smoothed gently with a bone file without anesthesia since the bone is dead. This is a procedure that may need to be repeated intermittently. Hyperbaric oxygen has not been shown in my

small series of patients to be of great value in reestablishing vascularity to the area.

Marginal or segmental bone resections have been done by some of my colleagues. In the treatment of osteoradionecrosis, we tend to resect back to bleeding bone since there is an end to the radiation field and damage that accompanies it. While it has been reported that you can do segmental resections to bleeding bone, in bisphosphonate associated osteonecrosis patients it is unclear as to whether or not that trauma will precipitate additional bone necrosis. This puts the clinician in a difficult situation of developing a successful margin. Bone grafting with cancellous bone or with vascularized grafts are relatively contraindicated since the grafts are unlikely to heal to the necrotic bone edges.

One of the apparent, but not scientifically well documented, side effects of these drugs is altered bone metabolism resulting in what has been termed bisphosphonate associated osteonecrosis.

There is no indication of the number of patients on these drugs that are experiencing this type of bone problem so the epidemiology is unclear. Patients with osteoporosis who take oral bisphosphonates do not appear to be at a risk level equivalent

to the intravenous drug group. It has also been seen that cessation of the drug does little to change the prognosis for these patients since the damage has already been done. In cases where the bisphosphonates are continued for the systemic well being of the patient, it is unclear whether or not additional damage ensues.

I am reminded of the old story of the scientist who invented an acid so powerful that it could eat through anything and that he was having a problem trying to store it. We have a problem that is developing in a subset of patients with very serious diseases. There may be no alternative to the cessation of bisphosphonate therapy in some primary or metastatic bone malignancies. I am seeing more patients like this on a regular basis referred from dentists or the treating physicians.

As dentists we are reminded that thinking rather than doing is in the best interest of these patients. Perhaps a pretreatment dental evaluation and treatment as in radiation patients would be appropriate. However once the patient presents with symptoms, a word to the wise....

Reference:

¹ Ruggiero, SL. et al. Osteonecrosis of the Jaws Associated with the Use of Bisphosphonates: A Review of 63 Cases. *Journal of Oral and Maxillofacial Surgery* 62 (5):527-534, 2002

² Marx, RE. Pamidronate (Aredia) and Zoledronate (Zometa) induced avascular necrosis of the jaws: A growing epidemic. *Journal of Oral and Maxillofacial Surgery* 61(9); 1115, 2003 (Letter to the editor)

SCPIE's Risk Management Corner

Pointing Fingers Is Risky Business

By Barbara Worsley

It is not uncommon for medical malpractice lawsuits to arise after one doctor expresses an opinion—inadvertently or intentionally—that a fellow oral surgeon, general dentist, or other healthcare professional was negligent. What often happens is that the finger-pointer ends up being drawn into the lawsuit as a codefendant or unwilling witness.

What follows are basic guidelines to avoid that scenario:

Do not place blame for an unsatisfactory outcome

Never assume that another member of the healthcare team has acted improperly based solely on statements made by the patient or one of the patient's relatives. Although such opinions are to be taken seriously, doctors should also keep in mind that patients and their family members may not be able to make objective, informed evaluations of courses of treatment. Unless you want a colleague to be sued, never tell a

patient that another healthcare professional mishandled some aspect of the patient's care.

Avoid terms that imply others were careless: "Mix-up" and "snafu" are two examples. (Suggesting that something "could have been handled differently" can have a similar negative effect.) In addition, avoid statements that imply another healthcare professional lacks the necessary experience, qualifications or

Avoid making comments such as... "That symptom should have been recognized earlier"

knowledge to deal with the patient's problem.

Empathize, don't apologize

An apology for conduct by other healthcare professionals can easily be misinterpreted as an admission of negligence. Avoid making comments such as "I'm sorry that drug was prescribed for you" or "I regret the way this was handled." Never say, "That symptom should have been recognized earlier" unless you want to be personally and inappropriately blamed for the delay. Empathizing with regard to specific events is less likely to be viewed as admission of

negligence. "I'm sorry to report that a complication has occurred" or "I'm sad things turned out this way" do not imply negligence if they are heard correctly by the patient.

Do not comment before having all the facts

Rushing to defend the competence and qualifications of another healthcare professional before you know the facts—even without directly addressing the question of negligence—can give the impression you think the person was in fact negligent.

