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BHHS Panel Discusses Dangers of Drug Abuse

Pictured (from left): Colby Gilardian, Tiffany Davis, Dr. Alan Kaye, Aliza Grama, Jeffrey Newman, Jodi Barber, Doreen Kaye and Pam Congdon

Students in a Beverly Hills High School Medical Science Academy class were recently tasked with completing an independent project that offers significant benefits to the community. Senior Colby Gilardian, along with Dr. Alan Kaye, DDS worked together to create a panel of experienced individuals to share their stories of drug abuse to emphasize the risks of drugs.

The panel featured Kaye, who delivered an enlightening presentation on the effects of drug abuse; Jodi Barber, who shared the heartbreaking story of losing her son to drug abuse; Aliza Grama, a former addict who has triumphantly overcome her struggle with various substances; Pam Congdon, Executive Director of CALAOMS; Sergeant Jeffrey Newman from the Beverly Hills Police Department and Tiffany Davis, who discussed drug abuse in the talent industry.

Gilardian told the Courier that the event left many students in tears and had a profound effect, with many students expressing increased resolve to stay away from drug use.

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* Oral & Facial Surgeons of California
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EDITORIAL

by Jeffrey A. Elo, DDS, MS, FACS
Editor, CALAOMS

The Vital Role Of Oral And Maxillofacial Surgeons In Advocacy

In the realm of healthcare, oral and maxillofacial surgeons (OMSs) stand as pillars of expertise, wielding skills to alleviate pain, restore function, and transform lives. Yet, this impact extends far beyond the confines of the operating room or our offices, reaching into the very heart of communities where our compassionate care serves as a beacon of hope.

The specialty of oral and maxillofacial surgery is defined by precision, skill, and a deep commitment to patient well-being. From complex reconstructive procedures to more "routine" dental extractions, OMSs navigate a diverse array of challenges with unwavering determination and expertise. However, it is not merely technical proficiency that sets OMSs apart, but rather an innate capacity for empathy and compassion that truly distinguishes us as healers in the truest sense of the word.

Beyond clinical responsibilities, OMSs possess a unique opportunity to make tangible differences in our communities. Whether through volunteering at local health clinics, participating in outreach programs (e.g., California CareForce), or providing pro bono services to those in need, OMSs have the power to effect positive change on a grassroots level. By leveraging these skills and resources for good, OMSs embody the spirit of altruism and service that lies at the core of the profession.

As champions of safer patient care, OMSs possess a wealth of expertise and insight that extends far beyond the walls of our clinics. In an era defined by shifting healthcare landscapes, OMSs have stepped into new roles as advocates for safer outcomes in dentistry, particularly regarding the safe delivery of anesthesia in dental offices.

At its core, advocacy is about more than just raising awareness to local, state, and federal lawmakers about what we do daily in our practices—it's about effecting meaningful change and championing policies and initiatives that prioritize the well-being of patients and our members. As trusted leaders within the healthcare sphere, OMSs are uniquely positioned to lend our expertise to a range of critical issues, from improving access to care to advocating for patient-centered approaches to treatment and advancing research and innovation in the field, not to mention trying to improve dental insurance.

OMSs have a critical role to play in shaping the future of healthcare delivery and ensuring that the needs of patients remain at the forefront of decision-making processes. In the intricate tapestry of healthcare, OMSs are the skilled artisans weaving together precision, compassion, and expertise to transform lives. Yet, beyond the operating room, a realm of immense opportunity awaits—one where our voices can resonate as powerful agents of change. Through advocacy, OMSs can amplify the voices of our patients and our members, advocate for policies that protect patients' rights and dignity, and forge a deeper connection with the communities we serve.

CALAOMS 2024 Annual Meeting Recognizes Members For Their Contributions To The State And The Specialty

At the 2024 Annual Meeting held in Long Beach on May 4-5, residents from all five southern California OMS programs presented on anesthesia-related topics. Featured speaker Dr. Jeffrey Poage served as the moderator for Sunday's resident presentations. Several CALAOMS members were recognized for their tremendous contributions and lifelong service to the organization and specialty of oral and maxillofacial surgery.

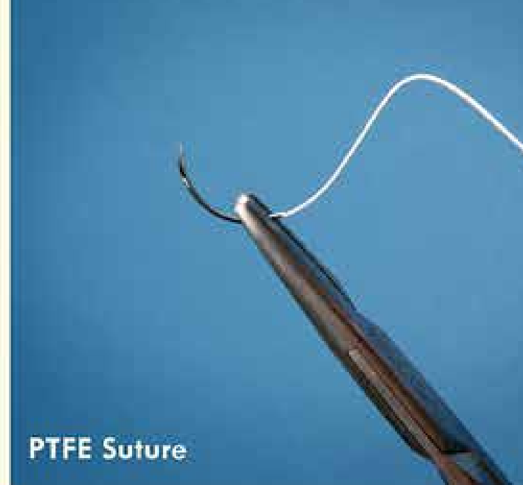
Left to right: Loma Linda University Department of Oral and Maxillofacial Surgery faculty members Dr. Samuel Young, Dr. Alan S. Herford, and Dr. Chi T. Viet. Dr. Herford was the recipient of CALAOMS's 2024 Distinguished Service Award.

Dr. Peter Scheer was awarded CALAOMS's Committee Member of the Year; however, he was unable to attend the Annual Meeting. In his absence, Dr. Scheer's staff member, Mr. Martin Flavely, accepted the award on his behalf.

