

# The Compass

Staying the Course Through Service and Education



Volume XIII, Issue 3, Fall 2011

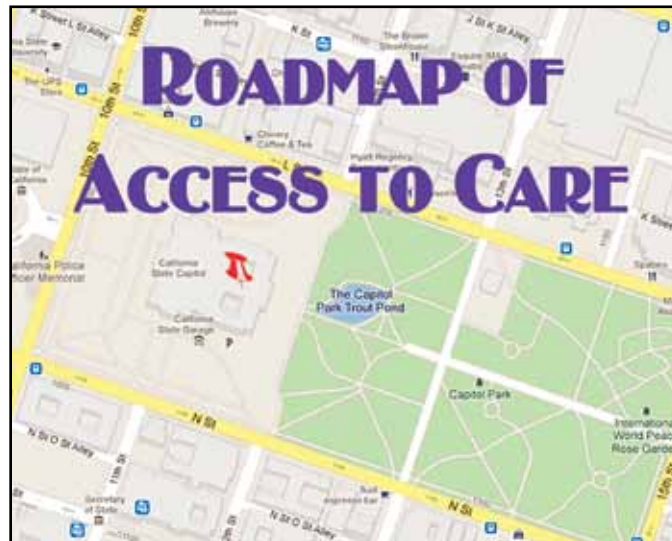
## Delegates OK Access Recommendations

**T**he CDA House of Delegates voted to file the comprehensive report and recommendations Phased Strategies for Reducing the Barriers to Dental Care in California during its annual meeting Nov. 11–13 in Sacramento.

In addition, the house approved two resolutions to accompany the report. Resolution 2RC-2011-H calls for CDA to pursue the recommendations in Phase 1 of the report, including enabling legislation and to seek an increase in post-graduate residency opportunities for general dentistry instead of supporting a mandatory one-year post-graduate residency, as originally proposed in the report. Resolution 24S1-2011-H states that CDA will oppose any scope of practice changes allowing non-dentist providers to perform irreversible procedures until compelling data

exists on the quality, safety, and cost-effectiveness of such procedures. The report and recommendations, which are the result of a multi-year deliberative evidence-based process by volunteer workgroups, serve

as a road map for CDA to address access issues for the 30 percent of the population who experience barriers to oral health care, while preserving the dental delivery system that serves the majority of Californians. The house approval clarifies the association’s leadership role on legislative initiatives regarding access to care and dental providers.



Children’s Partnership has introduced a bill (SB 694) in the California legislature to advance a new dental workforce model next year. In addition, several national

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## Editor's Corner



Jeffrey A. Elo, DDS, MS  
Editor of the Compass

### Integrity-Based OMS Practice

“If you have integrity, nothing else matters. If you don't have integrity, nothing else matters.”  
— Alan K. Simpson

Integrity is one of the many characteristics possessed by successful surgeons. And it's important in every aspect of our business.

With almost all of a difficult first few years behind him, a colleague and I recently connected for a casual discussion. This colleague appeared 10 years older than his age--perhaps because of worry that his office had not been producing what he expected over this period of time. As the end of the year drew nigh, he just wanted to talk. When I asked him where he wanted to be at this time next year, he said, “Next year, I'd like to feel hopeful and proud instead of afraid and ashamed, like I feel this year.”

We began a heartfelt discussion about how he might turn his fear into hope, and shame into pride. We kept going back to the same word--integrity. Our conversation developed an idea for an integrity-based business, one that had an excellent chance of getting my friend out of the sad place he found himself now--and into the place he wanted to be.

After our meeting, I realized that although baring his neck so completely was unusual, it was not surprising. The ache to transform fear into hope and shame into pride is felt by many presidents, CEOs, COOs, and other high-level leaders whose companies are going through hard times. Our plan for an integrity-based business has a good chance of working for my friend and colleague, and it may work well for other surgeons facing the same dilemma.

#### INTEGRITY OF VISION

Create the greatest-value service. By exceeding patients' and referring dentists' expectations, you will satisfy them--and instill pride in your staff. If you do good business, it's good for business. Don't rest on your organizational laurels and risk losing your commitment to patients and referrals, much less the possibility of being exposed as mediocre. In my friend's case, this meant improving the design, quality, and reliability of the service(s) his office produced to match what he had been doing in his “heyday” years earlier. Creative pricing strategies could then be developed by looking at and learning from the other leading practices in the area that are known to give patients great value for their money.

#### INTEGRITY OF MISSION

Make your office's quality and value the best that it can be regardless of whether you're contemplating selling your practice. Work to increase your company's value by improving every aspect of it. Cut costs wherever possible without cutting quality. Avoid cutting corners and half-hearted efforts, and you won't have to be concerned that your competition has already passed you by. For my friend's office, this involved a concerted effort to utilize new technologies--encouraging an enthusiastic (re)connection with current and past

referring doctors, while still going after new ones. He pursued a rigorous cost-benefit analysis of expenditures, leading him and his staff to ask a question they'd been avoiding for years: “Is what we're getting worth what we're paying (vendors)?”

#### INTEGRITY OF FUNCTIONS

All functional units need to be the best that they can be. A strong engine won't make up for a weak transmission. Work together toward mutually agreed upon goals to correct any staff member's previous practice of acting like a prima donna with disregard for other staff members, and expose inadequate employees that try to hide their incompetence. Promote an environment of willingness to serve patients by leading with your example.

#### INTEGRITY OF TEAM MEMBERS

Each person needs to do his or her best in all aspects of their job. People show strength of character and commitment by giving their best effort to every responsibility in their job, even when they don't want to. It's called professionalism. If we as surgeons don't feel confident in a particular area of surgery, we seek assistance or training. Don't do anything behind anyone else's back. Avoid the counter-productivity of excuses, blame, not meeting commitments or keeping promises; and counter concerns of inadequacy by directly addressing deficiencies. Employees who once raised criticisms and complaints at my friend's office are now helping to find realistic solutions to problems--and they are committed to taking action. Team leaders/office managers now hold everyone accountable.

#### INTEGRITY OF FINANCIAL COMPENSATION

Tie pay to performance. Basic compensation includes salary and benefits. Bonuses need to be saved for sustained performance above and beyond the call of duty rather than an assumed part of compensation. Prolonged impaired performance needs to be met with disciplinary measures and financial consequences. Set quarterly goals and develop an objective performance evaluation method that involves the owner, office manager, and employees. Bonuses and raises tied to

popularity, political savvy, and squeaky wheels are less effective than bonuses tied to productivity. If the health and success of the office is at stake, confront overpaid and overextended staff members--perhaps including yourself.

#### INTEGRITY OF NON-FINANCIAL COMPENSATION

Respect, gratitude, and recognition should also be tied to performance and attitude. Don't treat employees who stroke the boss better than conscientious and loyal workers. If you favor undeserving workers who flatter you or the office manager and play politics, conscientious and responsible workers may become demoralized, which could result in sloppy work.

#### INTEGRITY OF SECURITY

Develop a plan that shores up the stability and security in the face of the changing needs, abilities, and stamina of devoted, conscientious, long-term employees. Don't treat employees like commodities; if you do, insecure workers could retaliate by stealing, lying, or doing poorly. If you take advantage of people, how can you expect people not to do the same to you? It's been said that every job is a self-portrait of the person who does it. Autograph your work with excellence and integrity.

“Try not to become a man of success but rather try to become a man of value.” ~ Albert Einstein

### A Message from the CALAOMS Board of Directors

“CALAOMS members are encouraged to take trauma call in their area hospitals. We realize this is very difficult at times and there is little reimbursement, however, it is important for OMSs to remain active in their local hospitals.”