On the other hand, you should never deliberately mislead a patient by stating that care was good when the only evidence you have suggests the opposite. Since you will rarely have all the facts needed to determine what really happened, the best response in most situations is to explain that you cannot give an opinion without more information.

Do not write in the patient's medical record that someone else was negligent

Limit your notes to objective, nonjudgmental statements. For instance, a written comment in the record that an injury was due to "treatment delay" or "slow response" by another healthcare provider is unnecessary for ongoing patient care and implies a negative judgment of that person's conduct. Also, do not directly disagree in the record with something

that was written by another person unless you provide an explanation.

For example, if a prior note states the patient has no allergies but you are told of a probable allergy to penicillin, record this as a new note. There is no benefit from adding a comment that the earlier note was incorrect. If there is no danger to the patient from the prior record, additional documentation probably is not indicated at all. If, for example, you disagree with a prior chart entry containing an opinion about the patient's personality, but the entry creates no direct danger to the patient, there is no need to document your opinion.

Do not prematurely document a plan for corrective action

Jumping to a conclusion and taking action before you have the necessary information to support the conclusion may imply that you believe negligence took place. A common conclusion of this type is to chart an entry in the medical record suggesting the cause of an injury without evidence to back it up. Not only can medical record entries based on premature conclusions help plaintiff attorneys establish legal causation in malpractice cases, they also can prevent defense attorneys from successfully arguing that other factors not noted in the record might have been the cause of a problem.

Conclusion

Perhaps the best way to head off problems before the above guidelines

even need to come into play is by communicating well within the healthcare team. Foster an open environment that encourages participation and input from all team members. Respect other healthcare professionals and their ideas, even if the professionals are new or less experienced. Finally—and most important—discuss differences of opinion in a private environment away from patients.

Barbara Worsley is Vice President, Risk Management, for The SCPIE Companies



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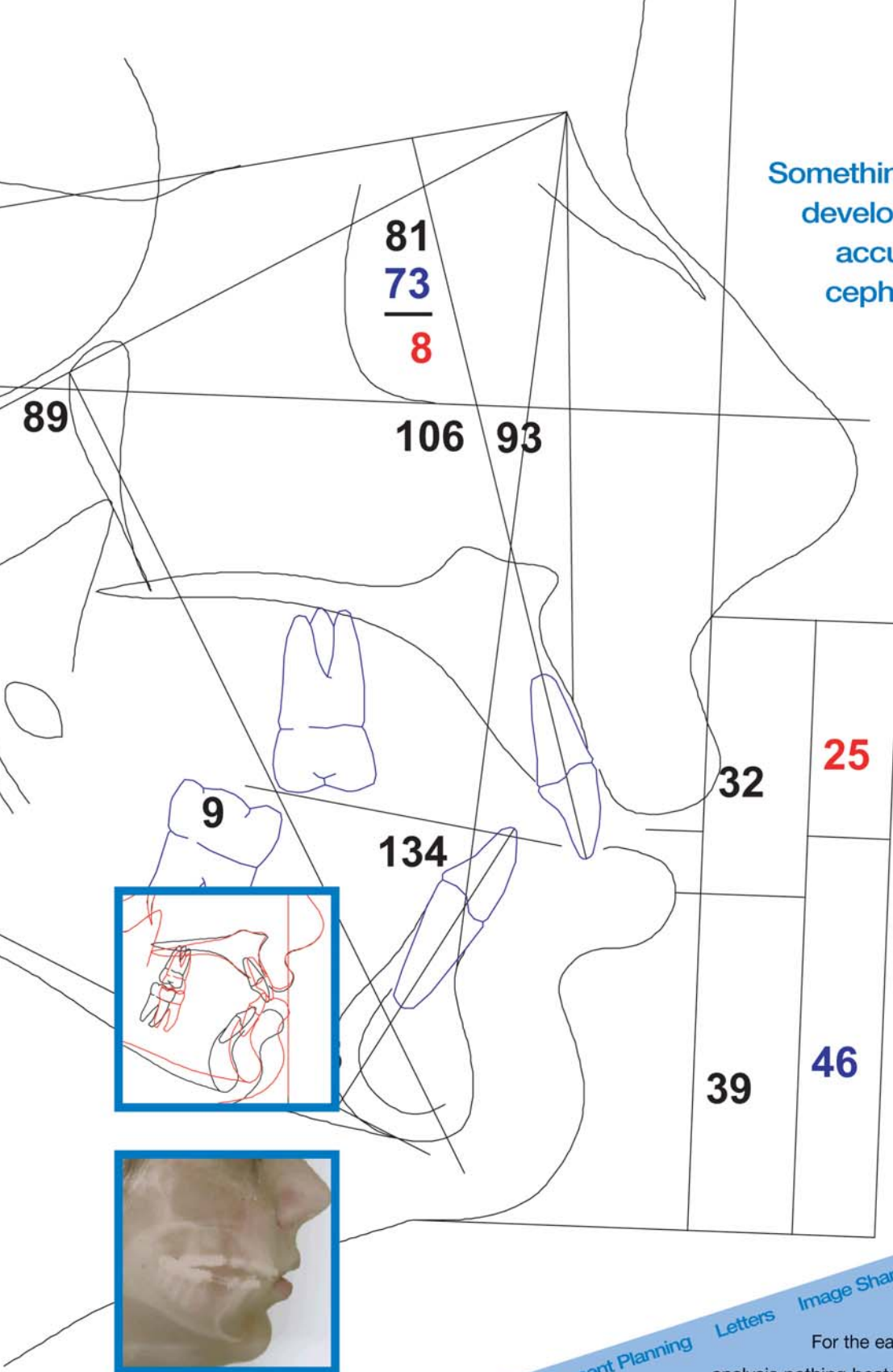
We would encourage existing examiners and GA Permit holders to attend this course. Dr. John Yagiela will be speaking as well as members of CALAOMS.