Harbor-UCLA Medical Center Department of Oral and Maxillofacial Surgery (left to right): Drs. Fadi Farsakh, Alexandria Sawyer, Thomas Lecheminant, Jared Johnson, Allen Chu, Alan Cho, Eric Crum, Samuel Lui, Sirish Makan, Felix Yip, Jettie Uyanne.

Residents from the five southern California OMS residency programs presented at the Annual Meeting in Long Beach on May. 5, 2024. Left to right: Dr. Steven Zbarsky (Loma Linda University), Dr. Svetlin Penchev (Navy Medical Center), Dr. Grant Nishimura (UCLA), Dr. Simon Youn (USC), Dr. Alan Cho (Harbor/UCLA), and Dr. Jeffrey Poage (Moderator).

Left to right: Paul Tollett, President of Goldenvoice; CALAOMS Executive Director Pamela Congdon; Skip Paige; and CALAOMS President Dr. Ash Veeranki. Mr. Tollett and Mr. Paige were honored as the CALAOMS Annual Meeting Dedication Award recipients in Long Beach on May 4, 2024. Paul, Skip, and Mr. Jerry Moss (co-founder of A & M Records with Herb Albert) have generously supported California CareForce clinics in the Coachella Valley and have donated funds and resources to provide 10 clinics in this community. Sadly, Mr. Moss passed away last summer. CALAOMS and California CareForce are grateful for their dedication to helping the under- and uninsured.



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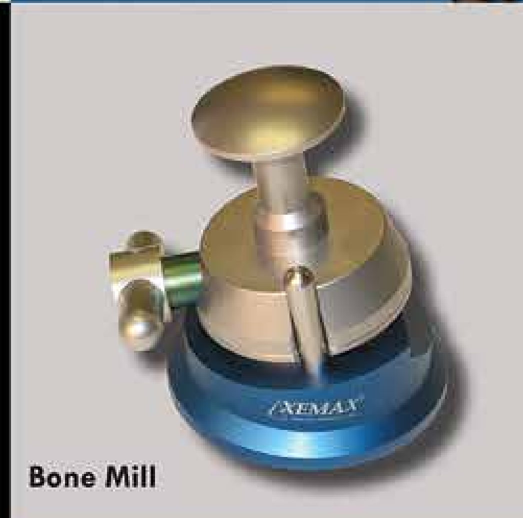

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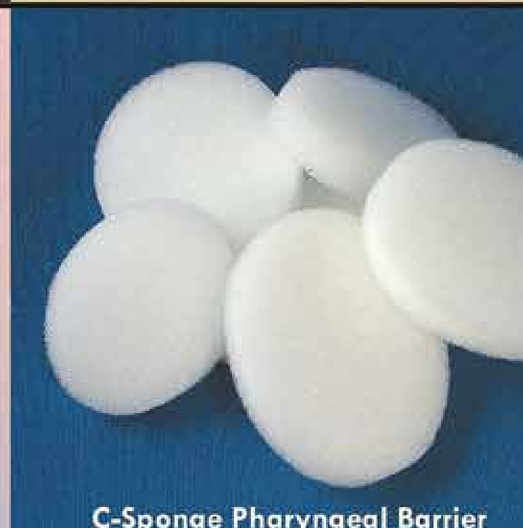

PRESIDENT'S MESSAGE

Ashok N. Veeranki, DDS
CALAOMS President

It is my honor and privilege to serve you as president of CALAOMS for the year 2024. CALAOMS consists of 710 members and is the 2nd largest oral and maxillofacial surgery organization in the U.S. after AAOMS. We should all take pride in being members of this organization.

Volunteerism

The intelligent way to be selfish is to work for the welfare of others. - Dalai Lama

It is an interesting quote by Dalai Lama. When you think about it, it makes sense. Small selfless acts lead to immense change in many lives, which, in turn, transform your own life. I would encourage our membership to embrace this and consider looking for opportunities to volunteer. I am quite certain that most of you are involved in one way or another in your local communities or professional societies, but I would like to highlight a couple of other opportunities for you to consider.

CALAOMS committees. CALAOMS is only as strong as its volunteers and active committees. Most of the day-to-day action of our association happens at the committee level. A few of our most active committees are:

1. Continuing Education Committee: This is CALAOMS's largest committee and is mainly involved with planning the continuing education (CE) events based on the current needs of the membership. Typically, the committee is working on events 2 years ahead. The committee also is tasked with overseeing the California-based OMS programs' Resident Presentations.
2. Exhibits Committee: This committee is responsible for gathering the sponsors and exhibitors for the CE events.
3. OMSA Committee: This committee is tasked with keeping the content current for the oral and maxillofacial surgery assistants (OMSA) course.
4. Legislative Committee: This committee works closely with CALAOMS Legislative Advocate, Mr. Gary Cooper, to advocate for issues of importance to California state legislators.
5. Publication Committee: This committee works to produce two issues of The California Journal of Oral and Maxillofacial Surgery each year.
6. Ethics Committee: This committee reviews any complaints regarding incidences of unethical or unprofessional conduct of our members. This committee also is tasked to review applications from prospective CALAOMS members.
7. Peer Review Committee: Similar to the Ethics Committee, this committee is tasked with reviewing applications from prospective CALAOMS members.
8. Retention and Leadership Development Committee: This committee works on different methods and strategies to retain and encourage membership in CALAOMS.

