

The Compass

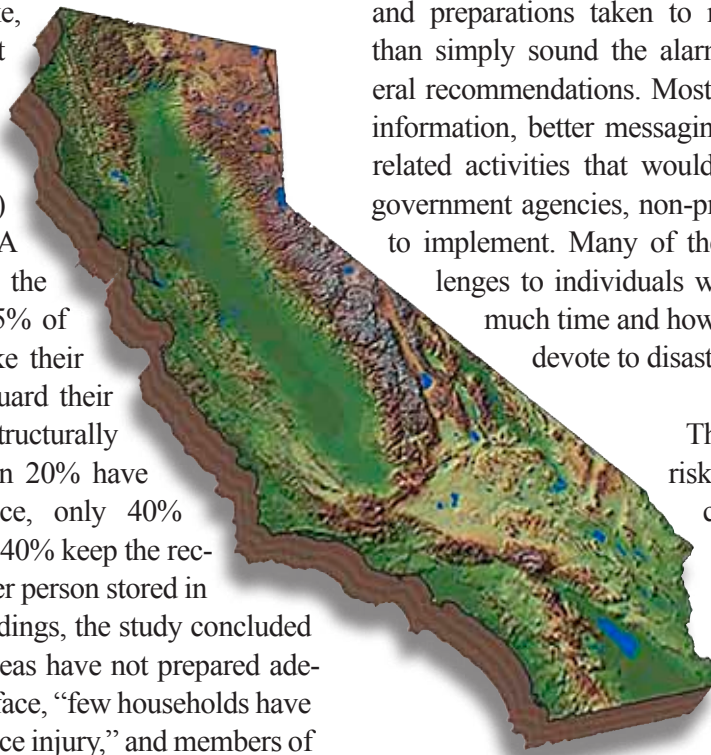
Staying the Course Through Service and Education



Volume XIII, Issue 1, Spring 2011

Is California Ready For The Big One?

A UCLA study released March 4th finds that Californians have not prepared for the next big earthquake, which most experts regard as inevitable. Commissioned by the California Emergency Management Agency (CEMA) and conducted by the UCLA School of Public Health, the study reported that less than 35% of Californians know how to make their home structure safer and safeguard their finances, less than 20% have structurally reinforced their home, less than 20% have purchased earthquake insurance, only 40% have a family disaster plan, and 40% keep the recommended 3 gallons of water per person stored in their home. Among its other findings, the study concluded that Californians in high risk areas have not prepared adequately for the greater risk they face, “few households have acted to mitigate losses and reduce injury,” and members of the Hispanic population were the least likely to have made preparations.



The study points out the gap between the risk of damage a future earthquake could cause in California and preparations taken to mitigate the damage. Rather than simply sound the alarm, the study also makes several recommendations. Most involve the dissemination of information, better messaging, and community education-related activities that would presumably fall upon local government agencies, non-profits, and community groups to implement. Many of these entities face similar challenges to individuals when trying to figure out how much time and how many resources they want to devote to disaster preparedness.

Thinking about catastrophic risk and its relation to practical preparedness measures is more complex than one might expect. In Richard A. Posner’s article “Thinking About Catastrophe,” which appears in a book called *Blindside: How to Anticipate Forcing Events and Wild Cards*

Continued on page 19

Compass Direction

Editor's Corner	4	Screw Retained Restoration	10
President's Message	6	Self-healing Ulcerative Pseudolymphoma	17
Anesthesia Examiner	7	Risk Management Does Not Stand Alone	20
From the Desk of AAOMS President	8	Classified Ads	22
2011 ABOMS Oral Exams	9	Upcoming Events	23

We hate lawsuits. We loathe litigation. We help doctors head off claims at the pass. We track new treatments and analyze medical advances. **We are the eyes in the back of your head.** We make CME easy, free, and online. We do extra homework. We protect good medicine. We are your guardian angels. **We are The Doctors Company.**

The Doctors Company is devoted to helping doctors avoid potential lawsuits. For us, this starts with patient safety. In fact, we have the largest Department of Patient Safety/Risk Management of any medical malpractice insurer. And, local physician advisory boards across the country. Why do we go this far? Because sometimes the best way to look out for the doctor is to start with the patient. Our medical professional liability program has been exclusively endorsed by CALAOMS since 1987. To learn more about our program for CALAOMS members, call (800) 852-8872 or visit us at www.thedoctors.com/calaoms.



www.thedoctors.com

The COMPASS
Published by the
**California Association of Oral
and Maxillofacial Surgeons**

Board of Directors

John L. Lytle, DDS, MD
President (818) 952-8183
johnlytle@earthlink.net

W. Frederick Stephens, DDS
Presidnet-Elect (626) 440-0099
dr.wfstephens@mac.com

Alan H. Kaye, DDS
Treasurer (310) 275-1134
bonegraft@aol.com

Alan S. Herford, DDS, MD, FACS
Vice President/Secretary (909) 558-4671
aherford@llu.edu

A. Thomas Indresano, DMD
Past-President (415) 929-6649
atindresano@acmedctr.org

Alan S. Herford, DDS, MD, FACS
Director (909) 558-4671
aherford@llu.edu

Monty C. Wilson, DDS
Director (714) 998-7450
montywilson@sbcglobal.net

Leonard M. Tyko, DDS, MD
Director (707) 545-4625
ltyko@hotmail.com

Steve M. Leighty, DDS
Director (530) 272-8871
smlzenos@pacbell.net

Pamela Congdon, CAE, IOM
Executive Director (800) 500-1332
pamela@calaoms.org

Jeffrey A. Elo, DDS, MS
Editor (714) 556-7000
jeff_a_elo@hotmail.com

Steve Krantzman
Associate Director (800) 500-1332
steve@calaoms.org

CALAOMS' The Compass © Copyright 2010

Published 3 times a year by the California Association of Oral and Maxillofacial Surgeons. The Association solicits essays, letters, opinions, abstracts and publishes reports of the various committees and members; however, all expressions of opinion and all statements of supposed fact are published on the authority of the writer over whose signature they appear, and are not regarded as expressing the view of the California Association of Oral and Maxillofacial Surgeons unless such statement of opinions have been adopted by its representatives. Acceptance of advertising in no way constitutes professional approval or endorsement.