Calibration and recommendations from the Blue Ribbon Panel will be discussed.

The Dental Board of California is organizing the classes and will announce the locations for both dates early next year.

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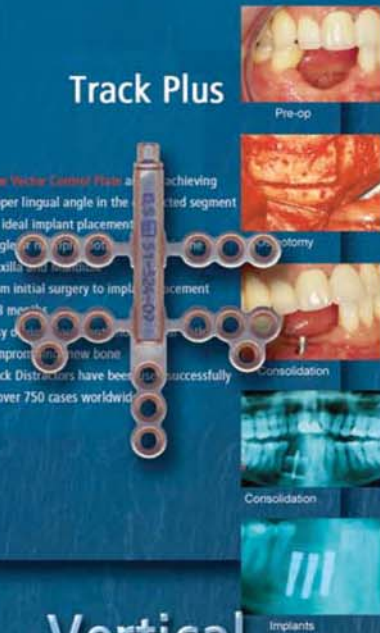
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The periotome is sold complete with 3 different blades. Additional blades can be purchased separately.

Periotome

The R. Quélin Bone-Mill

Designed for pre-prosthetic and reconstructive procedures.

- Designed to grind bone of various densities, especially compact cortical bone
- Bone particles as small as 0.1mm effective to produce graft material
- Specially designed for efficient grinding from each harvest
- on the grinding wheel
- Collector cup
- No metal residue on the grinding wheel



Bone Mill

Cut
A high technology blade efficiently cutshavings on surfaces. No saws, osteotomes, trephines, rongeurs.

Collect
While cutting, shavings combine with the blade for collection. No forceps, searching.

Deliver
The instrument safely transfers the graft, then delivers it directly to the recipient site. No additional graft handling!



Autogenous Bone Grafts ... Naturally!

Effectively cut and collect autogenous bone. Autogenous grafts no longer difficult and time-consuming. The MX Grafter Bone Grafting System is a self-contained, single-use instrument that produces a "Gold Standard" bone graft. The "Gold Standard," with ease, is harvested from the patient's own natural bone. Harvest autogenous bone with the MX Grafter Bone Grafting System. The donor site - shaving reveals bone, less pain, less time, less cost. The MX Grafter Bone Grafting System is enclosed in a sterile, single-use, easy-to-use, and easy-to-clean container. The MX Grafter Bone Grafting System cuts, collects and delivers the bone graft. The MX Grafter Bone Grafting System is the natural choice for bone grafting. Autogenous Bone Grafts... Naturally!