These are just some of the examples of the great work done by CALAOMS' OMS volunteers to further our specialty and organization. If anyone is interested in learning more about any committee or possibly volunteering to join one, I highly encourage you to contact Mrs. Pam Congdon, CAE, CALAOMS' Executive Director. We will do our best to assign interested members to an appropriate committee. I cannot stress enough the importance of getting involved.

California CareForce (CCF): CCF is the charitable arm of CALAOMS which promotes the health and well-being of those in need through volunteer-supported, no-cost healthcare clinics throughout California. I request your consideration to either donate to CCF on an annual basis or volunteer at one of CCF's several great clinics. The experience is tremendous and invaluable. CCF hosts medical, dental, and optometry

clinics at no cost to those in need. This helps take care of those who cannot afford quality healthcare.

2024 Annual Meeting

CALAOMS held its Annual Meeting on May 4th and 5th. The meeting was well attended in Long Beach, and attendees benefitted from learning about new drugs concerning our practice of outpatient anesthesia. The meeting was dedicated to Goldenvoice and Mr. Jerry Moss for their generous contributions to California CareForce over the years. I extend my deepest gratitude to Drs. Vivian Jui and Nima Massoomi and the entire CE Committee for all of their great efforts.

I encourage you all to consider attending the future meetings organized by CALAOMS not only to fulfill your CE requirements, but also to enjoy the camaraderie of fellow colleagues.

Teri Travis celebrates 20 years of dedicated service with CALAOMS

Ms. Teri Travis was honored for her 20 years of service with CALAOMS. Teri, along with Mrs. Pam Congdon and Mr. Steve Krantzman. comprise the backbone of CALAOMS - helping run the administrative duties efficiently. Teri's comment, "I would say, 'Here's to 20 more;' however, I don't think you want me waddling around at the meetings in my 80s." Teri, we would gladly take 20 more years!

CALAOMS' Continuing Education Coordinator Teri Travis is recognized for 20 years of service with the association. Teri is pictured here on the right with CALAOMS' Executive Director Pamela Congdon on the left.

Legislative Activity

2024 has been a busy year with trying to pass the dental loss ratio bill and defending our specialty. CALAOMS has been busily working on several legislative bills as highlighted by the Legislative Update from our Legislative Advocate, Mr. Gary Cooper. I want to thank CALAOMS' Legislative Committee chair, Dr. Jeff Elo; our lobbyist, Mr. Gary Cooper; and CALAOMS' Governmental Affairs Council chair, Dr. George Maranon, for volunteering countless hours of their evenings and weekends strategizing on managing the many legislative bills and issues.

I would like to end my message by asking the membership to reflect on Dalai Lama's message and be more involved and volunteer time with CALAOMS.

LEGISLATIVE UPDATE

by Gary Cooper
Legislative Advocate, CALAOMS

Spring 2024 Legislative Report

The first five months of year two of the 2023/24 legislative session have not been uneventful for CALAOMS. Since January, CALAOMS has been very involved in the legislative process. Traditionally, CALAOMS plays both a proactive and reactive role with regard to legislation affecting the profession. This year has been no exception.

As has been discussed previously, the issue of Medical Loss Ratio (MLR) for dental plans has been very important to CALAOMS. MLR is the percentage of the patient premium that is actually spent on direct patient care as opposed to administrative expenses and salaries. In 2010, the federal Affordable Care Act ("Obamacare") mandated that health insurance plans meet an MLR of 85% for large plans and 80% for smaller plans. If those numbers were not met, rebates would be issued to consumers of the plans. Dental plans were not included in the ACA legislation.

In California, legislation was passed in 2014 that mandated that dental plans make their MLR numbers public. Data from the last 9 years show that the MLR percentages for the dental plans range from the 80s to some as low in the 20s. In 2022, Massachusetts introduced a ballot initiative that would require dental plans to meet an 83% MLR. The initiative was heavily supported by dental groups, including the California Dental Association (CDA) as well as organized labor groups. The measure passed 72%-28%. Subsequently, other states introduced legislation that required plans to report their annual MLR percentages. Since California currently has that mandate in place, CALAOMS is committed to moving legislation similar to the Massachusetts initiative.

In February, with the strong backing of organized labor and many dental organizations, CALAOMS co-sponsored AB 2028 (Ortega) that would require dental plans to meet an 85% or provide rebates to consumers. Currently, because of the lack of support from CDA, AB 2028 is stalled in the legislative process. However, while the bill may be stalled, the dental MLR issue remains a valid and concerning issue. CALAOMS is committed to continuing to move the issue forward. CALAOMS asks members to voice support for the issue when asked.

CALAOMS was actively involved in the opposition of AB 2526 (Gipson). This measure is sponsored by the organization representing CRNAs. While CALAOMS certainly supports the existence and abilities of CRNAs, this bill, as it continued to evolve, runs counter to the team anesthesia model supported and utilized by OMSs throughout the country. The bill proposes to allow California CRNAs to obtain a General Anesthesia permit from the Dental Board of California (DBC) and to administer GA to a patient whether or not the providing dentist is trained in anesthesia. The most recent proposed version also makes office and equipment inspections by the Dental Board discretionary. These two provisions alone have garnered opposition from not only *CALAOMS,* but from the *California Society of Anesthesiologist*s, *California Society of Dental Anesthesiologists*, and the *American Academy of Pediatrics.* AB 2526 passed the Assembly Business and Professions Committee and was sent to the Assembly Appropriations Committee. Unfortunately, the sponsors of the bill continued to weaken safety provisions in order to lower costs. CALAOMS continued to oppose AB 2526**.** On May 15, 2024, the Dental Board of California proposed taking a "Support If Amended" position on AB 2526. However, after a strong lobbying effort by CALAOMS and others, the DBC voted 10-0 to OPPOSE AB 2526. Subsequent to that vote, AB 2526 was held in the Assembly Appropriations Committee, essentially killing the bill for 2024.