## WHY I OPPOSE THE MID-LEVEL PROVIDER--ONE MAN'S OPINION



By Gerald Gelfand, D.M.D.

*This article is reprinted with modification with the permission of the San Fernando Valley Dental Society.*

I graduated from dental school in 1971. Throw in those four years of school and that's forty-four years that I've been in dentistry. I've been in leadership positions on the local, state, and national levels for many years--both in organized general dentistry, as well as in our specialty's organizations, and still continue as a delegate to the Houses of Delegates (HOD) of the American Dental Association, California Dental Association (CDA), and the American Association of Oral and Maxillofacial Surgeons debating the vital issues of the day.

During these many years, there have been numerous issues of significant importance to the profession of dentistry with which we have dealt successfully, for the most part. There may even have been a crisis or two--though there are really few true crises. However, I believe we are facing one now. I believe that the contemporary concept of adding a new auxiliary to the dental team, labeled--for lack of a better term--the mid-level provider, licensed to perform irreversible/surgical procedures, including, but not limited to, extractions, pulpotomies, cavity preparations, etc., is

just such a crisis and is the most important issue that dentistry has faced in my time and no doubt for many years to come. It has placed dentistry at a crossroads, and the decisions we make as organized dentistry will help determine our future as respected and integral members of the health care profession. Will we remain such a group--our services being delivered only by professionals trained at a post-doctorate level? Or will the environment deteriorate into a trade being delivered by "lay" people having served a short "apprenticeship," trained to deliver a group of technical skills? While this contentious issue threatens to tear at the very fabric which makes this profession so great, it is our responsibility to stay informed and act vigilantly and responsibly on behalf of what is in the best interest of the dental profession and the patients it serves.

Until recently, the CDA had not taken an official position on the mid-level provider doing irreversible/surgical procedures. However, in response to member activism, they since have taken a position and the House recently voted in agreement. While the CDA's now-official position--ratified by the 2011 HOD--does oppose non-dentist providers doing irreversible/surgical procedures, there is a caveat--that this position will remain until such time as there are valid studies performed to confirm the safety and cost effectiveness of mid-level providers performing these types of treatments.

That's not good enough for me, and here's why I oppose the mid-level provider regardless of the outcome of such studies.

I like to believe that I keep an open mind about the issues with which I'm involved in. I listen to the debate and formulate calculated and thoughtful decisions. Yet on this one I'm intransigent. Let's assume that the above-referenced prospective studies indicate that these minimally-trained auxiliaries can, in fact, perform well and safely and yes, even less expensively, than a dentist. There's really no surprise that treatment may be rendered less expensively without the overhead burdens facing practicing dentists. But you still

get what you pay for. More importantly, a positive outcome merely means that you can take a young man or woman and train them to a minimal level of competence to do specific technical procedures. So what? Ours is not a profession of mechanics; it is a profession of scientists who do mechanical procedures. We refer to our profession as "the art and SCIENCE of dentistry." You could, perhaps, teach a chimpanzee with a little innate talent the art, but you can't teach it the science. The CDA has always stood for supporting the highest level of education, training, and continuing education for its members and has always been dedicated to the highest standards of care. Ensuring the safest possible delivery of dental services has always been a priority for the CDA.

Dental services, by their very nature, may result in unpredictable intraoperative challenges and post-treatment outcomes and complications even following what may have appeared (pre treatment) to be the most routine of procedures. Early recognition of these challenges and complications and prompt and appropriate treatment is of paramount importance in averting negative outcomes. Achieving positive outcomes with the greatest frequency requires nothing less than a dental education. It is for these reasons that it is my opinion that all irreversible/surgical procedures delivered within the scope of the practice of dentistry should only be provided by practitioners having attained the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), or their equivalent (those with an M.D. where permitted by law).

It is inconsistent with current standards to subject patients to two levels of care when requiring irreversible/surgical procedures. There are better ways to deal with whatever "access" issues we perceive, and those perceptions run the gamut from a severe issue to no real access to care issue at all. While the dental profession has been exemplary in providing pro bono care and care for the disadvantaged, the government just wants to throw the entire problem in our laps and have us solve it; but, by the way, there's no money for any support of any program. I don't believe that's a fair burden for us to bear.

There are better ways to deal with whatever access issues exist than mid-level providers which I guarantee will not be the answer.

There are many unemployed and underemployed (recent) dental school graduates who live in our state--making up a ready and willing workforce for a serious government that is willing to provide funding to support them providing care to the underserved population. Policymakers must appropriate adequate funding to allow dentists to better serve patients in underserved areas rather than settle on mid-level providers to treat this population, a program that is destined to fail as an answer to the so-called "access to care" issue. There is only one way to ensure the protection of patients seeking dental services. Providing these services by anyone without the requisite education, training, and experience places patients at risk and constitutes an unacceptable compromise to the welfare of the public.

## RAM California and CALAOMS' Humanitarian Partnership Continues

by Pamela Congdon, CAE, IOM  
Executive Director, CALAOMS

With CALAOMS' support and hosting of the RAM 2011 Sacramento and Oakland clinics this past April, over 7000 people received care that otherwise would not have. And, with the state's budget cuts for dental services, the dental section of the clinics saw the highest number of patients. In fact, on Saturday, April 2, the dental section alone saw 952 patients. This set a record for RAM. Out of 639 RAM expeditions, this clinic saw the most dental patients ever in one day at a RAM event. I like to brag that it is because we had 22 CALAOMS members volunteer that day, with 45 total for the entire event.

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Partnering with RAM has given CALAOMS the opportunity to shine as an organization. It keeps us diligent with our mission statement of public service and allows us to be compassionate leaders in California. Stan Brock, the founder of RAM reported that the Sacramento and Oakland expeditions, 639 and 640 were the best clinics RAM has ever provided. The reasons, as I stated in my last article, were because of the organization of the clinics by CALAOMS as hosts, the number of volunteers, and the appreciation by the patients. Because the need for health services for the under- and non-insured people in our state is increasing and with the success of our clinics, Mr. Brock proposed that we establish an affiliate of the RAM Foundation in California.

At the CALAOMS Board meeting this past May, our Board voted to assist in the formation of RAM California, and to be the official hosts. RAM California was incorporated on September 19, 2011. The RAM CA office will be housed at CALAOMS Headquarters. RAM CA's mission is to provide free medical, dental, and vision care to the under- and non-insured residents of California. RAM CA's goal is to raise enough money to purchase a vision lab, dental chairs, and medical equipment so we can hold clinics throughout the state without the need for the equipment to journey from Tennessee. At our CALAOMS Board meeting in November, our Board voted to provide the first five dental stations for RAM CA.

CALAOMS will assist RAM CA in providing two free health care clinics in 2012. Because of the success of the clinics in Sacramento and Oakland, we were asked to return. The first clinic will be March 22-25, 2012, in Oakland at the Coliseum followed by one on March 30-April 2 at Cal Expo. I hope that you and your staff will volunteer one or two days to represent CALAOMS at the clinics and provide much needed care to those in our communities. I truly believe you will find it one of the most rewarding experiences of your life. Please go to the RAM CA website to register. [www.ram-ca.org](http://www.ram-ca.org)

In 2013, we plan to provide clinics in the southern parts of the state. We hope that you will continue to support CALAOMS and our humanitarian partnership with RAM CA. ●



[www.RAM-CA.org](http://www.RAM-CA.org)

***Delegates OK Access Recommendation  
Continued from page 1***

organizations, including the Pew and Kellogg Foundations, are funding efforts to create new provider models in a number of states.