Bone Graft Kit

GRAFT KIT 1.0/1.5/2.0 COMBO



Included in Kit:

- 1 x Container
- 1 x Screwdriver
- 1 x Blade
- 2 x 1.5mm x 9mm S
- 1 x Twist Drill

Bone Graft Kit

Clarizio Sinus Lift Instruments



TOOL# DESCRIPTION

- 01-041-00 EXTRACTING FORCEPS, #102, UPPER ANTERIOR
- 01-041-01 EXTRACTING FORCEPS, #107, UPPER UNIVERS
- 01-041-02 EXTRACTING FORCEPS, #174N, LOWER ANTE
- 01-041-03 EXTRACTING FORCEPS, #190, LOWER FURC
- 01-041-04 EXTRACTING FORCEPS, #17D, LOWER MOI
- 01-041-05 EXTRACTING FORCEPS, #145E, LOWER ROO
- 01-041-06 EXTRACTING FORCEPS, #1251, UPPER ROO
- 01-041-07 EXTRACTING FORCEPS, #112, LOWER UNIV
- 01-051-01 SEMI-TOOTH PICK
- 01-105-94 CLARIZIO ELEVATOR, #6R, BERRAZO
- 01-105-99 ELEVATOR, #07R, KLS MARTIN MODIFIE
- 38-297-02 WELDER RETRACTOR, LARGE
- 20-652-17 NEEDLE HOLDER, MARTIN, TC 17CM, 6-3/4"

Sinus Lift Instruments

CALAOMS FOUNDATION



By Gerald Gelfand, DMD
President, Foundation Board

Thanks to all of you who responded to my solicitation on behalf of the CALAOMS Health Foundation over the summer. Your generosity has allowed us to more than double the sum donated to the Foundation in 2004 as compared to 2003. Of course, two times not very much still isn't too much. But it's a

start, and if we can double it again next year and then double it again the following year then we will be gaining some significant momentum.

It takes time to change and adjust one's "giving" patterns. I understand that. My hope is to see the Foundation become relevant to the point that support by the CALAOMS membership will be automatic.

You can make a tax deductible contribution to the Foundation at any time. Please take a moment to use the pledge card on this page to support **your** Foundation. Either you have recently received your 2005 dues statement or will receive it soon as you read this. There's no easier way to support **your** Foundation than to include a contribution with your dues



remittance. Simply check off the amount of contribution you'd like to donate and include that amount with your check or credit card payment.

On behalf of the Board of Directors of the CALAOMS Health Foundation, thank you for stepping up and doing your part to promote oral health.

CALAOMS HEALTH FOUNDATION
151 N. Sunrise Ave., Ste. 1304
Roseville, California 95661
(800)-500-1332

Yes, I want to support My Foundation. Please accept my tax deductible donation of:

- \$1,000
- \$500
- \$250
- \$100
- Other _____

Name: _____

Address: _____

City: _____, State: ____ Zip: _____

Telephone: _____ Email: _____

Check enclosed

Credit card: Visa MC

Card Number _____

Expiration: _____ 3 digit security code _____

Signature _____

CALAOMS Health Foundation



Contributions are tax deductible
Nonprofit tax id number is: 95-4781831

General Announcements

Palm Springs Meeting January 14-16, 2005

By now you should have received a colorful brochure promoting the 2005 Palm Springs Meeting. If you took the time to read the brochure you no doubt know that for the first time in years we have broken away from the Hilton Hotel and Resort in favor of the Marriott Ranch Las Palmas Resort and Spa in Rancho Mirage. Although a nice hotel, the Hilton is older and is showing its wear, and it has become increasingly more difficult for the Hilton to meet CALAOMS's needs. The Marriott is a newer more glamorous

hotel that sports three 8 hole golf courses. The allure of this resort has peaked the interest of many doctors. With a limited number of rooms in the block they are sure to go fast. So we urge you not to delay. If you are planning on attending this meeting send in your registration early, and please call the hotel and make your reservations. Don't be one of those doctors that try to make reservations 2 weeks before the event and finds out that they will have to stay elsewhere.

The topic is "Clinical Practice of Oral and Maxillofacial Surgery: An Evidence Based Approach" delivered



by Thomas B. Dodson, DMD, MPH. Dr. Dodson is the Director of Resident Training at the Massachusetts General Hospital. He is an Associate Professor in the Department of Oral and Maxillofacial Surgery, Harvard School of Dental Medicine.