SB 980 (Wahab, et al) takes on the very ambitious goal of having Medi-Cal provide coverage for dental implants for patients of all ages as well as expanding coverage for laboratory-processed crowns to patients 13 years of age and older. Senator Wahab has reached out to CALAOMS for assistance

in making this bill workable and a meaningful piece of legislation. As difficult as that task may be, CALAOMS leadership has committed to working with Senator Wahab. The bill passed the full Senate floor unanimously and is currently in the Assembly Health Committee. It is our intent to continue working with the author of SB 980 throughout the process.

Finally, 2024 is the year that the Dental Board of California undergoes its periodic Sunset Review process in the legislature. This process happens every four or five years. It gives the legislature the opportunity to review the many licensing boards. Various issues are brought forth to the Business and Professions Committees of both the Senate and the Assembly. Senate Bill 1453 (Ashby) is this year's Sunset bill. CALAOMS is working very closely with both houses of the legislature and the Dental Board of California to ensure that the final provisions of the bill will have a positive impact on the members of CALAOMS as well as their patients.

Please continue to follow all the legislative activities as the 2023/24 session moves toward a conclusion in September 2024

CALAOMS Well Represented at ABOMS 2024

CALAOMS was well represented at ABOMS as nine of our members participated as board examiners for the Oral Certifying Examination of the American Board of Oral and Maxillofacial Surgery in Raleigh, North Carolina, February 5-9, 2024.

Front row, left to right: Alan S. Herford; Chan M. Park; Richard M. Berger; Ashok N. Veeranki; Wayne H. Ozaki
Back row, left to right: Robert S. Julian, III; John M. Allen; Jeffrey A. Elo; David R. Cummings

OMS PAPERS

by Peter A. Krakowiak, DMD, FRCD(C), FACD

OnabotulinumtoxinA (BOTOX®) Application in TMD Care – Something New For The Daily Grind

Despite advances in the non-surgical therapeutics and increased post-graduate education of general dentists, temporomandibular disorder (TMD) patients are still frequently delegated to the oral and maxillofacial surgery (OMS) specialist for management despite being largely non-surgical care cases. Approximately 12 years ago, I had a chance to outline some typical appliance-based methods to treat TMD patients in this Journal's predecessor, The Compass.

Since that time, there have not been any appreciable developments in the design of these devices, and appliance-based treatments remain the staple of diagnosing and treating TMD patients. I concluded my previous article with references to the emerging pharmacological management options for treatment of the TMD spectrum. NSAIDs, acetaminophen, opioid analgesics, corticosteroids, opioid-like analgesics including tapentadol (Nucynta®) and tramadol, benzodiazepines, anticonvulsants such as gabapentin, and antidepressants are proven contemporary methods of managing pain in TMD-related myofascial pain.

In the last few years, some evidence has emerged showing the potential reduction of pain presentation in TMD patients who utilize tetrahydrocannabinol (THC), a cannabinoid derivative. This newer therapeutic agent has not been widely studied and carries concerns of side effects that are increasingly emerging as with many other psychotropic agents.

I also referenced the potential consideration for the use of neurotoxins (botulinum toxin type A) as an emerging therapy. In the past decade, the use of the paralytic agent onabotulinumtoxinA injection (BOTOX®) has proven its efficacy and offers clear therapeutic benefits in management of muscular hyper-spasticity-related conditions such as myalgia and atypical myofascial pain as well as chronic migraines. BOTOX® can also be used to treat tardive dyskinesia spectrum disorders, particularly orofacial dystonia.

OnabotulinumtoxinA is produced by the bacterium Clostridium botulinum. The toxin is well known for its part in developing a life-threatening food poisoning condition called botulism (*Figure 1*.)

The majority of clinical BOTOX® applications are utilized in cosmetic procedures which treat the aging appearance of skin. Also, the toxin has been successfully used in management of hyperhidrosis, cervical dystonia, bladder hyperspasticity, blepharospasms, and strabismus. Recently, the application of BOTOX® has been advocated more in the literature as it pertains to myofascial pain and fibromyalgia-related conditions (*Figure 2*.)

BOTOX® should be administered within 24 hours after reconstitution. During this time period, unused reconstructed BOTOX® must sit in a refrigerator at +2°C to +8°C. BOTOX® vials are for single-use only. One should discard any unused portion. Botulin toxin inhibits muscle contractions by halting the release of acetylcholine (Ach) from presynaptic vesicles. Protracted lack of Ach migration from the motor end plate across the synapse causes muscular paralysis for up to six months. The toxins target several proteins which are responsible for the ability of Ach-containing vesicles to fuse and exocytose its content affecting electrical impulse transfer across the motor synapse. These degraded proteins include SNAP-25 (synaptosomal-associated protein of 25 kDa), Syntaxin, and VAMP (vesicle-associated membrane protein), and it takes between 4 to 6 months for the human body to resynthesize their stores to levels which allow for return of the motor function. The paralysis of muscle activity is one of the main mechanisms of BOTOX® treatment; secondary effects on pain perception have also been outlined which are attributed to modulation of release of substance P and heat-related noxious stimulant - transient receptor potential vanilloid receptor type 1, as well as calcitonin-related peptide localized in the C sensory fibers.