“Proposals coming from outside the profession do not value the same things dentists value,” said Daniel Davidson, DMD, CDA's newly-installed president and past chair of the Policy Development Council. “CDA's role in this arena is first and foremost to be an advocate for the dental profession and the public's oral health.”

The report is the result of nearly a decade of work that started when the 2002 CDA House of Delegates adopted an access to care position paper affirming that access to oral health care is a matter of importance for all Californians to maintain overall health and well-being. In 2008, the house reaffirmed this commitment by adopting Resolution 36S1-2008-H, which directed the association to engage in a broad study of ways to improve access to care for underserved populations.

As a result, two dedicated volunteer workgroups—the Access Workgroup and the Workforce and Forecasting Research Taskforce—initiated comprehensive research to fully understand the issue.

The completed research encompasses seven separate CDA-commissioned studies, presentations by more than 20 invited subject experts, reviews of publications and articles, and many meetings and discussions by volunteer dentists.

During the process, CDA members were briefed and updated often through a variety of ways: the Update, CDA Presents lectures, a dozen statewide forums and webinars, meetings, conference calls, and emails. The entire report and accompanying research is posted on [cda.org/access](http://cda.org/access), and the CDA Journal will be publishing much of the research in two dedicated issues in January and March.

The report outlines a 3-phase strategy that contains a series of 20 targeted and prioritized recommendations with the following goals:

- Establish state oral health leadership and optimize existing resources;
- Focus on prevention and early intervention for children; and
- Innovate the dental delivery system to expand capacity.

The first phase focuses on establishing a foundation for public oral health programs and enhancing the capacity within the dental public health system, including promoting the ability of Federally Qualified Health Centers to contract with private practice dentists in the community to provide care to clinic patients. It also calls for the promotion of community water fluoridation and increasing care to children, expanding on programs such as the CDA Foundation Pediatric Oral Health Access Program. Phase 1 also calls for the alignment of CDA Foundation strategies with the phased approach, recognizing that as the philanthropic arm of CDA, the Foundation has a role in supporting and promoting many of the proposal recommendations. The final objective in Phase 1 recommends further study on the safety, quality, cost-effectiveness, and patient satisfaction of irreversible dental procedures performed by traditional (dentists) and non-traditional dental providers.

“This investigation will put us in the driver's seat in responding to any legislative initiatives regarding new provider models,” said Paul Reggiardo, DDS, a member of both the Workforce Taskforce and Access Workgroup and one of three panelists who presented the recommendations at the House of Delegates and member forums throughout the state. “We need to be able to deliver the solid, research-based facts necessary to engage in the current environment and guide CDA's position regarding scope of practice or dental workforce changes.”

Phase 2 of the proposal focuses on prevention and early intervention for infants and children by reaching them in school-based/school-linked programs, preschools, and in Women, Infants, and Children programs. This phase also includes incentivized Medicaid reimbursements to qualified dentists for selected services for infants and preschool-age children to increase care to very young children, support dentist participation in Medicaid, and lower caries risk through early prevention.

Phase 3 anticipates the re-establishment of adult Medi-Cal dental benefits and seeks to build the capacity of hospital-based dental care.

“The 3-phase approach is all about building one effort on another, focusing first on what's been shown to work and putting our efforts where they can be expected to have the greatest impact,” said Jared Fine, DDS, a panelist who also served on the Workforce Taskforce. “This ‘road map’ will be re-evaluated along the way to ensure that it stays relevant and achievable over time. The phases leave room for CDA to learn and fine tune as we go.”

The entire access report, commissioned research, and a video presentation can be found at [cda.org/access](http://cda.org/access). The accompanying house resolutions can be found at [cda.org/about\\_cda/leadership/house\\_of\\_delegates/house\\_of\\_delegates\\_2011](http://cda.org/about_cda/leadership/house_of_delegates/house_of_delegates_2011).

*This article is provided courtesy of CDA Communications.* ●

## President's Message



John L. Lytle, DDS, MD  
President, CALAOMS

excited to have him on the team and look forward to his counsel in dealing with the myriad of legislative issues constantly facing us. Please make sure to welcome Fred at our next state meeting in San Francisco this coming January.

The culmination of our legislative efforts regarding the provision of in-office general anesthesia has finally resulted in the first certificates for the Dental Sedation Assistant program being issued by the state of California. Having successfully maneuvered six of my assistants through the course, I can say it is a worthwhile process. My certified staff members can now administer intravenous medications at my direction, interpret monitors, and remove intravenous catheters as part of their job descriptions. I know many of you will want to become instructors for your staff in the coming year. All you need to do is call CALAOMS headquarters in Roseville (800-500-1332) and get your application started. Your participation will further strengthen our position as the leader in dental anesthesia in California.

We are happy to announce that Remote Area Medical California (RAM California) has now been incorporated through the efforts of our Executive Director, Pamela Congdon, CAE, IOM, and staff. Our goal to host a permanent humanitarian outreach is a reality. Two clinics are planned for next year (Oakland, March 22-25, and Sacramento, March 30-April 2, 2012). To give you an idea of the magnitude of this project, we have just signed on four major northern California medical centers as co-sponsors, allowing us to screen and help even more people. We are also actively looking for opportunities in southern California. If you have any ideas, please let us know. You can contact Steve or Pam in the central office for specifics. As always, there is a need for money, equipment, and volunteers. If you are looking for something significant to do, this might just be it.

I am very proud of the fact that CALAOMS is the largest state OMS association in the nation. We are a well-organized and proactive group that has consistently set the bar nationally. When problems

## Expanding Humanitarian Outreach in California

**W**ith the holidays right around the corner and the busy summer season under our belts, we are fast approaching the end of my term as CALAOMS President. It has been a privilege to serve you, and I am happy to report that we have a financially sound and vibrant organization. We have been and continue to be actively involved with policymakers at state and national levels.

I would personally like to thank all of you who served on committees, performed countless duties, and volunteered your free time to help us succeed as an organization. We would not have accomplished what we did without you.

There have been some notable achievements this year worth mentioning. CALAOMS filled a huge void when we hired a new state legislative analyst this past spring. Fred Noteware joins us with extensive experience in Sacramento as a contract lobbyist. I am

occur at the national level, the first question frequently asked by others is, "What is California doing?" I am happy to say that your CALAOMS Board of Directors and central office staff are a dedicated group of people who will continue to respond to the issues of the day. Thank you again for a terrific year! I look forward to the continued success of CALAOMS in 2012.

## Risk Management Corner

### Weighty Surgical Concerns with Opioids and the Obese

by Susan Shepard, MSN, MA, RN CPHRM  
Director, Patient Safety Education

**W**ith 93 million obese Americans, the issue of accommodating the obese is one that all physicians with surgery in their practice must consider. Nationwide, a surge is underway to expand and retrofit hospital emergency rooms to accommodate obese patients.

Numerous case reports of adverse postoperative outcomes with the obese include respiratory arrest exacerbated or caused by obstructive sleep apnea (OSA).

When considering opioid pain medication with obese patients, consider the following: Include a focused history and calculation of BMI and neck circumference in the preoperative evaluation.

Consider a sleep apnea study prior to scheduled surgery.

Identify patients at substantial risk or history of OSA, and place them on continuous monitoring—ideally with apnea monitors, oximeters, and capnometers.