If you did not receive the registration brochure, or need further information on this event, please contact the central office at:
800-500-1332

Upcoming Events

2004

OMSA Expanded November 10, 2004	Pleasanton
OMSA Weekend Seminar November 13-14, 2004	Newport Beach

2005

Palm Springs Meeting January 14-16, 2005	Palm Springs
OMSA Home Study Course Begins January 15	Spring Course
Residents' Presentations February 9, 2005	North State TBD

Medical Emergencies in the Dental Office March 16, 2005	North State TBD
PALS March 19, 2005	San Diego
ACLS March/April 2005 TBD	Suisun
OMSA Home Study Course Begins April 15	Summer Course
CALAOMS 5th Annual Meeting May 20-22, 2005	Newport Beach
Residents' Presentations September 28, 2005	South State TBD

AAOMS District VI Update



Richard A. Crinzi, DDS, MS
AAOMS District VI Trustee

I've just returned from a whirlwind, transcontinental journey that took me to San Francisco for the 86th AAOMS Annual Meeting, Scientific Sessions, and Exhibition and on to the ADA Annual Session in Orlando, Florida where I served as an ADA Delegate from WA. The overlapped Mtg. resulted in AAOMS Board members departing the AAOMS Annual Meeting early to attend to responsibilities at the ADA House of Delegates in Orlando.

Early evaluations of the 2004 AAOMS annual meeting indicate this was an outstanding program with more than 4,000 AAOMS members, clinical staff and guests attending. Thanks go to the Committee on Continuing Education and Professional Development, which planned the program; the program faculty, who made the presentations meaningful; the enthusiastic and loyal exhibitors, who filled the exhibit hall and provided a comprehensive look at the products that are so necessary to OMS practice; and to the AAOMS staff, who made it

possible for all these elements to come together so successfully.

In addition to the educational aspects of the 86th Annual Meeting, the AAOMS House of Delegates met to conduct the business of the association. A number of resolutions were considered with final details to be published in the upcoming AAOMS Today and in the final Report of the 86th Annual Meeting, Scientific Sessions and Exhibition. Briefly :

The HOD elected to defer action on changes in the AAOMS Code of Professional Conduct pending further review by the Board of Trustees. They voted not to have the CPC Committee evaluate advertising complaints unless they were felt to be "egregious."

Clarifications were provided for membership qualifications for state office anesthesia evaluations and re-evaluation.

ROAAOMS resident member application procedures for AAOMS membership were simplified and they were encouraged to begin the process in this last year of residency.

The HOD contributed \$60,000.00 in 2005 to fund a final year of the Third Molar Study.

The HOD authorized an additional \$100,000.00 to fund another 3-years- Faculty Education and Development

Award (FEDA) for a total of 6 FEDA awards annually.

Passed an operating budget anticipating revenues of \$13,200,000.00 with expected expenses of \$13,000,000.00 for 2005.

The House also elected officers and trustees for the coming year. The members of your 2004-2005 Board of Trustees are:

- President:
Dr. Daniel J. Daley, Jr.
- President-elect:
Dr. Jay P. Malmquist
- Vice President:
Dr. W. Mark Tucker
- Immediate Past President:
Dr. Elgan P. Stamper.
- Speaker of the House:
Dr. Steve Nelson.
- Treasurer:
Dr Ira Cheifetz

Trustees

- District I: Dr. Lee Pollan
- District II: Dr. Edwin Slade
- District III:
Dr. Lanny R. Garvar
- District IV:
Dr. Thomas Skiba
- District V: Dr. R. Lynn White
- District VI:
Dr. Richard Crinzi

On Sunday, September 23 and Monday, September 24, the final meeting of the 2003-2004 AAOMS Board of Trustees was held. Following are the highlights of that meeting.

- ♦ Reviewed the Annual Meeting program. The 2004 Annual Meeting was the second largest in our history, just behind the 2002 meeting in Chicago. As a result of our excellent attendance, revenue for this year's annual meeting will exceed budget.
- ♦ Approved a recommendation from the Steering Committee on Faculty Recruitment and Retention to seek additional funding from corporate sources to increase the number of available FEDA grants. Each grant is a three-year, \$30,000 per year, commitment. The effort was already begun this year with funding from 3i-Implant Innovations, Inc. and W. Lorenz Surgical. Also in response to the Steering Committee's recommendations, the Board agreed to develop a master file of research funding opportunities for faculty use and to create a model mentoring program for those programs without adequate resources to develop their own.
- ♦ Received a report from JOMS editor Dr. Leon A. Assael, who provided an update on the September 2004 supplement to the Journal on dental implants. The Supplement, which includes 13 original clinical articles, accompanied the September issue of JOMS. It was also distributed via door drop to those attending the ADA meeting in Orlando. A second supplement to JOMS on dental implants is planned for distribution in 2005.
- ♦ Acknowledged the distribution of the Dental Implant Patient Education Supplement to the October 1, edition of USA Today and the release of the dental implant video news release, which will be shown on United Airlines domestic flights throughout the month of October. Additional copies of this excellent publication maybe ordered through the AAOMS office.
- ♦ In addition to the Board of Trustees meeting, meetings were held with OMSNIC, the American Board of Oral and Maxillofacial Surgery, the Canadian Association of Oral and Maxillofacial Surgeons, the British Association of Oral and Maxillofacial Surgeons, the American Academy of General Dentistry, the American Academy of Pediatric Dentists and the American College of Oral and Maxillofacial Surgeons.