The reconstituted proteins of BOTOX® are typically injected transcutaneously or transmucosally, and ideally are deposited into muscle tissues hoping to target the motor end plates. In cases where small muscle structures are being targeted, use of electromyography is beneficial to achieve best results and reduce the risk of ectopic deposition of this potent and quite expensive substance.

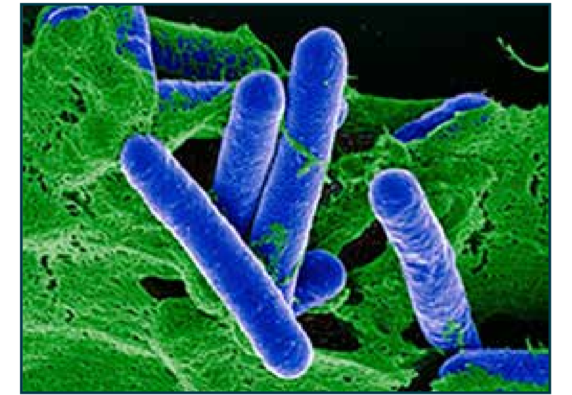

Fig 1. OnabotulinumtoxinA (BOTOX®) is produced by the bacterium Clostridium botulinum.

Local side effects are directly associated with the percutaneous injections and consist of transient pain, hematoma formation, and edema at the injection site; and these can typically last for a few days. On the other hand, systemic adverse events are related to spread of the toxin to locations distant from the site of injection. These can produce serious conditions such as a botulism-like syndrome which is characterized by dysphagia, general weakness, and symptoms that can resemble botulism.

There are specific maximum doses that have been suggested by the manufacturer which limit the total dosages to 400 units in a 3-month period. Higher doses above 600 units have been studied, but there does not appear to be a consensus about any benefits of exceeding the recommended dosages.

Fig 2. BOTOX® Cosmetic neurotoxin from Allergan comes in 50-, 100-, or 200-unit dosages.

OnabotulinumtoxinA intramuscular (IM) dosing for chronic migraine prophylaxis in patients who suffer more than 15 days of episodes lasting more than 4 hours is site dependent. The recommended total dose is 155 units, as 0.1 mL (5 units) IM injections per site divided across seven head and neck muscles every 12 weeks.

- Frontalis: 20 units divided in 4 sites.
- Corrugator: 10 units divided in 2 sites.
- Procerus: 5 units in 1 site.
- Occipitalis: 30 units divided in 6 sites.
- Temporalis: 40 units divided in 8 sites.
- Trapezius: 30 units divided in 6 sites.
- Cervical paraspinal muscle group: 20 units divided in 4 sites.

(*Figure 3 and 4*)

Fig 3. Frontalis, procerus, corrugator, and temporalis injection sites for treatment of migraines.

OnabotulinumtoxinA injection dosages for non-splint-responsive bruxism, myalgia, and hyper-spasticity into the lower and middle third of the masseter is 50 units per side, and 50 units are injected into the mid-temporalis as well. The total dosage of injected medication for the treatment of myofascial pain and masticatory myospasms is 200 units total (*Figure 5*.)

Patients who suffer with tardive dyskinesia may require standard masseter and temporalis injection as well as, ideally, electromyography (EMG)-guided medial pterygoid injections with 20 units per side. Extraoral and intraoral approaches are possible. A 1.5-inch needle is placed medial to the ramus, lateral to the pterygomandibular raphe. Alternatively, an inferiorly-based transcutaneous approach at the antegonial notch with lateral angulation of the delivery needle can be utilized to deliver the agent to the medial pterygoid muscle close to its insertion into the mandibular sling (*Figure 6*.)

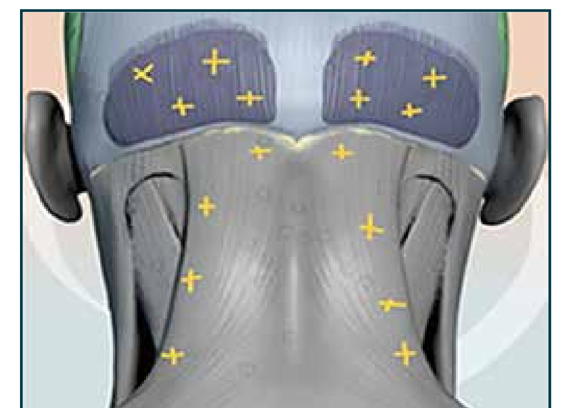

Fig 4. Cervical and occipitalis injection sites for myofascial pain and occipital neuralgia.