Consider the use of nonopioid medications (such as NSAIDs) instead of or in combination with judicious and careful opioid dosing, and use regional analgesic techniques rather than systemic opioids whenever possible.

Consider constant positive airway pressure machines (CPAPs) to alleviate postoperative airway obstruction and decrease major postoperative complications.

Carefully titrate pain medication. Avoid assuming that BMI directly correlates to medication dose.

Be aware that oral opiates may cause respiratory depression in OSA patients.

Encourage patients with CPAP devices at home to use them while in the hospital, especially if they are receiving narcotics.

Ensure that everyone involved in the patient's treatment plan is aware of the diagnosis or suspected diagnosis of OSA, particularly in obese patients.

Train health care professionals providing postoperative monitoring to recognize potential signs of sleep apnea.

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## Technical Articles



Peter Krakowiak, DMD, FRCD(C)

### Immediately-Loaded Fixed Transitional Full Arch Prosthetics

It's hard to turn on the radio these days without hearing advertisements from dental offices claiming that you can come "with your 'rotten stinking teeth' and walk out with a set of 'beautiful permanent white teeth' in just a few hours."

Immediate tooth replacement has become the new promotional gimmick dentists are using to lure new patients into their practices. It's become the new Zoom!, ViziLite, digital x-rays, and CEREC machines of today's marketplace. If you listen to these ads, you'd think the wheel has been reinvented in dentistry. Except...the advertising is not always what it's made out to be.

When (most) patients actually come in for their consultations in these offices, a different treatment

plan is eventually presented to them. In fact, if you listen carefully to the verbiage used in the promos, a lot of the advertising borders on unprofessional and deceitful, as terms such as permanent teeth (that truism always depends on how long the patient lives) or natural perfect white teeth (white is a natural color for porcelain toilet bowls only) are used. These are all typical baiting tricks. Then comes the deal sealer—"free consultation, free exam, free x-ray, free C.T. scan, and free oral sedation" (how about a free oil change and free hair cut, as well) that are thrown in to further demean the value and expertise required of doctors that are supposed to be highly-trained, accomplished professionals. And always, as in any bait and switch marketing, the final procedure fees become somehow "enhanced" by additional fees--above the advertised "\$899/implant," or whatever other ridiculous fee was cited in the ad.

The arrival of large dental implant centers (staffed with some of our own OMS colleagues) and their huge corporate advertising budgets has also added to the large volume of buzz about this concept, and patients are now bombarded with a lot of hype and misinformation, as well. Patients are now coming into our individual offices and many of our G.P. referrals are asking specifically asking about whether we perform these "same-day smile makeovers." It's no surprise that patients are assuming that they may now be candidates for this "instantaneous transformation." Most are not aware of any limitations of these therapies. They also are not made aware that their overall oral health care will always be best addressed in a traditional referral-based structure with individual dedicated experts working together as a team, and not the one-stop-shop doctor carousel drive-through setting.

The advertisers do not make any disclaimers and fail to indicate in their ads--that the full arch immediate solutions are not suitable for everyone; and that dental implants should only be utilized as part of a patient's comprehensive dental care, and only after other oral conditions have been evaluated and treated. There is nothing "one day" or "in an hour" about

that. Also, no one has addressed the reality that, thus far, no long-term data from prospective randomized multicenter trails is yet available on the longevity of these prostheses or long-term bone maintenance around angled or splinted implants. The only available data with at least a 10-year follow-up comes from the Paulo Malo (Malo Clinic) research group (small financial consideration there) and shows an approximate 94% implant (survival) success rate. As OMSs, we all know that survival does not equal bone and soft tissue stability or esthetics.

All that aside, the techniques of immediate full arch rehabilitations have been around for decades in various forms, and have had various rates of success. They do possess certain merit, and hopefully will not suffer failures when they are applied in inappropriate settings with inadequate follow-up care and unrealistic patient expectations.

It is incumbent upon us to educate ourselves to make these techniques part of our armamentarium so we can support our local referrals and are able to offer these treatment modalities to their patients who fit the patient criteria. Referring doctors also need to have enough knowledge and exposure to the immediate full arch reconstruction technique that they feel comfortable discussing it with their patients and answering their inquiries. Hopefully, they can inform their patients that they, in conjunction with their partner OMS, can provide the same types of procedures without having to leave their practice environment.

This article aims to review the basic concepts and highlight some key elements of delivering the immediate temporization of implant-based restorations utilizing currently available components and contemporary protocols.

Dr. Paulo Malo has done significant work on the "all on four" concept of full arch reconstruction. Others have incorporated the technique into their practices with varied number of implants utilized. The technique is based on full arch reconstruction supported by as few as four endosseous fixtures per

arch. The final (one-piece) prosthesis is supported by four implants which are splinted together by either a cast base metal or milled titanium alloy bar. The technique has also been referred to by some (wittily) as "all on four, or none on three" because if any implants fail, the prosthesis will no longer support a full arch reconstruction. Most fixed single-piece full arch prostheses are made to replace dentition up to the first molars, especially if four angled fixtures are used. The advantage of the angled fixtures is that a better anterior-posterior (A-P) spread can be gained by distalizing the implant platform, yet still keeping the implant apices anterior to the mental nerve and anterior maxillary sinus wall. This, of course, means no larger regenerative procedures are utilized in the posterior regions--saving time and costs for the patients.

The angled implant concept has been greeted by many with skepticism as the off-axis loading issues appear to cause significant peri-implant bone loss in short-span or single-unit restorations. This has not been seen, however, with full cross-arch restorations, either in bench-top biomechanical model research or short-term clinical data. It is believed that the forces directed in off-axis directions are dissipated over all the fixtures that are rigidly connected to the framework as long as a passive fit is present. Nobel Biocare (Noble Biocare USA, LLC, Yorba Linda, CA) has probably spent the most time developing this concept and has a range of prosthetic connections to allow for correction of the inherent angulation discrepancies.

The contemporary implant designs allow this concept of splinted implant-based restorations to be applied to immediate denture cases that traditionally have been handled by staged extractions, site preservation/reconstruction, followed by implant placement with 4-6 months of osseointegration. Early success rates of immediate fixture placement and splinting with an acrylic denture have been similar to single implant immediate placement cases. Of course, the biggest patient advantage here is the same-day placement of a full arch fixed restoration.

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The implant types best suited for these procedures are based on a steep thread pitch and aggressive thread profile to increase maximum initial stability and insertion torques. The most common fixture line used currently (worldwide) is the Nobel Active and Nobel Speedy (Nobel Biocare USA, LLC, Yorba Linda, CA) fixtures, although other implants can be used as long as angled multi-unit abutments are readily available. Longer implant lengths (>8-10mm minimum) are recommended to increase the likelihood of gaining primary stability. Also, it's important to have multi-unit connectable and direct implant connectable temporary abutments available for whichever system is being used.

The most important step in the application of this technique is to identify the appropriate clinical situation and the right patient. Often, patients with salvageable dentition are presented with this treatment option simply because it offers what may seem like a rapid comprehensive treatment. The reality is that with all of the dentition gone, all of the proprioception will be gone during mastication. Also, areas that are loaded by the implants will atrophy from non-use. If needed later, these areas may not offer much bone stock and will need more extensive regenerative therapy. It is important to note that in younger patients there is a higher chance that the prosthesis and/or implants could eventually fail and require a "re-do" with a new configuration of support elements. The mechanical life of the prosthesis may not exceed 20 years; hence, in some cases delaying the full edentulation by a decade or two may ensure that it is the final prosthesis for the patient. Any failure of the prosthesis affects the entire reconstructive scheme unlike that of segmented restorations. The patient and the doctors both must be prepared for it. That's why I cringe when I hear the word "permanent" in the aforementioned ads. If the patient is 99 years old, then this concept may be just that and live up to that promise; but if they're only 40, it may not be so.