**Your CALAOMS
Central Office Staff**

Your staff is here to help you with any questions about membership, continuing education courses, certification, and events. Please do not hesitate to contact us with questions or concerns at:

950 Reserve Drive, Suite 120
Roseville, CA 95678
Office: (916) 783-1332
Office: (800) 500-1332
Fax: (916) 772-9220
Web Site: www.calaoms.org

Executive Director

Pamela Congdon, CAE, IOM
Phone Extension: 12
email: pamela@calaoms.org

Associate Director

Steve Krantzman
Phone Extension: 11
email: steve@calaoms.org

Continuing Education Services

Teri Travis
Phone Extension: 13
email: teri@calaoms.org

Membership Services

Barbara Holt
Phone Extension: 10
email: barbara@calaoms.org

CALAOMS © 2010

CALAOMS also does business as:

- * Southern California Association of Oral and Maxillofacial Surgeons
- * Southern California Society of Oral and Maxillofacial Surgeons
- * Northern California Association of Oral and Maxillofacial Surgeons
- * Northern California Society of Maxillofacial Surgeons
- * California Society of Oral and Maxillofacial Surgeons
- * Southern California Oral and Maxillofacial Surgeons

Make a difference in *his life...*
the lives of *his children...*
and *his grandchildren...*



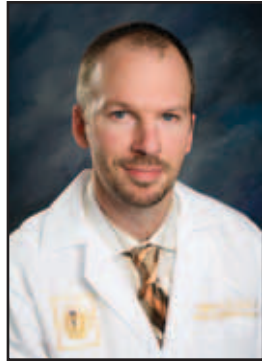
Photo © www.KarlGrob.com

TEACH
▪
TRAVEL
▪
LEARN

www.hvousa.org



Editor's Corner



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

Professionalism

Because dentistry is a profession and oral and maxillofacial surgeons (OMSs) are professionals, it is important to have a clear understanding of what “professionalism” means. As OMSs in-training, we all developed a personal sense of what it meant to be a professional. We gained an appreciation for the doctor-patient relationship. This relationship has evolved towards shared decision making, respecting the patient as an autonomous agent with a right to hold views, make choices, and take actions based on personal values and beliefs. Patients have been increasingly entitled to weigh the benefits and risks of alternative treatments, including the alternative of no treatment, and to select the alternative that best promotes their own values.

WHAT DOES IT MEAN TO BE A MEMBER OF A PROFESSION?

The words “profession” and “professional” come from the Latin word “professio,” which means

a public declaration with the force of a promise. Professions are groups which declare in a public way that their members promise to perform in certain ways, and that the group and the society may discipline those who fail to do so. The profession presents itself to society as a social benefit, and society accepts the profession, expecting it to serve some important social goal. The profession usually issues a code of ethics stating the standards by which its members can be judged. Traditionally, professions have most notably included medicine, dentistry, law, education, and clergy.

The marks of a profession are:

- competence in a specialized body of knowledge and skill;
- an acknowledgment of specific duties and responsibilities toward the individuals it serves and toward society;
- the right to train, admit, discipline, and dismiss its members for failure to sustain competence or observe the duties and responsibilities.

WHAT IS THE DIFFERENCE BETWEEN A PROFESSION AND A BUSINESS?

The line between a business and a profession is not entirely clear, since professionals may engage in business and make a living by it. However, one



crucial difference distinguishes them: professionals have a fiduciary duty toward those they serve. This means that professionals have a particularly stringent duty to assure that their decisions and actions serve the welfare of their patients or clients, even at some cost to themselves. Professions have codes of ethics which specify the obligations arising from this fiduciary duty. Ethical problems often occur when there appears to be a conflict between these obligations or between fiduciary duties and personal goals.

Professionals responsible for the health and welfare of society, whose actions can literally save or take a life, should appropriately be held to higher ethical standards.

WHAT ARE THE RECOGNIZED OBLIGATIONS AND VALUES OF A PROFESSIONAL DENTAL SPECIALIST?

Professionalism requires that the practitioner strive for excellence in the following areas which should be modeled by mentors and teachers and become part of the attitudes, behaviors, and skills integral to patient care:

- Altruism: OMSs are obligated to attend to the best interests of patients, rather than self-interest.

- Accountability: OMSs are accountable to their patients, to society on issues of public health, and to their profession.
- Excellence: OMSs are obligated to make a commitment to life-long learning.
- Duty: An OMS should be available and responsive when “on call,” accepting a commitment to service within the profession and the community.
- Honor and integrity: OMSs should be committed to being fair, truthful, and straightforward in their interactions with patients and the profession.
- Respect for others: An OMS should demonstrate respect for patients and their families, other physicians and team members, dental students, and residents.

These values should provide guidance for promoting professional behavior and for making difficult ethical decisions.

Ethical behavior is defined in terms of morality and is recognized as the mark of a good and decent person and, likewise, of a trustworthy organization. Although we value it in all aspects of life and have been dismayed by its flagrant absence in some modern examples in the business world and in government, it is, of course, most critical for those individuals and organizations whose actions touch our very lives.

Professionals responsible for the health and welfare of society, whose actions can literally save or take a life, should appropriately be held to higher ethical standards. Likewise, organizations such as ours, trusted to provide information to healthcare providers, the public, patients, and policy makers, and thus with the ability to have a profoundly beneficial impact on society, must similarly follow the highest ethical standards. The foundation of all we do is based on the public’s trust.

President's Message



John L. Lytle, MD, DDS
President, CALAOMS

State of the Association

2011 is off and running! All indications are that the economic environment is improving, and I look forward to a great year for our organization. Thank you for giving me the opportunity to lead our association. If you have any questions or concerns, please email me at JohnLLytle@earthlink.net, or call me at 818-952-8183.

As oral and maxillofacial surgeons, we have developed and employed a unique and highly successful approach to the practice of dentistry. Nationally, it is known as the oral and maxillofacial surgery team concept of combined anesthesia and surgery (best known as the operator/anesthetist model). One surgeon and a highly-trained team provide all of the surgical and anesthesia care to the patient. We all know this to be a safe and successful approach. It has stood the test of time.

Unfortunately, our team model has come under attack once again. In October, 2010, the American

Society of Anesthesiologists revealed their opposition to our approach. This opposition appears to be politically motivated and has no scientific basis. Our leaders at AAOMS have responded, and preparations are being made to put this issue to bed once and for all.

In April/May of this year, AAOMS will fund and begin a benchmark study. This randomized prospective study will be completed rapidly by a small subset of our national membership. Surgeons will be chosen randomly to participate. If chosen to participate, please take the time to assist in this most important study. The time spent will be appreciated by all of our members.

As a companion study, a registry will be set up by AAOMS to collect basic outcomes on a national level.

In October, 2010, the American Society of Anesthesiologists revealed their opposition to our approach (the operator/anesthetist model.)

All members will be asked to participate in this study which will generate large volumes of data very rapidly. Again, I implore all of you to participate. This data is crucial to protect and defend our specialty and our way of practice. Remember, anesthesia is what makes us unique, and nothing short of full participation will suffice.