Lateral pterygoid injections have also been described with either a transoral retro-tuberosity-toward-the-lateral-pterygoid-plate vector or a percutaneous

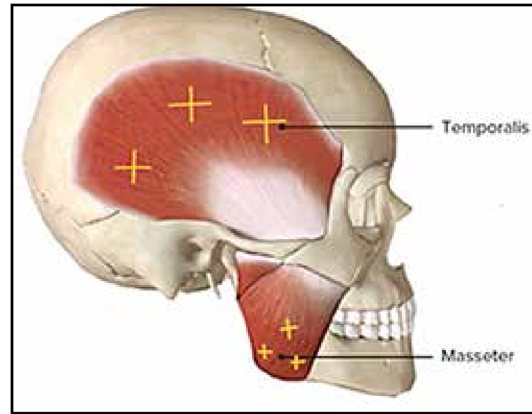

Fig 5. Standard areas of BOTOX® treatment for bruxism in masticatory hyperfunction and TMD care.

Fig 6. Patient with severe right masseter hypertrophy before BOTOX® injections (top) and 3 months post-BOTOX® injections (bottom).

injection via the sigmoid notch recess with anterior inclination of the needle just below the articular eminence. These techniques are usually best combined with EMG and 15-20 units can be deposited per site. Patients with trigeminal neuralgia, atypical facial pain, and neuropathic pain may also benefit from BOTOX® injections of 5 units to the trigger points or 5 units per centimeter of the dermatome affected by the neuropathic pain.

Two additional conditions for the OMS use of BOTOX® are in treating patients with post-trauma/parotidectomy cases of parotid fistula and Frey's syndrome (i.e., gustatory sweating, auriculotemporal syndrome). Dosages for these conditions vary with 5-30 units injected per site. The mechanism of action is down modulation of acetylcholine activity on secretory glands of the skin and parotid gland.

BOTOX® use for treatment of TMD muscle parafunction is not an FDA-approved therapeutic method, but it clearly delivers relief to many patients who have failed other conservative treatments of myofascial pain and parafunction of the masticatory apparatus. It is important to let patients know that the medication is FDA-approved for facial cosmetic purposes, blepharospasms, and migraines; but its use specifically for myofascial pain, occipital neuralgia, and parafunction is currently off-label. Also, extra care must be taken of authenticity, as there are emerging reports of sales of counterfeit BOTOX®; and in April 2024, the FDA issued a public warning to patients and providers to be on the lookout for these potentially harmful knock-off substances.

The care of the TMD patient is multifaceted and often requires many strategies to provide relief through collaborative treatment. This may involve dental, medical, psychiatric, as well as physiotherapy principles. Understanding the potential therapy components that are available to the providers of this complex care will allow us better case management and improved patient outcomes. BOTOX® myofascial injection is just one of these components, but for a limited subset of TMD and migraine/neuralgia patients, it offers real relief and carries a relatively high therapeutic index. It is hoped that full FDA approval will arrive soon for BOTOX®-based TMD care with further research and clinical off-label applications that we provide in our daily OMS practices. As maxillofacial surgeons, we are in the best position to deliver this beneficial minimally-invasive care and support our dental and medical colleagues who look for additional options beyond splint and pharmacological care for these complex patients.

by Solomon Poyourow, DDS, MD, MPH

Current Treatment Options for MRONJ

The problem of medication related osteonecrosis of the jaws (MRONJ) continues to be an issue in the practice of oral and maxillofacial surgery despite its identification 20 years ago, and even longer if we consider phossy jaw (phosphate associated osteonecrosis of the jaw) that occurred with the occupational exposure of 'strike anywhere' matchmakers from 1858-1906.

MRONJ is often a minor problem addressed with antibiotics, chlorhexidine rinses, and sequestrectomy. The incidence of MRONJ in patients being treated for osteoporosis is very low – a fraction of one percent according to published literature. Additionally, MRONJ in osteoporosis patients is more responsive to treatment and less likely to recur after surgical intervention. On the other hand, patients undergoing treatment for multiple myeloma or bone metastases have a much higher incidence of MRONJ, with some studies suggesting an incidence of 5-20%. These patients are generally much sicker and may be malnourished and immunocompromised, which significantly impairs their ability to heal.

These unfortunate individuals being treated for hypercalcemia of malignancy may not have the option of stopping antiresorptive treatment. These cases can be challenging and may require the surgeon to 'throw the kitchen sink' at the issue. The purpose of this article is to explore the current treatment options when faced with a challenging case of MRONJ.

As a brief summary, MRONJ is defined as exposed bone in the mouth for longer than 8 weeks in a patient with a history of antiresorptive drug therapy. Medications implicated in this condition consist of:

- *Bisphosphonates*: alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), pamidronate (Aredia®), zoledronic acid (Zometa®, Reclast®), etidronate (Didronel®), clodronate (Bonefos®), tiludronate (Skelid®)
- *Monoclonal antibodies*: romosozumab (Evenity®), denosumab (Prolia®, Xgeva®)
- *Synthetic parathyroid hormone*: teriparatide (Forteo®), abaloparatide (Tymlos®)
- *Antiangiogenic medications*: bevacizumab (Avastin®), aflibercept, sunitinib, temsirolimus, everolimus

Bisphosphonates were the most commonly associated drugs implicated in MRONJ, giving rise to the original acronym for the condition - BRONJ. Bisphosphonates are divided into nitrogen- or non-nitrogen containing. Nitrogen-containing bisphosphonates include alendronate, risedronate, ibandronate, pamidronate, and zoledronic acid. Non-nitrogen-containing bisphosphonates include etidronate, clodronate, and tiludronate.