A general guideline that can be used is that if less than four teeth are deemed salvageable or have a good 5-year prognosis in the maxilla or the mandible, the full arch option can be moved to the forefront of our therapeutic choices. This is especially valid in maxillary cases with no posterior dentition present, reduced vertical bone height, and significant sinus pneumatization.

Finally, the cost factor is often a consideration. The full arch immediate approach can be more appealing than staged regenerative therapy in terms of number of surgeries. However, this approach requires placement of multiple implant fixtures and multiple multi-unit cast restorations, all of which carry various costs.

**OVERVIEW OF THE TECHNIQUE:**

Regardless of whether the final prosthesis will be a hybrid fixed denture or an overdenture, the immediate full arch concept relies on the splinting of immediately-placed fixtures with an acrylic temporary denture. This denture can have either palatal acrylic coverage in the maxilla or be a ridge lap-only design in both the maxilla and mandible. It's usually a good idea to reinforce the acrylic with a wrought wire twist or titanium mesh to prevent acrylic fractures during the transitional healing process (Figure 1).

During the work-up, important parameters to note are the patients' skeletal relationships, vertical facial heights, and lip positions in maximal animation with respect to the gingival margin and tissues (Figure 2). This is key in determining the length of the buccal flange of the prosthesis. Also, assessment of the vertical interarch dimension must be made to determine how much reduction alveoplasty will be required to accommodate the prosthetic connections below the new denture. A transitional appliance is fabricated prior to the date of surgery to match the pre-treatment dental arrangement. The patient can have the all-on-four modality applied either in existing fully edentulous cases or in immediate extraction scenarios. Minimal bone stock compared to the traditional

implant placement is needed as the reduction of alveolar ridge height usually sets the platform position into the wider alveolar or basal bone. A pre-treatment cone beam C.T. scan (CBCT) is highly valuable to assess the potential placement sites. In fully edentulous cases, guided surgery can be applied with a high degree of fixture precision. In immediate extraction and fixture placement cases, the placement of the implant fixture is more dictated by extraction site morphology, bone volume, and bone quality subsequent to tooth extraction; hence, guided surgery may be of less value here.

Most cases require the entire process to be completed in two consecutive sessions. The surgical portion involves extractions, alveoplasty, and bone grafting, as well fixture placement. Some surgeons will place angled and/or straight multi-unit abutments at this time while some will place healing abutments and then turn the cases over to the restorative doctor. In my practice, I have found that it's easier for the patient to have both parts of the therapy completed in our office. Some of our restorative doctors have come in to our practice and placed the prosthetic abutments and installed the temporary restorations at the end of the surgical procedures. However, several of our referrals prefer to have us place the temporary prostheses, and they like to take the case over after integration of implants has fully occurred. This way they only have to be involved in fabrication of the final restoration. The procedure time varies, but can range from 3-5 hours to complete (including the transitional restorative connection and temporary delivery).

In cases where teeth need to be removed prior to fixture placement, this is accomplished with full thickness envelope flaps and with the fixtures placed per either bone anatomy or surgical guide after the necessary reduction alveoplasty (Figure 3). Once the fixtures are placed, the implants with the most initial stability (measured by either the Ostell ISQ reader or insertion torque) are chosen to support the interim restoration. In cases where more than four fixtures are placed, this gives the operator some options. I have found that connection of more than four fixtures is unnecessary as long as the ones used have an ISQ of over 60. The non-loaded implants receive cover screws and are submerged as per traditional two-stage protocol. The other advantage of using only four connected abutments at the time of surgery is that it reduces future chair time and component costs. Each time the appliance is removed, it is easier to only have to remove and reinsert four screws and deal with only four access holes. Of course, the final prosthesis will be



**Figure 1. Reinforced transitional prosthesis**



**Figure 2. Patient with maximal animation showing lip and gingival soft tissue correlations**



**Figure 3. Fixture placement into extraction sites engaging the apical socket and adjacent basal bone**

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# 2012 January Anesthesia Meeting

## January 14-15, 2012

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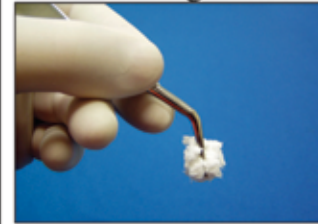
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**Speaker: James Ruskin, DMD, MD, FACS**

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made on as many implants as is indicated by the final restorative scheme. In some cases, some implants may not have to be engaged and can be left for potential future consideration and serve somewhat as ridge preservers in the meantime.

The connection of fixtures on the day of surgical placement involves the use of either angled (Figure 4) or straight multi-unit abutments. Currently, stock angled 17 degree and 30 degree connections are available in the Nobel Biocare lines. If implants are ideally positioned for connection access, one can also use a titanium temporary sleeve directly over the implant platforms. However, it is more convenient in the long-term to use the multi-unit abutments on all fixtures at the time of initial connection and use temporary sleeves that become incorporated into the acrylic base of the temporary over them. As it is well-known now, the less the fixture abutment interface is disturbed, the less hard and soft tissue changes will occur. The angled and straight multi-unit abutments come in different heights to bring the abutment-prosthesis connection level to the gingival cuff height. In most cases, posterior implants that were angled to avoid either the antrum or mental nerve will require angulation correction. However, if anterior fixtures have high labial insertion flare, they can also be connected to the temporary prosthesis by angled multi-unit abutments. It is desired to have the access holes located lingual to the incisal aspect of the acrylic teeth in the prosthesis. Ideally, the emergence should be located in the posterior sextants over the lingual half of the prosthetic crown. Further lingual placement will increase the bulkiness of the final restoration. In the anterior sextant, 2-3 mm lingual of the incisal surface is considered an ideal emergence. However, if acrylic teeth are used on the temporary and final prostheses, or if an overdenture is the final restoration, the anterior fixtures may be restored over straight abutments as long as good composite color and translucency match is available to close the access holes in the labial surfaces of the restorations.

Once the implants receive the multi-unit abutments, the transitional prosthesis is then retrofitted to allow for connection by drilling out access holes in the base over the emerging abutments (Figure 5). Passive fit is needed over all connections. The temporary abutments that connect to the multi-unit abutments should be reduced down to be just 1-2 mm short of the oral surface of the temporary prosthesis when it is fully seated. It is imperative to use a reference jig to set the prosthesis in the A-P and transverse vectors



Figure 4. Angled multi-unit abutment



Figure 5. Transitional prosthesis adjusted to fit over the temporary abutments



Figure 6. Reference jig made with ImpregumTM prior to alveoloplasty and abutment connections



Figure 7. External reference point checks

especially if significant bone removal was undertaken (Figure 6). The other important dimension verification that must be verified at this point is the desired vertical dimension check at the anterior and external reference points (Figure 7). Similar techniques and reference points used in orthognathic surgery can be used here.