CALAOMS has again taken the lead in advancing the OMS team concept by pioneering the Dental Sedation Assistant Permit. The statutes and regulations are in place, and courses were started on a trial basis last year. We are close to obtaining the first permits from the Dental Board of California. Those who

have permits will assess monitors, administer medication under the provider's supervision, and remove I.V. catheters. The first permits should be mailed out in the next few weeks. This permit will further strengthen our team model, and I urge all providers to promote this in their offices in the coming year. If you have any

questions, please feel free to contact the CALAOMS office.

CALAOMS and the Board of Directors wish you a healthy and prosperous new year. ●

The Anesthesia Examiner

by Anesthesia Committee, CALAOMS

The long-proven practice of oral and maxillofacial surgeons (OMSs) providing general anesthesia and sedation has come under scrutiny from many different outsiders. Their questions range from, "Should we, as OMSs, be administering general anesthesia?" to "Are OMSs qualified or adequately trained to provide such?"

A permit to administer general anesthesia is issued by the Dental Board of California provided that the candidate meets the criteria established and delineated in the California Code of Regulations. The permit holder is also required to undergo periodic in-office general anesthesia evaluations. This periodic on-site office inspection and evaluation of the surgery-anesthesia team consists of:

- Evaluation of the office facilities and equipment
- Treatment records (including the anesthesia record and informed consent)
- Required drugs for emergencies
- Demonstration of a general anesthetic
- Demonstration of competency in 12 simulated office anesthesia emergencies

While the Dental Board of California oversees the process, the evaluation is administered by two CALAOMS members--oral and maxillofacial surgeons--who are, themselves, holders of general anesthesia permits. Scheduling of the evaluation is coordinated through the office of Ms. Jessica Olney (at the Dental Board).

As evaluators, we are charged by the state to provide a thorough and unbiased evaluation of the candidate. Evaluators are mindful that they are acting as agents of the state of California on behalf of the public. Adherence to the evaluation criteria set forth in the Code of Regulations demonstrates our commitment to quality service and patient care that the public expects from a well-respected profession such as ours.

The Dental Board of California presents a periodic 'calibration course' for experienced and prospective evaluators. Included in the course is a review of existing and new regulations, as well as recommendations for the type of evaluation the Dental Board would like to see conducted.

Not only can we as evaluators strive to keep the standards very high for our specialty in providing anesthesia services to our patients, but we are given the opportunity to observe anesthesia being delivered in perhaps a different, but equally effective, manner as administered by our peers.

Current evaluators and any interested OMSs were encouraged to attend the calibration courses, given free of charge, in both northern and southern California in March of this year. ●

From the Desk of AAOMS President



Larry J. Moore, DDS, MS
President, AAOMS

In order to defend our specialty's safe and effective method for the delivery and monitoring of office-based anesthesia, AAOMS will soon contact a randomly selected group of 300 actively practicing fellows and members, and ask that they participate in the new benchmark study. Participants will each be assigned a month during which they will enter patient data using a secure, state-of-the-art, HIPAA compliant, online data collection system for those patients who meet the study criteria.

In addition to providing the specialty with concrete data that unequivocally support the OMS anesthesia team model, the study offers unexpected benefits. It will, for example, provide a risk management tool that reflects the intent of AAOMS to adopt quality improvement strategies, and it will provide researchers with a valuable data set that will meet the criteria of journal reviewers.

If you are among the OMSs contacted to participate in this landmark study, please offer your assistance. This is a critical project for oral and maxillofacial surgeons and their ability to practice the full scope of the specialty.

Once the benchmark study is underway, AAOMS will also launch an anesthesia registry, which will capture a broader range of data from the entire membership. Additional information about the registry will be available within the next few months.

While it is true that winter on the east coast can be cold and snowy, it is also true that September in Philadelphia is glorious with colorful fall foliage and warm temperatures. Add to this idyllic scene the largest and best continuing education program offered

Greetings to all my friends in California. It was a pleasure to see many of you at the recent CALAOMS meeting in Monterey. The venue was striking in its natural beauty, and the continuing education program was excellent.

AAOMS INITIATES ANESTHESIA BENCHMARK STUDY

As the first quarter of 2011 winds down, activity at the AAOMS headquarters office is revving up for what promises to be a very eventful year. Of primary importance to the specialty is the prospective, statistically valid study for office-based anesthesia practice, benchmarks and outcomes, which the association will conduct over the next 12 months with OUTCOME™, the group that has been our technical partner in the successful anesthesia outcomes study.

Working with the AAOMS Committee on Anesthesia and the Special Committee on Outcomes Assessment, the association's Board of Trustees recognized that despite an impressive record of patient safety and satisfaction, the current political and economic healthcare environment is prompting challenges to our oral and maxillofacial surgery anesthesia team model from our dental and medical colleagues.

anywhere to OMSs and their staff, and you will want to join AAOMS in Philly this September 12-17, 2011 for the 93rd Annual Meeting, Scientific Sessions and Exhibition. This year's meeting will be held in conjunction with the Scandinavian Association of Oral and Maxillofacial Surgeons. AAOMS' hotel reservation system opened March 7, and registration for the annual meeting opens in early April.

I look forward to seeing all the California and District VI fellows and members in Philadelphia this fall.

Warm Regards,

Larry J. Moore, DDS, MS

California Sets New Record for Examiners at 2011 ABOMS Oral Examinations



The number of CALAOMS members that participate on the American Board of Oral and Maxillofacial Surgery Examination Committee has increased steadily over the last several years. At the 2011 ABOMS Oral Examination held in Dallas, TX earlier this year, 14 CALAOMS members were on the Committee, setting a new record for the state. The members that participated this year in Dallas are (from left to right): Drs. John Lytle, Alan Herford, Earl Freymiller, Vincent Farhood, Alan Felsenfeld, Lester Machado, Jeffrey Dean, Robert Relle, Mary Delsol, Sanford Ratner, Richard Leathers, William Clark, Bruce Witcher, and Frederick Stephens.



Technical Articles



Peter Krakowiak, DMD, FRCD(C)

Screw retained restorations are on the comeback...again.

I often receive inquiries from my referring doctors asking for some guidance in matters related to choice and application of restorative components. I am sure most of us do. Looking at the cases, I am still very much involved in final abutment and prosthetic appliance selection in over 75% of cases, as all of my referrals, with the exception of two prosthodontists, are generalists. In the past two years, we have started employing a larger number of milled restorative connections, which has exposed me to a whole new selection of possibilities for milled custom cementable and screw-retained restorative options. The precision of these connections is amazing and holds great promise for reducing all of the past connection problems faced in implant restorations. This article will briefly review the connection options and benefits, as well as the disadvantages of each option. Ultimately, each case has to be individually planned and executed, hence, at this time, no one single solution will fit all the cases. Understanding the benefits of

each option can guide the practitioner to make the best selection and optimally complete these cases.