Bisphosphonates work by attaching preferentially to actively resorbing hydroxyapatite, impairing osteoclast resorption. The nitrogen bisphosphonates inhibit farnesyl transferase, which affects osteoclasts' attachment to bone. The osteoclast fails to attach to bone and cannot initiate resorption. Non-nitrogen bisphosphonates work by altering adenosine triphosphate (ATP) within the osteoclast, causing apoptosis. Nitrogen bisphosphonates are more potent. Non-nitrogen bisphosphonates can cause osteomalacia, and for this reason are not broadly used anymore.

While oral bisphosphonates are still used, I see far more patients treated with Zometa® or Prolia®. When given for osteoporosis, Zometa® is dosed once a year and Prolia® every 6 months. When given to control malignant bone lesions, they are given monthly and at higher doses. Zometa® and other bisphosphonates are problematic, in part, because of their long half-lives. Prolia® has a half-life of 28 days. This allows for more careful timing of surgery depending on the individual surgeon's protocol. My protocol aims to wait 3 months after the last Prolia® injection before proceeding with surgery. This allows for the next injection to occur 3 months after the surgery.

My experience has been that patients treated for osteoporosis who develop MRONJ have eventually healed, with some taking over a year to do so. However, I have been referred patients with multiple myeloma or bone metastases who underwent an extraction and developed MRONJ. Their clinical course takes a different path.

Before exploring the treatment options, it is helpful to briefly review the stages of MRONJ:

- **Stage 0:** No visible (exposed) bone but nonspecific symptoms. Common treatment includes symptomatic treatment and conservative management of underlying dental issues.
- **Stage 1**: Exposed, necrotic bone without symptoms. Common treatment includes antimicrobial rinses (if infection is not present), and debridement/sequestrectomy.
- **Stage 2**: Exposed, necrotic bone confined to the alveolus with local signs or symptoms of infection. Standard treatment includes symptomatic treatment, antimicrobial rinses, systemic antibiotics, and debridement/sequestrectomy.
- **Stage 3**: Exposed, necrotic bone with pain and infection beyond the alveolar bone; pathologic fracture, extraoral fistula, and extensive osteolysis. Standard treatment includes symptomatic treatment, systemic antibiotics, and surgical resection of the necrotic bone.

Let us now explore the various treatment options. A Cochrane review from 2017 on MRONJ treatment examined the evidence for platelet rich growth factors (PRF), hyperbaric oxygen (HBO), and fluorescence-guided sequestrectomy. While not statistically significant, there was a trend supporting the use of PRF during extractions in patients on antiresorptive medications. The randomized controlled trial (RCT) was comprised of a treatment group of 91 patients and control of 85. All patients were given Zometa® for metastatic cancer. There were no cases of MRONJ in the PRF group, and 5 cases in the control group. The relative risk (RR) was 0.08 but was not significant with a confidence interval (CI) of 0.00-1.51. However, being such a simple and cost-effective treatment, there is minimal downside to utilizing PRF in at-risk patients.

In the same Cochrane review, HBO was evaluated with an RCT with 49 participants, but only 18 remained at the end of the 2-year follow-up period. The RR was 1.56 with a CI of 0.77-3.18, failing to indicate a benefit. However, a more recent meta-analysis demonstrated that HBO decreases pain and reduces the size of exposed bone lesions. HBO is expensive, and insurance authorization remains up to the whim of medical insurance companies. There is very little downside and, therefore, if available as an adjunctive treatment, it appears worthwhile.

Initially, treatment of BRONJ and MRONJ was aimed at conservative, limited surgical intervention. However, there are several studies that support the use of resection. I recall in residency that BRONJ patients were often treated with Peridex® rinses and watchful waiting, allowing spontaneous sequestrectomy. This may be reasonable for cases arising from oral bisphosphonates, but more aggressive disease may call for a more involved surgery.

In 2014, Dr. Eric Carlson wrote on the advantages of marginal or segmental resection to obtain a cure. He discouraged limited debridement for cases of osteonecrosis. His arguments are persuasive. In his experience, resection was associated with a 90-100% success rate, whereas debridement was associated with 48-55% success rate. Dr. Carlson furthermore pointed out the bias that exists in the literature against resection and suggested avoidance of the term 'management' and instead use of 'palliation' when referring to a debridement. He suggested the term 'cure' be used when describing the goal of surgical resection. His ideas remain controversial as the literature is mixed and there appears to be no clear standard of care regarding extent of surgery.

The last treatment I would like to cover is one which I employ regularly. It is pentoxifylline and tocopherol (vitamin E), also known as PENTO protocol. I must credit Dr. Eric Sung of UCLA's Hospital Dentistry department with educating me on this protocol. PENTO is effective as a prophylaxis for MRONJ as well as in the resolution of active lesions. Pentoxifylline (PTX) is a drug that was developed to treat peripheral artery disease and fibrosis. It does this by increasing red blood cell flexibility and decreasing blood viscosity, thereby improving blood flow. Tocopherol (vitamin E) is an antioxidant that decreases fibrosis and inflammation.

PENTO protocol has proven effective in treatment of osteoradionecrosis as well as MRONJ. Typical doses of pentoxifylline are 400 mg twice a day (bid) to three times a day (tid). Tocopherol is dosed as 800 (international) units daily. One recent study examined the effect of PENTO in conjunction with marginal resection of exposed bone in MRONJ patients. The results showed no patients in the PENTO treatment group developed refractory MRONJ, thereby resulting in a cure. However, in the control group which just received sequestrectomy or resection, there was a 71% recurrence rate. PENTO is well tolerated with few side effects. It is important to have a baseline creatinine when starting pentoxifylline, but no other monitoring is required. PENTO is an inexpensive, easily accessible adjunctive therapy that increases the success of surgery and decreases recurrence.