At the Orlando ADA HOD Meeting, important resolutions and policy included:

The ADA challenged the nation to improve access to oral health care for the underserved populations and calling the extent and severity of untreated dental disease especially among underserved children "unacceptable" while reaffirming a single standard of oral health care.

The ADA's HOD also passed a separate resolution calling for im-

proved high-quality dental care for Alaska natives.

The ADA again is on record as opposing tongue splitting and perioral piercing.

The ADA will work with the American Dental Education Association and the National Health Service Corps Loan Repayment Program to encourage legislation/funding to provide student loan deductions for full-time faculty who remain in education programs.

The ADA HOD also elected Minnesota OMS Dr. Bob Brandjord as President-Elect.

With the conclusion of the Annual Meeting, we are now looking ahead to the Dental Implant Conference, December 3-4, at the Sheraton Chicago Hotel and Towers in Chicago. This popular program will again be preceded by the hands-on courses on soft and hard tissue. If you haven't registered yet, do so quickly before available space fills up.

As I enter my last year as your AAOMS Trustee, I appreciate the opportunity I've had to represent the 6th District. In summary I pledge to work to the best of my ability to continue to communicate with you and represent your interests to the AAOMS BOT. Please feel free to contact me with your suggestions or concerns.



OMSA

CALAOMS Announces a New Strategy for Delivering OMSA Classes



A

t the central office, the one recurring issue that our members have with the OMSA courses is that they do not want to wait up to 6 months to have a new assistant certified. Currently, CALAOMS runs four OMSA courses a year. Two courses are in the spring (one in the north state, and one in the south state), and two in the fall (north and south state as well).

CALAOMS has evaluated the situation and has determined that by adding additional classes, the number of students per course would be drastically reduced. The problem with fewer students per course is that it becomes more difficult to break even on the courses run. So adding additional courses is out of the question, unless we raise the fee per student significantly. We felt that this was unacceptable, so we came up with an alternative solution.

We are now spacing out the four existing courses, so that a new course starts every three months, at alternating geographic locations. This way we are not diluting the number of students per course so we can keep the cost lower; yet you never have to wait longer than three months for the start of a new course.

This new course schedule becomes effective the first of the year and is as follows:

<u>Course Name</u>	<u>Start Date</u>	<u>Weekend Seminar</u>	<u>Location</u>
OMSA Spring	January, 15 2005	May 14-15, 2005	South
OMSA Summer	April 15, 2005	August 6-7, 2005	North
OMSA Fall	July 15, 2005	October 23-24, 2005	South
OMSA Winter	October 15, 2005	February 5-6, 2006	North

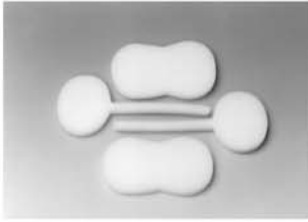
The weekend seminars are also used to recertify OMS Assistants with current certificates. We hope that this new schedule affords you better flexibility in the certification of your assistants. This is just one more way that we are striving to improve the benefits of CALAOMS membership.

If you or one of your assistants has questions on the OMSA course, please feel free to contact me at 1-800-500-1332 or email me at debi@calaoms.org.

Debi Cuttler
OMSA Coordinator

www.xemax.com

1-800-257-9470



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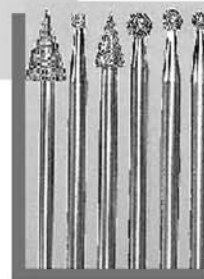
Bone Trimming Burs



SS White Burs

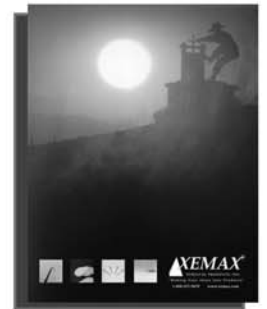


Trepine Burs



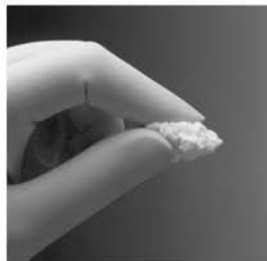
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Diplomate, American Board of Oral and Maxillofacial Surgery

To: CALAOMS Members, please take a few minutes to fill the survey below and fax or mail it back to me and I will print the results in the next CALAOMS Newsletter. I know this looks like a survey from commercial accounting offices, but I thought we might like to know a few facts for ourselves.