As we have recently progressed into the third-generation of abutment connections in implant prosthetics recognizing that most abutment systems are now internally based with some aspect of platform switching as part of their design, the old controversy of whether to use a screw-retained or a cemented restoration still exists. The new platform switching design (figure 1) allows for better retention of crestal bone, and, as such, supports the interproximal soft tissues better. The new abutment design locates the abutment connection internally; however, the design has not affected issues of subgingival cement retention at the restoration-abutment interface. The North American market is largely based on cementable restorations for most single- and short-span fixed partial denture (FPD) restorations. As we follow these cases for extended periods of time, the incidence of peri-implantitis secondary to cement retention (figure 2) is increasing and will continue to do so as more fixtures are being placed and followed.

In Europe, the screw-retained concept has been popular for many years. Initially, that was the core concept of the Branemark design, and the cementation of restorations was not part of that early equation. But due to off-label, experimental, and (sometimes) salvage restorative techniques in anterior esthetic cases, the cemented restoration became popular. After initial success, the relatively high rates of screw and abutment connection instability noted with first-generation connections and screws have made the use of cementable restorations more risky and often problematic when the restorations required servicing or screw retightening. However, the ability to cement implant-supported restorations using techniques similar to conventional fixed prostheses overwhelmingly simplifies treatment planning and execution of the restoration of implants for novice practitioners.

The key disadvantage of cementing implant-supported restorations, as noted, was the potential difficulty in retrieving the restoration. Should an

abutment loosen, or any repair of the restoration become necessary, the restoration may be destroyed during the removal procedure if the cement seal cannot be easily broken. Furthermore, and more importantly, any force applied to a restoration on a loosened abutment has the potential to damage the internal threads of the implant.

There is an overriding biomechanical issue that needs to first be addressed in any discussion of this issue, the stability of the abutment-to-implant screw joint. Long-term stability through reduced micro-motion is the single most important requirement for cemented restorations. The same abutment-to-implant stability is essential for screw-retained restorations, as well. Today's manufacturers have developed adequate materials, implant sizes, and manufacturing protocols to resolve this issue. Implant diameters have been increased, and in conjunction with increased implant platform size, this has resulted in greater overall implant strength and resistance to tilting forces. Improved abutment-to-implant connections, particularly at the internal interface, using interference-type machining, likewise, has dramatically improved abutment stability. Finally, improvement of the abutment screws through design changes, refinement of materials, surface coating, and exact torque protocols now produce higher mating forces to the joint and improved the initial preloads.

With the improved connections and screw retention, the cement-retained concept had gained greater acceptance, especially out of practical need to empower even the entry-level skilled dental operators to restore more dental implants. In the last decade, large numbers of new implant care practitioners have presented to the market. The cement technique has allowed for the most parallel process to the standard "tried, tested, and true" crown and bridge therapy taught in most dental schools in North America. Also, with cementation, it has been easiest to overcome structural integrity and coupling discrepancies which often exist in some of the less-than-accurately manufactured prostheses. Implant companies realized this and heavily marketed the simplicity of this technique with product names that highlighted the ease and simplicity of the restorative process.

When cemented abutments are utilized, it is paramount that the cement margin is shaped to maintain a relationship with the scalloped gingival margin. With many prefabricated stock abutments, the cement margin is level vertically and equal circumferentially (figure 3), which can lead to deeply localized cement margins. Cement removal becomes difficult, if not impossible, with connections

Continued on page 14



Figure 1.



Figure 2.



Figure 3.

CALAOMS

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

11th Annual Meeting

May 21-22, 2011

TAD's - A Maturing Perspective

Dedicated to: Frank Pavel, Sr., DDS



“Transitional Anchorage Devices: Concepts, Biomechanics and Treatment Protocols”

Speaker: Jason B. Cope, DDS, PhD

“Surgical Technique for Miniplates: Illustrated With Cases”

Speaker: Anders Nattestad, DDS, PhD

9.5 CE\CME

“Maxillary Zygomatic Anchorage Plates”

L. Douglas Knight, DDS, ABO, FAGD

“Complications of Dentoalveolar Surgery”

Speaker: Alan L. Felsenfeld, DDS



TERRANEA.

L.A.'s Oceanfront Resort

100 Terranea Way, Rancho Palos Verdes, CA 90275 (310) 265-2800

WWW.TERRANEA.COM

1.800.257.9470

XEMAX
SURGICAL PRODUCTS, INC.

www.xemax.com

Implant Presentation Kit



- Choose from five available options
- Improved patient education and higher treatment acceptance

Subperiosteal Tissue Expanders



- Designed to assist in the management of alveolar deficiencies
- Minimizes surgery, dissection, pain, and swelling

C-Sponge Pharyngeal Barrier



- The common sense alternative to a gauze throat pack
- Highly absorbent; can be drained while remaining in place

Cytoplast Membranes



- Cost effective for common applications
- High-quality PTFE material
- Variety of sizes available

Xemax has a wide variety of innovative and time-saving products, as well as excellent prices on your favorite burs, membranes and other essential items!

Call for an updated catalog!

Para Drill Aid



- Highly intuitive and easy-to-use implant paralleling device
- Compatible with any contra-angle or E-type handpiece

Collatene Microfibrillar Collagen



- Provided in individual sterile packaging
- Cost-effective, 0.1 gm units
- Completely absorbable
- Non-pyrogenic
- Microfibrillar

Cusp-Lok Impacted Cuspid Brackets



- Strong 14k gold chain attached to orthodontic bracket
- Variety of styles available (Mesh, Swivel, Low Profile)

Cordless Curing Light



- Compact, cordless curing light, with *Continued on page 13* over 600mw/cm²
- Preset curing times of 10, 20, and 30 seconds





Figure 4.

"Screw Retained Restorations" Continued from page 11

being made 1mm or more below soft tissue margins. It can lead to soft tissue irritation initially, and after the final restorations are in place, you will see an increasing number of cases presenting with severe localized peri-implantitis with resultant fixture, esthetic, and functional failures. Deeply placed connection margins that cannot be corrected by abutment selection are, therefore, a contraindication for stock abutment-based cement retention. Milled abutments offer the option of differential margin location and correct the emergence profile for maximum restoration balance and soft tissue health (figure 4).

In addition to using scalloped margins, other techniques to reduce subgingival cement retention have been suggested. These include seating of the luted restoration on an abutment model or replica once prior to seating on the actual abutment in the mouth. Such pre-seating allows for expression of excess cement from the crown prior to final seating, and hence, less likelihood of expression of that excess cement below the gingival contour. Crowns have also been constructed with a small relief hole on the lingual aspect to allow for a controlled avenue for cement expression that is away from the actual subgingival margin. Yet another popular strategy has been utilizing more biocompatible cements of dissolvable luting agents, such as TempBond or eugenol-based cements. These are believed to more readily dissolve, and hence, have lesser chance of staying at the marginal junction over time.