When the desired position is achieved, a fast self-curing resin is injected around each temporary abutment to index them and pick them up in the denture base. If both arches are restored simultaneously, one upper arch is indexed first and the other is done second. Special care must be taken to prevent flowing the resin below the abutment connections by using a rubber dam draped and sealed over each temporary abutment (Figure 8). This is one mistake you do not want to make. If you do, it will be the only time you do so... Once the resin has set, the screws are removed from the temporary abutments and the prosthesis is lifted from over the multi-unit abutments. The temporary abutments will at this point be rigidly attached to the transitional prosthesis. The remainder of the temporization process involves the adjustment of acrylic contours around the attachment points with flowable acrylic or composite, and (potentially) the removal of existing palatal coverage if a full denture is to serve as the temporary prosthesis (Figure 9). The prosthesis is then polished and delivered back onto the multi-unit abutments. Temporary abutment screws are replaced and tightened to 15 N•cm and access holes are sealed with flowable composite. Cotton pellets must be placed over the screws before the access holes are sealed to facilitate their retrieval. The occlusion must then be checked and adjusted to ensure there are no unbalanced occlusal contacts or uneven load distributions and that only a group function scheme is present. Strict diet instructions are given to the patient regarding the required diet. It is important not to chew or bite any solid foods for four to six weeks. The patient is then seen for several follow-up visits to ensure normal healing and to reassess and adjust any hyperocclusal contacts.

Once the implants have integrated, the temporary prosthesis can be converted to either an overdenture or a hybrid full arch fixed denture. This is accomplished by removing the temporary acrylic prosthesis, evaluating/adjusting soft tissue levels, and taking abutment level impressions of the multi-unit abutments on all fixtures suitable for restoration. The open tray impression (Figure 10) is then used to make a master cast (Figure 11) which will be either scanned for a computer milled bar or be used as a working cast,

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Figure 8. Rubber dam application over temporary abutments



Figure 9. Refinement of temporary restoration prior to delivery



Figure 10. Open tray impression at multi-unit abutment level



Figure 11. Master hard and soft tissue model with multi-unit abutment analogs

*Arch Continued from page 19*

and a traditional wax-up can be done for a cast restoration framework. The advantage of the virtual restorative and prosthodontic planning is that the bar will be milled in optimal orientation to be accommodated into whichever prosthetic solution is used. A key step before any large substructure is fabricated is the verification of the accuracy of the master model. This is done by having the lab make a rigid verification jig (Figure 12) which is tried before any other lab work is undertaken. To develop the final prosthesis, the lab will manufacture--from the verified and accurate master model--a wax base plate with a single temporary cylinder (Figure 13) to place in the patient's mouth for the standard esthetic denture set up. Midlines, canine positions, smile curves, incisal positions, and most importantly, lip drape boundaries in maximal animation are registered on the wax base plate (Figure 14). The lab will then set the teeth in the wax base plate as standard for a denture set-up. A final wax try-in is then performed (Figure 15). Once approved by all involved, the wax-up is optically scanned and mated with a scanned image of the master model with virtual spatial location pegs indexing each implant position (Figure 16). The lab technician will then set the substructure thickness, height, and position within the boundaries of the superimposed final restoration envelope (Figure 17). In the case of a hybrid prosthesis, a choice can be made for an acrylic wrap or polished metal contact surface design. The design is then electronically submitted to a milling facility where the metal substructure will be milled out of single piece of titanium alloy. It will be returned to the lab for either a retentive element attachment, as in overdenture cases (Figure 18), or an acrylic wrapping and tooth setting in the hybrid option (Figure 19). As an alternative to the CAD-CAM process, the bar can be waxed up and cast using the traditional lost wax technique. Disadvantages of the traditional approach are the extra costs for each abutment wax up sleeve and the ever-increasing cost of noble alloys. Also, there is always room for impression distortion, wax-up error, processing and over-polishing issues with this technique; however, most labs are able to deliver these services with improved familiarity.

The final prosthesis is then delivered and the patient reaches the end of their not so quick "in a day" immediate full arch rehabilitation. The important points to remember when delivering the denture is to use a set of brand new screws to set the prosthesis into the multi-unit abutments, balance the occlusion, and as always, ensure a passive fit of the prosthesis by the single screw test on each abutment to elicit any lifting. It should be unlikely that the



Figure 12. Verification jig in place



Figure 13. Wax base plate with single connector



Figure 14. Denture set-up lines and reference planes



Figure 15. Final denture set-up try-in

milled framework would be distorted especially if the verification jig was used appropriately earlier on. The patient must be given follow-up care instructions, diet instructions, and bruxism protection measures if any parafunctional habits are even remotely suspected. The patients will need to return to the primary oral hygiene care provider to clean the hybrid prosthesis every 3-4 months, and every 3-6 months for the overdenture maintenance. Each will require removal of the fixation screws and elevation of the substructures from the abutment level connection for inspection and deposit removal.

The comprehensive knowledge of the entire process and the ability of an oral and maxillofacial surgeon to deliver the surgical and the associated prosthodontic therapy (at least in the provisional stages of the restoration) is paramount in aiding our restorative colleagues and ensuring the most efficient and definitive delivery of care to the patient. Although only a few patients are the ideal candidates for, or have the desire to go through, the extra expense of this treatment modality, it is important to have these techniques at our disposal and be able to offer them to the right patient under the right circumstance.

Full arch restorations can always be staged in a traditional time frame without the immediate fixed provisional and still employ the same final restorative options of four to five implants to support a milled bar. The patient would simply need to have a removable temporary and have a second stage procedure to uncover the fixtures after 3-4 months of standard submerged implant healing. The restorative and surgical doctors must work in very close cooperation and have excellent communication and procedural coordination. It is also very important to work with a laboratory that not only has the technical scanning equipment, but also has experience in virtual planning and prosthesis design. Finally, the implant components must be readily available with ample back-up parts and wide selections of sizes. If one part is not available at any point in the process, it may seriously jeopardize the successful completion of the case. The all-on-four concept is a great way to provide patients with an instantaneous rehabilitation of their smile and really make an immediate impact on their appearance and self confidence. This, along with the opportunity to work side-by-side with my favorite restorative referrals, has been the most rewarding aspect of being able to deliver this contemporary treatment modality.



Figure 16. Master model in a scanner

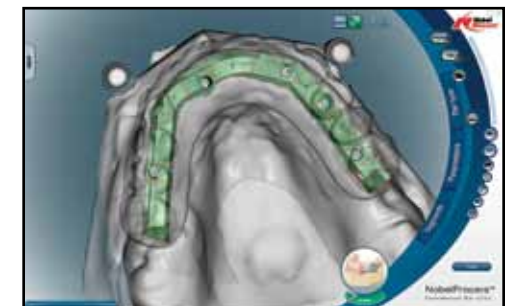


Figure 17. Virtual substructure planning with prosthesis overlay



Figure 18. Milled overdenture with laser-welded locator attachments



Figure 19. Hybrid partial acrylic wrap on a milled substructure

## Tools of the Trade Across Borders

Article by Armond Kotikian, DDS, MD

Photo essay by Sara Anjargolian

I got in very late Sunday night into Stepanakert, the capital of Karabagh, Armenia. After the eight-hour bus ride, my body wanted to lie down, but my heart and mind were pumping with adrenaline.

Question after question raced through my brain. Are the parents going to trust me to treat their children, being that I am from another country? Are the anesthesiologists going to be able to intubate some of the more challenging patients that I have met via the web for the past four months? What kinds of instruments are going to be available to me to perform these challenging surgeries? This was uncharted territory and I was anxiously awaiting sunrise.

Earlier this year, the Armenian Medical International Committee connected me with Dr. Sasun Vahanyan, the only oral and maxillofacial surgeon in all of Karabagh, which has a population of close to 200,000. After looking me up online and watching one of my interviews on YouTube, Dr. Vahanyan invited me to come to Karabagh to perform surgeries together.