ABOUT YOUR OFFICE:

1. Which patient accounting software do you use:
a. Practice Works OMS Vision Win OMS
b. Rovak other _____
2. Do you use the wireless patient data entry (tablet or PDA)? Yes no
3. Do you have a web site? yes No
a. PBHS provides service yes no
b. Is the web site worthwhile (practice builder/facilitator)? Yes no
4. Whose insurance do you have SCPIE OMSNIC other
5. Do you plan to retire in _____ years.
6. Do you have a retirement plan
a. Defined benefit plan SEP-IRA 401k
b. Other _____
7. Do you bill electronically? yes no
8. Do you send out statements? yes no
9. How much time off (vacation, etc.) do you take per year? _____ weeks
10. Do you provide for your office staff:
a. Medical insurance yes no
b. Paid holidays yes no
c. Salary or hourly pay salary hourly
d. Male / female employees male ___ female ___

ABOUT YOUR SERVICE:

11. Do you provide General anesthesia or deep sedation? GA Deep Sed
12. Do you use Brevital or Propofol? Brev Propofol
13. What do you use for sedation agent? Valium Versed Barbituate
14. What do you use for analgesic agent? Fentanyl Demerol other _____
15. Do you give anti-nausea agents: no - yes _____ (name)

ABOUT CALAOMS:

15. What do you think about the Dental Board of California General Anesthesia exam?
a. Necessary Good Helpful Bad
b. How often should the general anesthesia exam be given? _____ years
16. What do you think of the job done by CALAOMS:
a. Great - Necessary - Good - Could be better - Bad - Waste of time
b. How can it be made better: _____
17. What do you think of the job done by AAOMS:
a. Great - Necessary - Good - Could be better - Bad - Waste of time

PLEASE FAX OR SEND YOUR RESPONSE TO THE ABOVE FAX # OR ADDRESS

Your Name is optional

Classified



A
d
s

Equipment For Sale

MAXILLOFACIAL AND E.N.T. EQUIPMENT

Smith nephew facial endoscopy instrument system (23-5070) for endoforhead and endofacial cosmetic proceedures: in sterilization case: \$1800

Cannula for 5.0 mm richards scopes
Dark coated laser protected elevators
Dark coated laser protected sissors
Dark coated laser protected graspers
Electrocautery attachment for above
Richards 5.0 mm zero degree wide angle endoscope for general surgery, plastic surgery, otolaryngology.
Richards 5.0 mm thirty degree wide angle endoscope for general surgery, plastic surgery, otolaryngology

RICHARDS INSTRUMENTS FOR FUNCTIONAL ENDOSCOPIC SINUS SURGERY (FESS):

Weil-Blakesly thru-cut (straight 4.8mm) \$220
Weil-Blakesly forceps (straight) \$110
Backbiter cutter (straight 2x10 mm) \$210
Hopkins sinus endoscope: thirty degree angle \$750
Hopkins sinus endoscopic sheath with irrigation ports \$500
Stryker endoscope: seventy degree angle \$750
Stryker endoscope: ten degree angle \$750

STRYKER MICROELECTRIC ATHROPLASTY/ SINUS POWER DEBRIDMENT SYSTEM with irrigating handpiece and foot pedal. \$1100

CUDA FIBREOPTIC LIGHT SOURCE with dual quartz halogen bulbs and headlight and light transmission cord. \$750

List Continued Next Column

STORZ MAXILLARY SINUS CANNULA (have two items) \$110 ea

STORZ MAXILLARY SINUS TROCARS (have two items) \$110 ea

WELLS-JOHNSON SUCTION LIPECTOMY UNIT with halligurton carry case and separate footswitch.\$750

ORTHOGNATHIC INSTRUMENT SET (extensive) \$ 4400

R. QUETIN BONE MILL for alveolar grafts/ implants \$1500

contact 858-442-1551 pacific time

FOR SALE,

***Defibrillator** MRL Portapulse 3 - Connect to Criticare Monitor 407-E & 507-E \$1,950 New. Asking \$1,500 or BO.

***Exam Chairs** - Plan Mecca Proline Powder Blue/White Fully Automatic \$6,177 New. Asking \$4,000 or BO.

***HP Scanjet 4C/T** Scanner with transparence adapter to scan x-rays & films. Original Manual on SCSI adapter. Asking \$600 or BO.