Figure 5.

The other absolute contraindication to cement-retained implant restorations is the clinical situation where there is extremely limited interocclusal space present which limits the vertical wall heights on abutments. Also, obviously misaligned implants in which axial wall reduction becomes so extreme that in attempting to achieve parallelism, individual abutment retention is lost.

The pendulum seems to swing back with new fabrication and milling technology becoming readily available. Implant companies are shifting their marketing efforts to the screw-retained restorations. The ceramic and silica-based abutments can be shaded and directly glazed with porcelain or high index composite enveloped. Access holes can now be readily located on the facial as closure resins can very well match the shading and optical properties of the milled abutments and investing finishes. With no metal substructures, the issue of having to opaque metal and bond to porcelain has been eliminated. Another concept that is driving the screw-retained approach is the hybrid and full arch immediate implant restorations.

These restorative solutions are gaining popularity and are all screw-retained and based on angled multi-unit connections with possible multi-planar angulation corrections of up to 30 degrees. These prostheses now utilize more composite-based denture teeth, which is much easier to camouflage the access hole.

Contemporary screw-retained dental implant restorations have a key advantage of relative ease of retrievability. This enduring design attribute permits necessary servicing of the implant superstructure as needed, and is particularly valuable in multiple-unit, full-arch, or cantilever prostheses, where some maintenance of restorative materials, structures, components, or implants will be necessary during the lifetime of that prosthesis. In traditional cast restorations, however, this design still demands precise placement of the implant fixture for lingual-to-incisal location of the screw access hole. Buccal-to-incisal direction of placement can lead to an unaesthetic restoration if screw retention is to be used. The issue is quite common in maxillary anterior fixture cases. To eliminate the presence of the screw access hole in esthetically-demanding areas, other methods have been used to connect implant restorations to abutments or implants.

These include the use of pre-angled abutments, which allow for screw-retained restorations, and the previously mentioned cemented implant restorations to angled or custom abutments. Stock pre-angled abutments can redirect screw access openings to the occlusal or cingulum areas of implant restorations. However, to allow the abutment to be retained on the implant and still provide sufficient abutment structure to house a retention screw for an implant restoration, the long axis of the implant and the path of the retention screw must significantly diverge. With custom abutments, whether milled or cast, this is less of an issue, but the costs of these abutments is significantly more than that of stock abutments. The option of lateral set screws in the restoration which allow for retention to the abutment are also an alternative technique. The use of a set screw permits a retrieval screw to be located in a position where a displacing force can be applied in the direction of the abutment to

break the cement seal and allow easier removal of the restoration. The access hole can be placed in a variety of locations, independent of the direction and position of the implant body. Luting agent can be mixed without using lubricant and still allow the predictable retrieval of the restoration. This technique has the potential to reduce stress to splinted implants, since the effects of minor marginal and connector misalignment of the framework are not transferred directly to the implants, as is the case with prosthesis-retaining screws. Moreover, the exposure of screw access holes in aesthetic areas of the mouth can be circumvented.

The disadvantages of a screw-retained implant system are numerous. First, there is the previously mentioned problem of a lack of esthetics at the screw access channel, particularly if the channel is cast in metal. Second, if the metal is cut back to hide the nonaesthetic metal, porcelain fracture around the screw access channel can occur. Third, screw-retained prostheses generally require both the abutment screws and bridge screws to be tightened using a torque driver to effect preload of the screws. This torquing appears to have lowered, but not eliminated, the incidence of screw loosening. Finally, the cast conventional screw-retained systems generally leave a microgap beneath the gingival crest, resulting in some chronic gingival inflammation. This will be less of an issue with increased use of milled connections based on virtual impressions, but microgaps will always exist.

Finally, the idea that somehow the screw chambers, with their resultant composite fillings, disrupt the occlusal design has been postulated by many. It was felt that the access hole reduces the ability to develop ideal occlusal design and forces the restorative occlusal scheme to contact on inclines of cusps which are not directly over the implant base, and, therefore, cause greater off-axis loading. But, it may not be a concept that is clinically relevant. We place occlusal access holes routinely for endodontic purposes. Also, a well-diagnosed implant treatment would have only 4 to 6 chambers in most routine full-arch situations, and

Continued on page 16

"Screw Retained Restorations" Continued from page 15 this, in splinted restorations, is hardly disruptive to the occlusion.

Cemented and screw-retained implant prostheses present their own distinct advantages and limitations. The major difference between the 2 strategies is that a screw-retained prosthesis can be removed and replaced by the clinician, while a cemented restoration is not intended to be retrieved. Each can be the best option, depending on the objectives of the pros-

thesis, patient factors, the attributes of the implant system, and the philosophy of the practitioner.

Credits:

Figure 2. Courtesy of Steve Hurson, Chief Engineer, NobelBiocare

Figure 5. Courtesy of Randy Carlson,, DDS, Bonsall, CA



E-MAIL & SOCIAL MEDIA MARKETING

Grow your oral and maxillofacial surgery practice with email newsletter campaigns. Professionally written content provides captivating, high quality information and visuals that will engage your referring doctors or patients.

With inForm you can:

- Build OMS Referral or Patient Newsletters
- Choose From our Library of Articles
- Send Specific Treatment Articles to Individual Patients
- Socialize your Articles, Coupons & Announcements to  & 
- Promote Office Specials with Trackable Coupons
- Manage Contacts
- Measure Your Response & Return on Investment



call 800.840.5383

visit www.pbhs.com



Self-healing Ulcerative Pseudolymphoma

by Lee Slater, DDS, MS, Scripps Oral Pathology Service, San Diego, California; Lecturer, Department of Oral & Maxillofacial Surgery, Loma Linda University School of Dentistry

If a patient presents with an ulcerative nodule of the tongue dorsum (Figure 1), then the surgeon might consider several possibilities in the clinical differential diagnosis: traumatic ulcer, traumatic ulcerative granuloma, infection (mycobacterial, deep fungal infection [histoplasmosis]), pyogenic granuloma, and malignant neoplasia. Squamous cell carcinoma is the commonest oral malignancy, but it rarely occurs on the tongue dorsum; so the second most frequent oral malignancy, lymphoma, could be included among the diagnostic considerations. An incisional biopsy revealed an atypical lymphoid proliferation worrisome for malignant lymphoma (Figure 2). However, the lesion spontaneously regressed following biopsy, and it completely resolved by the 5-week post-op appointment (Figure 3).