I arrived at the children's hospital in Stepanakert on a Monday morning, excited and apprehensive. I was soon greeted by the smiling 29-year-old Dr. Vahanyan, whom I had met only via Skype. As I approached the entrance to the oral and maxillofacial surgery clinic, there were about fifty parents and children hovering around the only entrance. They stared at me--their first impressions settling in--while I focused only on trying to get to the door. I



apologized about fifteen times before I was able to make it to the white door.

The clinic measured about 200 square feet but had everything I needed to get started--a brown desk and one examination chair. I hadn't had a chance to digest my surroundings when the patients and their parents began flooding in, with or without an appointment. This was nothing like an average day in my usual clinic. By 1 p.m., we had seen thirty-one patients and promised most of them we would perform their surgery. The needs were varied and included cleft lip and palate, trauma, oral and neck tumors, and wisdom teeth extractions. My years of training kicked in and I was excited to do as much as I could in the short time I had.

As we were getting ready to walk out of the clinic for lunch, something like a scene from a movie unfolded. A helpless mother from a neighboring village came in carrying her 27-month-old daughter who was minimally responsive. The child had a critical neck swelling which was keeping her from breathing normally. After a one-minute evaluation, we immediately took her to the operating room for an incision and drainage of the swelling on her neck. After draining the swelling, the child began to breathe easily and was obviously going to make a full recovery. I thought to myself that this was the most rewarding "lunch break" I had ever had.

Shortly afterward, we headed to the adult hospital. There we saw a 60-year-old patient with a painful swelling in the floor of his mouth which he had been tolerating for the past three months. It looked to me like oral cancer. He also was going to need surgery.

Over dinner that evening we reviewed all the patients we had seen that day and mapped out our approach for the rest of the week. Over the next four days, Dr. Vahanyan and I operated on twenty patients and averaged 12-14 hour days. We performed multiple cleft palate and cleft lip cases, removed several oral and neck tumors from adult and pediatric

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patients, performed cleft lip revisions, removed one set of wisdom teeth, and even did a bone graft from the hip to the oral cavity for a patient with a defect in the upper jaw. There was no air conditioning in the hospital and the temperature would reach the low 90s at noon. The nurses had special sterile instruments to dab our foreheads so we wouldn't contaminate the field with our sweat. The hospital water occasionally ran out and the operating nurses had to rinse our arms and hands with small buckets of water after we scrubbed. I was operating with instruments I thought didn't exist anymore. Despite all this, things went as smoothly as they do in our comfortable operating rooms in the United States. I learned quickly that as long as you have the skill set and desire, everything else falls into place.

My only regret is that I could not stay longer. On my last day, I was proud of our work, but wished we were able to treat more people. There were close to a dozen patients who still needed surgery--a reason to return in the near future. I hope that the surgeries we performed will make life for our patients a bit easier, and I hope some of the skills I passed on to the staff will help them treat patients for years to come.

Perhaps most importantly, half-way across the globe, I found a good friend and excellent colleague in Stepanakert, Armenia. The exchange of knowledge and experience between us taught me lessons that no modern day dental or medical school can teach. The only major disagreement between myself and Dr. Vahanyan that week was the endless debate over the check after every meal.

I would like to thank all the faculty and staff at the University of Michigan Oral and Maxillofacial Surgery program, and especially, the late Dr. Upton.



## Important Notice Regarding the OMSA course

CALAOMS has decided to take the whole Oral and Maxillofacial Surgery Assistants Course (OMSA) on-line in 2012. It is targeted to be up and running by the end of August 2012.

In order to make this happen, there will need to be a brief interruption in the OMSA course offerings. Those assistants who's certificates expire in 2012 will have their certification extended to the end of that year.

The on-line Home Study portion of the course will remain the same; however there will no longer be weekend seminars. Assistants are advised to keep their "BLS for Healthcare Provider" cards current, as they will not be able to start the course until a copy of their card is received at the CALAOMS office.

For more information and periodic updates, we invite you to visit the CALAOMS website at [www.calaoms.org](http://www.calaoms.org).

## Press Release



*Richard C. Robert, Jr., DDS, MS*

### Dr. Richard C. Robert Named AAOMS Committee Person of the Year

**R**ichard C. Robert, DDS, MS, South San Francisco, CA, received the 2011 AAOMS Committee Person of the Year award on September 14 during the opening ceremony of the 93rd Annual Meeting, Scientific Sessions and Exhibition of the American Association of Oral and Maxillofacial Surgeons in Philadelphia, PA.

Dr. Robert was recognized for his leadership of the AAOMS Committee on Practice Management and Professional Allied Staff, where as a member and chair of the committee, he has been instrumental in the development and execution of many programs for oral and maxillofacial surgeons and their clinical staff, including the association's Dental Anesthesia

Assisting National Certification Examination (DAANCE) program.

In addition, Dr. Robert chaired the AAOMS Task Force on Anesthesia and was key to the development of a DVD entitled, "Anesthesia: Safety and Comfort in the OMS Office," an advocacy video that discusses the extensive training and ongoing education received by oral and maxillofacial surgeons who administer anesthesia in their OMS practices.

Currently in private practice, Dr. Robert is also Clinical Professor of oral and maxillofacial surgery in the residency program at the University of California Medical Center in San Francisco. At the University, he directs the office anesthesia curriculum and co-directs the curriculum in surgical anatomy. He has been active in hospital affairs and has chaired the section of Oral Surgery and Dentistry at Mt. Zion Hospital in San Francisco and Seton Medical Center in Daly City, California.

Dr. Robert, who received his DDS from Emory University in Atlanta, conducted bone graft research at the Letterman Army Institute of Research and completed his oral and maxillofacial surgery training at the University of Michigan in Ann Arbor.

Dr. Robert is a diplomate of the American Board of Oral and Maxillofacial Surgeons, and in addition to his work with AAOMS, is an active member of the California Association of Oral and Maxillofacial Surgeons (CALAOMS) from which he has received the Committee Person of the Year twice, as well as the Distinguished Service Award in 2008.

More than 5,000 registrants, including oral and maxillofacial surgeons from around the world, attended the AAOMS Annual Meeting where they conducted association business, discussed surgical procedures, earned continuing education credits, and met with dental industry suppliers.

*Press Release provided courtesy of AAOMS.*



**Figure 1. Melanoacanthoma.** A 30-year-old black woman presented with a 2 cm circumscribed slowly-enlarging brown macular discoloration of the buccal mucosa, of 1 week's duration. The patient was re-evaluated 2 weeks after an incisional biopsy: the brown spot had enlarged, was more irregular, and a similar pigmented lesion had arisen on the contralateral buccal mucosa. When she returned 1 month later, both pigmented lesions had completely resolved. Image courtesy of Dr. Carl Allen.