***CPU Back-up Power Supply** APC - Smart UPS 450. Original Manuals & Drivers. Asking \$300.00. Call (559) 447-0544

FOR SALE: Nellcor Puritan Bennett NPB-75. Combination capnograph and pulse oximeter. Compact 7"x3"x2" size. Uses microstream sampling for CO2 allowing excellent waveform even in "open" (i.e.:non-intubated) anesthetic systems. Includes pole mount, manual, finger probe and sampling cannulas. New equipment purchase leaves this unit unused. \$1750 OBO. Mark Grecco (209) 824-7230.

JOB OPPORTUNITIES/ PRACTICES FOR SALE

CORONA, CA

NEWLY RENOVATED OFFICE with 15 operatories. We are looking for an oral surgeon, board eligible, for a private practice. Please call, and ask for Lucy the Office Manager at (909) 735-7300 or Fax resume to (909) 549-1233.

DOWNEY, CA

This office has been an Oral Surgery Office Since 1963. The office is fully equipped for an oral surgeon with a general anesthesia license. This practice is being sold due to the death of the practitioner, Dr. Calvin Spoolstra. An oral and maxillofacial surgeon is needed ASAP to work the practice until sold. Please contact MaryEllen or Christina Spoolstra @ (714) 846-3940 or (562) 923-7257.

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EXCELLENT OMS OPPORTUNITY FOR ASSOCIATE with opportunity to buy into well established practice specializing in dental implant reconstruction in North San Diego County. No HMO/PPO. State of the art facility built three years ago. Looking for experienced OMS with background in implants looking to relocate. Send inquiries to Dr. Stephen L. Wheeler, 320 Santa Fe Drive, # 304 Encinitas, CA, 92024. Email: steve@wheelerdds.com

ORANGE COUNTY, CA

IMMEDIATE PART TIME POSITION AVAILABLE for an Oral and Maxillofacial Surgeon at a fast growing Orange County practice. Please call or fax Hugo at Phone: (714) 734-9363; Fax: (714) 734-9362

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ASSOCIATE WITH IMMEDIATE PARTNERSHIP POTENTIAL. Practice in Northern California's premier coastal area. Well-established, highly successful, multi-office, high-income OMS practice seeking a single/dual degree OMS who is board certified or an active candidate for board certification, for associate/early buy-in. Excellent salary, benefits and opportunity to assume leadership. Full-scope office/hospital practice with emphasis on implants and related grafting, orthognathic and cosmetic. Recreation opportunities and Lifestyle amenities abound. Please send CV to Dr. Terry W. Slaughter @ 420 E. Romie Ln., Salinas, CA 93901.

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Well established OMS practice seeking surgeon who is board certified or candidate for board certification. Full-scope practice with excellent facilities and

staff. Seeking associate with partnership intent Please contact Kyle Van Broklin, DMD, MS.

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areas with modern autoclaves. The office has 3 diagnostic and postoperative examining rooms; 2 surgical rooms and 2 recovery rooms.

The surgeon may have the opportunity to become Chief of Dentistry and Oral and Maxillofacial Surgery at a major hospital in San Francisco. In addition, the surgeon may have an opportunity to perform major pediatric oral and maxillofacial surgery at a Children's Hospital in the Bay Area. Fax resume to (415) 648-6068.

SANTA CRUZ/MONTEREY, CA

IMMEDIATE ASSOCIATE POSITION AVAILABLE Full scope oral and maxillofacial surgery practices seeking full and/or part-time associates to work in our Monterey Bay, Santa Cruz and Silicon Valley practice locations. Excellent opportunity for future partnership buy-in

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Phone (831)475-0221
Fax (831)475-3573

HAVING PROBLEMS logging into the members section of the web site? Do you have other technical questions? Call our Director of Information Systems, Steve Krantzman for help and answers to your questions @ (800) 500-1332 or (916) 783-1332. Questions can also be emailed to steve@calaoms.org.

WANT TO SELL EQUIPMENT, OR

A PRACTICE? Place an ad in the classified section of The Compass. We reach over seven hundred OMSs throughout the state. If you are a member there is no cost to you, it is a benefit of membership. If you are a non-member, the cost is very reasonable. Call (800) 500-1332 Ext. 13 to get rates, or to place an ad.

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