This case exemplifies the problem of atypical lymphoproliferative disorders (pseudolymphomas or prelymphomas). The term "pseudolymphoma" is appropriate because standard pathology methods (histologic evaluation, immunohistochemistry for lymphoid markers, clonality gene rearrangement studies) result in a malignant diagnosis (lymphoma or "worrisome for lymphoma") but clinical work-up and follow up reveal its true benign nature. Oral pseudolymphomas go by several names: lymphomatoid papulosis,^{4,20,24}

Continued on page 18



Figure 1. Self-healing pseudolymphoma at presentation. A 39 year-old man presented with a 1.5 cm painless ulcerated tongue nodule; it started as a small papule and enlarged over 10 days. He had a history of similar small tongue papules, but none had previously shown such alarming growth.

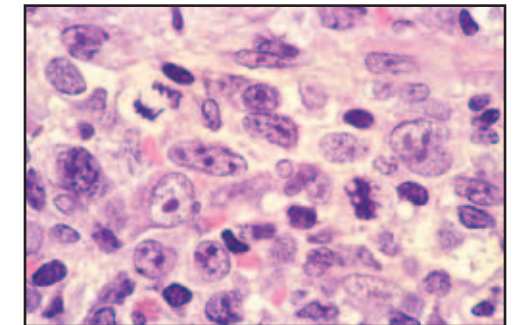


Figure 2. Self-healing pseudolymphoma, incisional biopsy. The biopsy revealed a lymphoma-like proliferation of large atypical lymphoid cells. An associated polymorphous inflammatory infiltrate included small lymphocytes and eosinophils (not shown).



Figure 3. Self-healing pseudolymphoma 5 weeks after incisional biopsy. The mass began spontaneous regression immediately following incisional biopsy. It had largely healed by 1 week, and by 5 weeks it had completely resolved.

"Ulcerative Pseudolymphoma" Continued from page 17

traumatic ulcerative granuloma with stromal eosinophilia,²³ CD30-positive T-cell lymphoproliferative disorder,¹ and EBV-positive mucocutaneous ulcer.⁵

If a surgeon biopsies an ulcerated tongue or buccal mucosal lesion and receives a diagnosis of malignant lymphoma, the surgeon should probably query the pathologist as to whether the lesion could be a pseudolymphoma (atypical lymphoproliferative disorder), particularly if the elderly patient has been receiving immunosuppressive therapy (methotrexate) for rheumatoid arthritis.^{5,11} Epstein-Barr virus (EBV) infection contributes to inducing pseudolymphomatous "EBV-positive mucocutaneous ulcers."⁵ Similarly, if a patient presents with an acute necrotizing ulcerative gingivitis-like (ANUG-like) gingival lesion (that is, a depressed ulcer showing evidence of neither a mass nor a radiolucent lesion) and the biopsy is diagnosed as lymphoma, then the surgeon should question the diagnosis: a lymphoma should present as a mass, not the absence of a mass. Pseudolymphoma would deserve serious consideration.

The prognosis of a pseudolymphoma is unclear. Some lesions regress when iatrogenic immunosuppression is decreased or discontinued.^{8,11,16,22} Some patients, after multiple "migratory" recurrences over years, never develop life-threatening lymphoma.^{24,27} A proportion progress to fully malignant lesions.¹⁴ The prognosis of cutaneous CD30-positive anaplastic large cell lymphoma, a histologically high-grade lesion related to lymphomatoid papulosis, is favorable (93% survive 5 years).¹² With atypical lymphoproliferative disorders, the true nature of the disease process is revealed only by staging (assessing the extent of disease) and follow-up. Rawstron,²¹ noted that 10% of elderly patients develop incidental clonal lymphocytic leukemic proliferations which rarely show clinical progression; such incidental leukemias may be analogous to pseudolymphomas (or incidental lymphomas). If a self-healing pseudolymphoma were treated with chemotherapy, a high complete-response rate would be expected. The spontaneously-regressing EBV-associated pseudolymphoma is typically a B-cell

proliferation,^{5,18} but a clinically similar clonal T-cell proliferation has been termed oral traumatic ulcerative granuloma with stromal eosinophilia (TUGSE); it also self-heals.^{1,23} As an aside, Langerhans cell histiocytosis of bone (eosinophilic granuloma) often spontaneously resolves as well.^{10,17}

Bibliography

1. Agarwal M, et al: [Traumatic eosinophilic granuloma is an indolent CD30-positive T-cell proliferation: 3 cases of tongue ulcerative nodules.] *Int J Surg Pathol* 16:286, 2008.
2. Beltraminelli H, et al: [Cutaneous T-cell proliferations: histology does not predict biologic behavior.] *Am J Dermatopathol* 31:317, 2009.
3. Delecluse H-J, et al: Epstein-Barr virus-associated tumors. *J Clin Pathol* 60:1358, 2007.
4. de Misa RF, et al: [Lymphomatoid papulosis of the tongue.] *Clin Exp Dermatol* 35:165, 2009.
5. Dojcinov SD, et al: [EBV-positive mucocutaneous ulcer: pseudolymphoma arising in old folks (old-age associated "senile" immunodeficiency) or induced by iatrogenic immunosuppression.] *Am J Surg Pathol* 34:405, 2010.
6. Engels K, et al: [Benign clonal B-cell proliferations in the bones of rheumatoid patients.] *Hum Pathol* 38:1402, 2007.
7. Geyer JT, et al: [Pseudolymphoma of the uterine cervix: an ulcerated lesion without a mass.] *Am J Surg Pathol* 34:161, 2010.
8. Hsiao S-C, et al: [EBV+ lymphoproliferative disorders in patients immunosuppressed by methotrexate.] *Pathol Res Pract* 205:43, 2009.
9. Kash N, et al: [Skin pseudolymphomatous proliferation with dermatophytic fungal infection.] *Am J Dermatopathol* 32:514, 2010.
10. Key SJ, O'Brien, et al: Eosinophilic granuloma [Langerhans' cell histiocytosis]: resolution of maxillofacial bony lesions following minimal intervention. *J Craniomaxillofac Surg* 32:170, 2004.
11. Kikuchi K, et al: [Maxillary gingival ulcerative EBV+ pseudolymphoma induced by methotrexate in a rheumatoid arthritis patient.] *Head Neck Pathol* 4:305, 2010.
12. Kinney MC, et al: Anaplastic large cell lymphoma [extensive review.] *Arch Pathol* 135:19, 2011.
13. Kojima M, et al: [EBV+ tonsillar pseudolymphomas.] *Pathobiology* 77:218, 2010.

"Ready for the Big One ?" Continued from page 1

in *Global Politics* edited by Francis Fukuyama, Posner explains some of the reasons behind society's frequent lack of preparedness for disasters. He points out that much of the difficulty in "dealing with catastrophic risks lies in the limitations of cost-benefit analysis." He suggests that private individuals possess "psychological discomforts" that prevent them from thinking enough about somewhat remote probabilities and digesting much of the data thrown at them by experts. Likewise, political officials, according to Posner, have incentives not to address the problem even if doing so could save the population a great deal of money in the future.