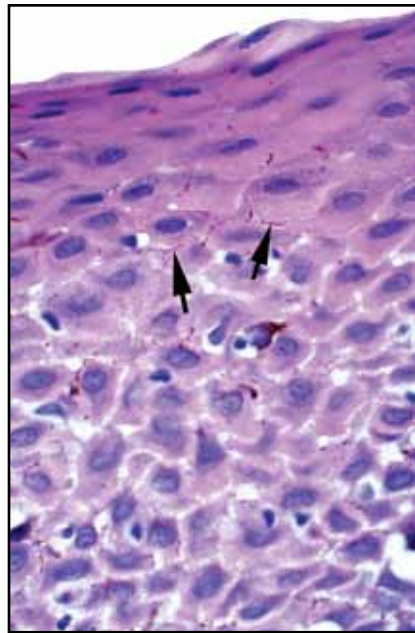


by Lee Slater, DDS, MS,  
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## Melanoacanthoma

If an African-American woman presented with a brown pigmented lesion (Figure 1), then the oral and maxillofacial surgeon's initial clinical impression would likely be racial pigmentation. However, in this case (Fig. 1) the enlarging variegated lesion of recent onset showed a somewhat indistinct diffuse periphery, evoking consideration of malignant melanoma. Melanoma is rather uncommon among blacks, but when it occurs, it often arises in nonpigmented areas (such as plantar or subungual skin or mucosa locations). Several entities might be included in the differential diagnosis: amalgam tattoo (unlikely in this case), melanotic macule, drug-induced pigmentation (chloroquine for lupus erythematosus, minocycline), blue nevus (neural crest hamartoma), postinflammatory hyperpigmentation (secondary to lichen planus or lupus erythematosus), and melanoma in situ (or the intraepithelial "radial" growth of malignant melanoma).

An incisional biopsy revealed increased melanin pigment in dendritic melanocytes (Figure 2), a finding indicative of melanoacanthoma (melanoacanthosis). The location of the melanin is diagnostically important. If it is predominantly in the cytoplasm of basal keratinocytes, then the a diagnosis of racial pigmentation (or the histologically indistinguishable melanotic macule) would be favored. If the melanin is predominantly in the cytoplasm of dermal melanophages, then the appropriate diagnosis would be postinflammatory hyperpigmentation, in which inflammation or trauma



**Figure 2. Melanoacanthoma.** Dendritic melanocytes showing slender "beaded" brown cytoplasmic process (arrows) extending between superficial spinous keratinocytes. Curvilinear white spaces with "railroad tie" intercellular bridges between spinous cells are indicative of intercellular edema (spongiosis). No evidence of nuclear atypia was seen; that is, no evidence of melanoma in situ was observed.

induces melanin pigment to drop from the epithelium into the connective tissue where it is endocytosed by phagocytes, "melanin incontinence."

Melanoacanthoma is uncommon, but its distinctive clinical features are readily recognizable. If a 15 mm brown spot of recent onset occurs on the buccal mucosa of a black woman, a clinical diagnosis of melanoacanthoma should be considered.<sup>(7)</sup> Multifocal lesions occur more frequently on the palate, but only about 20% of patients have multiple lesions. Cheek biting and denture trauma are the most frequently cited initiating factors, but sometimes the inciting cause is unclear. Most melanoacanthomas completely resolve following incisional biopsy, but some only partially regress, and a few persist.<sup>(7)</sup> Melanoacanthoma is a reactive lesion; malignant transformation has not been reported.

Patients with rather dark skin (for example, Asians, Hispanics, Pacific Islanders, Middle Easterners) also demonstrate oral mucosal racial pigmentation, and such individuals are predisposed to skin hyperpigmentation following dermal inflammation or trauma, postinflammatory hyperpigmentation.<sup>(9,10)</sup> Oral postinflammatory hyperpigmentation has been incompletely characterized in the literature,<sup>(11,12)</sup> but oral "melanin incontinence" appears to most frequently affect posterior palatal mucosa (personal observation). Postsurgical hyperpigmentation can occur in black patients; for example, normal pink palatal mucosal donor sites for free gingival grafts may turn brown postoperatively.<sup>(14)</sup>

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## "New Strategies to Protect Yourself when Negotiating or Renewing Your Dental Office Lease"

### Part Two of a Three Part Series

by Law Offices of Barry H. Josselson, A Professional Law Corporation

In The Compass's Summer 2011 first installment in this three-part series, we saw that during challenging economic times (such as that which the dental profession is currently confronting), the terms and provisions of your dental office lease contribute significantly to the financial success of your dental practice. All office leases deal with issues such as (i) annual rent increases, (ii) the right to sublease or assign your dental office lease to another dentist who purchases your practice, (iii) the right to exercise an option to renew to remain in your premises at your election, (iv) the allocation of responsibility between you and the landlord for making and paying for repairs, and (v) the landlord's right to recapture or take back your premises should you decide to sell your dental practice.

Your or your dental real estate attorney's discovering these hidden provisions in the lease, negotiating fairly these critical terms of your lease with the landlord, and being proactive in structuring your lease to address your long term professional and financial needs are a prerequisite for securing a fair lease and establishing a satisfactory landlord-tenant relationship.

#### 2. YOUR RIGHT TO ASSIGN OR SUBLET YOUR DENTAL OFFICE

Many dentists contemplate bringing in an associate dentist, entering into space-sharing or solo-group relationships to reduce costs, or assigning or subletting their premises to another dentist when they sell their practice. Leases prohibit professionals other than you from occupying and utilizing the premises. Most

leases also provide that any rent payments, money, or "other consideration" earned by you from the space-sharing relationship must be paid to the landlord. Leases also provide that any "value" attributed to your office lease in your practice purchase agreement upon the sale of your practice must be paid to the landlord. Be cognizant of lease clauses permitting the landlord to raise the office rent, to increase substantially the security deposit, or to withhold arbitrarily the landlord's consent to any requested assignment of your lease to another dentist. All of these provisions can work a financial hardship on you because the landlord has reserved the right (i) to change the economic provisions of your lease or (ii) to derive some or all of the economic benefit from your space-sharing or practice sale transaction. A careful perusal of this part of your lease by your dental real estate attorney and the deletion of this onerous provision before you sign your lease will save you much stress in years to come.

#### 3. OPTIONS TO RENEW

Options to renew your lease give you the right to stay for an additional period of time (e.g., 3 years) in your premises without having to obligate yourself if you later wish to relocate. Make sure your lease permits your options to renew to be exercisable by any subsequent dentist to whom you assign your office lease and not just you as the original tenant. Second, make provisions for determining the rent in the option to renew. (For example, the option period rent being the last year's rent increased by the CPI or the rent being the "fair market rent" for other dental space similarly situated in comparable buildings for that area). Lastly, make sure that you are given ample time

before the end of your lease term to exercise your option to renew (e.g., a period of six months to notify the landlord of your intent).

The next issue will address pass-through of operating expenses to the tenant and recapture of premises by the landlord.

Barry H. Josselson serves as an instructor in the UCLA School of Dentistry Graduate Practice Residency program and guest lectures at the UCSF, USC, and Loma Linda Schools of Dentistry and the UNLV School of Dental Medicine. He may be reached at 800-300-3525.

Any reprinting, copying, or reproduction of this article requires the prior written consent of Barry H. Josselson, Esq.

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<b>Residents' Night</b> February 1, 2012	<b>Concord CA</b>	<b>DBC Calibration Course</b> March 14, 2012	<b>Northern CA</b>
<b>Risk Management</b> February 8, 2012	<b>Southern CA</b>	<b>12th Annual Meeting</b> April 27-29, 2012	<b>Westlake Village CA</b>
<b>Risk Management</b> February 15, 2012	<b>Northern CA</b>	<b>Residents' Night</b> September 19, 2012	<b>Southern CA</b>
<b>DBC Calibration Course</b> February 22, 2012	<b>Southern CA</b>	<b>ACLS</b> October, 2012	<b>Solano CA</b>

\* From this year forward, Medical Emergencies course will be alternating between Northern and Southern California Locations in the Fall. This year it was held in Northern California, and next year (2012) it will be held in Southern California.



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