In addition, Posner points out other obstacles that limit the capacity of people to respond to risk. For instance, the infinite number of potentially catastrophic risks can lead to complacency as people begin to feel like there is no hope of preparing for all possible disasters. In some cases, people also tend to engage in discounting, essentially valuing the future less than the present, when making decisions about how much it is worth to spend money now to alleviate potential damage at some point in the future. Posner concludes by warning, "We simply cannot afford in this day and age not to think about catastrophic risks. But thinking about them is very difficult, doing something practical about them even more so. Society therefore faces a great challenge, to which it had better rise." California had better rise quickly.

In order to close the gap between Californians' current levels of preparedness and the threat of significant damage from the upcoming "big one," it is important to follow the guidelines laid out by CEMA. As we have seen, though, getting people to do this poses as great a challenge as ever. Motivating people to prepare will become much easier if California's agencies and community groups find ways to talk about risk and disaster preparedness that address the obstacles that prevent people from preparing.

Written by Brian St. Clair, and originally published by the San Diego Nonpartisan Examiner (March 6, 2011) and is reprinted with their permission. The editorial staff thought that in light of the tragic events that unfolded in Japan, we should all rethink our own disaster preparedness for both our homes and offices.

14. Marschalkó M, et al: [Patient with lymphomatoid papulosis for 40 years finally developed a lethal aggressive anaplastic large cell lymphoma.] *Am J Dermatopathol* 32:708, 2010.

15. Martin B, et al: [Skin senile EBV+ diffuse large B-cell lymphoma.] *Am J Dermatopathol* 32:190, 2010.

16. Miyazaki T, et al: Remission of lymphoma after withdrawal of methotrexate in rheumatoid arthritis: Relationship with type of latent Epstein-Barr virus infection. *Am J Hematol* 82:1106, 2007.

17. Moralis A, et al: Intralesional corticosteroid therapy for mandibular Langerhans cell histiocytosis preserving the intralesional tooth germ. *Oral Maxillofac Surg* 12:105, 2008.

18. Park S, et al: [Indolent EBV+ T-cell lymphoproliferative disorder of extremity skin.] *Am J Dermatopathol* 32:832, 2010.

19. Plaza JA, et al: [Benign clonal T-cell lymphoid proliferations of skin.] *J Cutan Pathol* 35:385, 2008.

20. Pujol RM, et al: [Lymphomatoid papulosis of the tongue.] *Dermatol* 210:53, 2005.

21. Rawstron AC: [Benign limited CLL-like lymphocytic proliferations in 10% of adults aged > 60 years; the clonal proliferation generally does not progress; incidental lymphomas.] *Histopathol* 58:81, 2011.

22. Rizzi R, et al: Spontaneous remission of "methotrexate-associated lymphoproliferative disorders" after discontinuation of immunosuppressive treatment for autoimmune disease. *Med Oncol* 26:1, 2009.

23. Salisbury CL, et al: [Oral traumatic ulcerative granuloma with stromal eosinophilia (TUGSE) is a benign clonal T-cell lymphoid proliferation.] *Am J Clin Pathol* 132:722, 2009.

24. Sciubba J, et al: [Lymphomatoid papulosis of the tongue.] *Oral Surg* 90:195, 2000.

25. Shimoyama Y, et al: [Senile EBV+ B-cell lymphoproliferative disorders: aggressive diffuse large B-cell lymphoma of the elderly.] *Pathol Int* 59:835, 2009.

26. Shiozawa E, et al: [Senile EBV+ indolent B-cell proliferations can progress to aggressive lymphoma. *Pathol Int* 57:688, 2007.

27. Vasiliu V, et al: [Self-healing ulcerative/necrotic EBV+ anorectal pseudolymphoma in an immunocompetent man.] *Am J Surg Pathol* 34:1715, 2010.

28. Wick MR, et al: Pseudoneoplastic lesions. General Considerations. *Arch Pathol* 134:351, 2010.

Risk Management Corner

Risk Management Does Not Stand Alone

Risk management, which has been part of the health care lexicon for decades, has firmly established the concept of minimizing liability and improving patient outcomes. However, in the last 20 years, new concepts—such as quality of care, regulatory compliance, and patient safety—have prompted the question, “is risk management still relevant?”

Before answering this question, let’s explore these newer concepts.

One of the earliest areas of focus involved quality of care (quality control, quality assurance, quality improvement, process improvement, etc.). Many professionals announced that quality initiatives would take the place of risk management because improving quality was what health care was all about. What they failed to recognize was that the legal system would continue to require a definition of the standard of care.

The standard of care is the minimum legal standard and is defined by what a reasonably prudent health care professional would do. Failing to meet this minimum standard is defined as negligence. While quality initiatives worked to provide the highest quality of care possible, risk management quietly monitored those minimum standards. This included a vast number of issues ranging from the safety of parking lots and access to facilities by disabled individuals, to placement of biohazard containers, dispensing of medications by non-pharmacists, and the analysis of lingual nerve injuries.

Quality initiatives and risk management programs have coexisted and to some extent overlap. We have learned to utilize the tools of both disciplines which have made the health care professional more effective and health care environments safer.

Another area of focus in recent years has been regulatory compliance. As the proliferation of regulations began to impact health care, there were those who thought that regulations would take over control of the delivery of health care. Some people said that regulatory compliance would make risk management irrelevant. But again, regulatory compliance has not taken the place of a comprehensive risk management program.

With the publication in 1999 of the Institute of Medicine’s report *To Err is Human: Building a Safer Health System*, the health care community realized that quality initiatives were taking us in the right direction but were not getting us far enough, fast enough. Providing high-quality care was not enough when the systems for delivering that care were rife with opportunities to make errors and harm patients. Patient safety became the number one priority of health care: providing high-quality care that was delivered safely.

As a result of this classic study *To Err is Human*, all providers became aware of their fallibility as humans and the need to develop systems that would help avoid errors. Fatigue, overwork, stress, and over-reliance on memory can be the precursor of an error. Understanding the interplay between human beings



and the systems in which they work reveals weaknesses that may be corrected.

The reality is that the oral and maxillofacial surgeon can greatly reduce exposure to malpractice claims in the support of patient safety initiatives by implementing and maintaining an effective office support system. The operational aspects of your office can have a big impact on avoiding claims. The Doctors Company now has available a system loss-prevention checkup tool, *Interactive Guide for Dentists and Dental Specialists*.

While we work to improve quality, comply with regulations, and adopt patient safety goals, we have come to the understanding that the standards against which health care is measured are constantly changing. We must not only adopt and implement patient safety goals, new regulations and quality measures, but we must also recognize that they are becoming the new minimum legal requirement. Failing to properly implement patient safety goals means that we risk being found negligent if our patients suffer as a result of our failure to meet these new standards and goals.

The purpose of risk management is to protect the assets of the organization. Assets are protected by:

- Providing a safe environment for patients, families, visitors, employees, and vendors, etc.
- Complying with case law, statutes, and regulations (The Dental Practice Act, HIPAA, Stark, pharmacy boards, workers’ compensation, ADA, etc.)

- Meeting minimum professional standards of care (evidence of the standard of care is derived from professional societies, scientific studies, etc.)
- Adopting and implementing patient safety goals (“Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery”, etc.)

Studies indicate that some of the most common bases for oral surgery lawsuits include:

- Wisdom tooth extraction errors and injuries
- Implant errors and injuries
- Failure to diagnose and treat post-surgical infections
- Improper administration of anesthesia
- Wrongful tooth extractions

The application of some straightforward risk management strategies in conjunction with application of quality and patient safety principles can reduce the risk of complaints, claims, or even regulatory investigations. Effective communication skills deployed throughout the interaction with the patient, especially during the consent process, are a pre-requisite. An honest reflection by the practitioner on their competence to carry out a procedure, considering their skills, the equipment and support available, can result in fewer legal cases.

No one discipline alone has the capacity to address all of the requirements placed on health care providers today. By enhancing your awareness of the value of applying the concepts of quality care, compliance, and patient safety along with risk management tools and resources, all oral and maxillofacial surgeons will minimize their liability risk while, at the same time, provide quality care to their patients.



Classified



A
d
s

EQUIPMENT FOR SALE

RITTER SURGICAL TABLE, Model F-Type 75, \$1500.00. Call Doug Fortney at 858-485-1783 or cell at 858-254-8461 or doctorfortney@hotmail.com

iCAT CONE BEAM UNIT
Take over lease purchase plan for \$150,000. If interested, contact: 800-955-4765

DOCTORS SEEKING POSITIONS

EXPERIENCED, BOARD CERTIFIED OMS seeks work for 3 to 3 ½ days per week in quality office, group or institution. Currently Associate Prof. of OMS at major residency program. Might consider locum tenens for 6 mo+. Call 303-328-1863 or e-mail eos@cftinet.com. CV on request.

RETIRED ORAL SURGEON of 1 year is bored. Looking for part-time and/or vacation fill-in work. Central Southern California preferred, open for Northern California as well. Contact Greg Welsh @ (805) 680-4887

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

BELLFLOWER, OMS position available. Full scope, group OMS practice in Bellflower, CA is seeking a full time associate; future partnership potential. For more information email resume to: Carolyn@oralsurgerycenters.com

LOS ANGELES, Immediate opening in a busy, well-established Los Angeles-area OMS practice. Amazing opportunity for a hard-working and outgoing OMS to develop a successful career. We are seeking an associate who is passionate about their work and strives for excellence. Position will lead to partnership and/or practice buy-out. Please email jobopp@live.com with inquires.

How to place an ad the Compass. Email steve@calaoms.org requesting placement along with the copy of how you would like the Ad to read. *There is no cost involved for CALAOMS Members

BRADY & ASSOCIATES

Experienced, Reliable

Practice Sales

Associate Recruitment

Partnership Formation Services

Cedric T "Ric" Brady

Scott A Price

Phone 925-935-0890

Fax 925-935-0110

Sellers and Buyers Call for a Consultation

Over 100 OMS References Available

JOB OPPORTUNITIES/ PRACTICES FOR SALE

SAN FRANCISCO EAST BAY AREA Board Certified/Board Eligible Oral Surgeon sought by UC Davis affiliated public hospital system in Contra Costa County. Located 30 miles east of San Francisco, with excellent weather, and close to outstanding cultural, recreational and natural attractions. One hour to the Napa Valley wine country or beach. 2 ½ hours to skiing. Martinez sits on San Francisco Bay, at the gateway to the Sacramento River Delta, for superb boating and fishing. New hospital & surgical facilities serve needs of ethnically and culturally diverse population, who have an fascinating variety of clinical problems. Excellent compensation package includes health care, vacation & sick leave, disability insurance, paid CME and defined benefit pension. Half-time Position available immediately.

CENTRAL ORANGE COUNTY OMS practice for sale. Established wide-scope practice, including dentoalveolar, pre-prosthetic/implants, pathology, orthognathic, and trauma. Great location in the center of busy medical/dental corridor. Close to major hospital and 2 major freeways. 3 ops. Great referral base. Newly renovated 1,891sq. ft office. Seller returning to academics. Interested buyers please contact Jeff at 949-679-3470

SAN FRANCISCO BAY AREA, Prestigious Practice, Busy Commercial District, 7 Years of Excellent Marketing Techniques to Capture a Unique Patient Base (30% of Practice), Unlimited Dental Coverage, 14 Ops, Includes \$800K Equipment, 2009 Gross \$2.7 Mil with \$350K oral surgery business referred out, 80% Financing Available. 2010 Forecast \$2.6 mil. Asking \$1.95 Mil. Contact ProMed (888) 277-6633 info@promed-financial.com



The Compass is published three times a year in the Spring, Summer and Fall.

Upcoming 2011 CE Events

For Doctors

ACLS March 26, 2011	Solano
11th Annual Meeting May 20-22, 2011	Rancho Palos Verdes
Residents' Presentation September 21, 2011	Southern CA
Medical Emergencies November 9, 2011	Foster City
ACLS October/November 2011	Solano

For Staff

OMSA Spring April 30 - May 1, 2011	Garden Grove <i>Weekend Seminar</i>
OMSA Summer April 15, 2011 August 27 - 28, 2011	Sacramento <i>Start of Home Study</i> <i>Weekend Seminar</i>
OMSA Fall June 15, 2011 October 22-23, 2011	Southern CA <i>Start of Home Study</i> <i>Weekend Seminar</i>
Medical Emergencies November 9, 2011	Foster City
ACLS October/November 2011	Solano

THE OMSNIC ADVANTAGE

At OMSNIC, we are dedicated to meeting the professional liability insurance needs of members of the American Association of Oral and Maxillofacial Surgeons across the country. Owned and operated by oral surgeons, our specialized knowledge of the field helps to ensure the best possible return on the preferred stock investment made by each policyholder. As an OMSNIC policyholder, you have full access to all aspects of the OMSNIC Advantage:

- Comprehensive yet affordable professional liability coverage and other valuable products
- Aggressive defense tailored to the OMS specialty to protect your practice, your reputation and your future
- Risk Management to help you deliver a higher quality of care and reduce the potential for claims

Call us at 800-522-6670 or visit www.dds4dds.com



Exclusively
Endorsed By



OMSNIC
DEFENDING THE SPECIALTY

Consistently Rated "A"
(Excellent) by A.M. Best