It is interesting that all the aforementioned treatments for MRONJ have been used for over 15 years, but yet there remains no consensus on treatment recommendations nor a standard of care. It will be interesting to see how this disease evolves as new drugs are developed and placed into use. Based on history, it appears drug-related osteonecrosis may emerge in new but familiar forms in the future.

by Mahr Elder, DDS, MD

GLP-1 Agonists and Perioperative Management

The world has been dreaming of a magical weight loss pill for centuries and it has finally arrived. This new class of type 2 diabetes medication not only improves blood sugar control but also helps patients lose weight. Glucagon-like peptide-1 (GLP-1) receptor agonists are a class of medications that mimic the action of the GLP-1 hormone which stimulates insulin release from the pancreas in response to food intake. By increasing insulin secretion, decreasing glucagon production, and slowing down the emptying of the stomach, GLP-1 agonists help regulate blood glucose levels and help manage diabetes.[1] Some of these medications are resulting in approximately 30% body weight loss.

GLP-1 agonists have taken the country and the world by storm and have dominated the news. There are also major economic ramifications in a world where people are eating less snacks and fast food. An entire weight loss industry exists to help people lose weight using tools and methods other than GLP-1 meds; an approach that has needed to evolve by incorporating medical programs or one that risks quickly going extinct. The total U.S. weight loss market is estimated to have grown to a historic peak of $90 billion in 2023, boosted by soaring GLP-1 agonist sales. There is a major shift toward medical programs, and a major challenge for competing commercial diet companies which lost $1 billion in revenues since 2022. All non-medical segments of the market have felt the pain of declining sales. Revenues of the major commercial weight loss chains (e.g., Weight Watchers, Nutrisystem, Jenny Craig, etc.) fell 25% from 2021 to 2023. They are scrambling to add medical programs to survive.[2] In the last 6 months, Weight Watchers has lost 80% of its stock price. The global market for anti-obesity medications reached $6 billion in 2023. By 2030, it could grow by more than 16 times to $100 billion.

Obesity has almost tripled around the world since 1975 and is the fifth leading risk factor for cause of death. Over half of the global population will be overweight or obese by 2035, compared to 38% in 2020.[3] Today, GLP-1 agonists are used by 10-12% of type 2 diabetic patients in the United States. This is expected to increase to 35% of diabetic patients by 2030. In addition, approximately 15 million obese patients will be taking GLP-1 agonists by the end of the decade. Overall, total GPL-1 agonist users in the United States may number 30 million by 2030 (or 9% of the population).[4] GLP-1 agonists are quickly becoming one of the most popular medications used by our patients. We are presented with the concern: *Do oral and maxillofacial surgeons need to modify their approach to anesthesia or surgery when patients are taking GLP-1 agonist medications?*

Gastrointestinal peptide (GIP) and glucagon-like peptides (GLP-1, GLP-2) are two incretins – gut hormones – that are released upon the ingestion of food in a biphasic manner to overcome postprandial hyperglycemia by increasing insulin secretion from beta cells and reducing glucose excursion and glucagon secretion. The incretin hormones also decrease gastric motility, inhibit beta cell apoptosis, and induce their proliferation.[5] Glucagon-like peptide-1 is an amino acid peptide hormone mainly secreted by three tissues in the human body: enteroendocrine L cells in the distal intestine, alpha cells in the pancreas, and the central nervous system. The primary mechanism of action for these medications consists of binding to the GLP-1 receptor. GLP-1 is a glucose hemostasis regulator that is released after the oral ingestion of carbohydrates or fats. GLP-1 enhances insulin secretion; it increases glucose-dependent insulin synthesis and in vivo secretion of insulin from pancreatic beta cells in the presence of elevated glucose. GLP-1 suppresses glucagon secretion, slows gastric emptying, reduces food intake, and promotes beta cell proliferation.[6]

GLP-1 has been shown to carry out numerous protective and regulatory functions in different organ systems and to have anti-inflammatory effects in multiple organ systems. GLP-1 medications will be used for non-diabetes or weight-related conditions in the future. The hormone affects the liver, pancreas, brain, fat cells, heart, and gastrointestinal tract. It has been used to treat depression, psoriasis, Alzheimer's, Parkinsons's, non-alcoholic fatty liver disease, and alcohol abuse.[7] GLP-1 receptors are also expressed in cardiomyocytes and vascular endothelial cells. GLP-1 receptor agonists promote myocardial glucose uptake and utilization, reduce oxidative stress, and inhibit cardiomyocyte apoptosis. These mechanisms collectively have cardioprotective effects on heart function and prevention of adverse cardiac remodeling.[8]

Current GLP-Receptor Agonists				
Name of Medication	**Indication**	**Dose**	**Route**	**Half-life**
Dulaglutide (Trulicity®)	Type 2 diabetes	1 mg once weekly	SC	5 days
Liraglutide (Victoza®, Saxenda®)	Type 2 diabetes	1 mg once daily	SC	12 hours
Exenatide, Immediate Release (Byetta®)	Type 2 diabetes, weight loss	10 µg twice daily	SC	2 hours
Exenatide, Extended Release (Bydureon®)	Type 2 diabetes	2 mg once weekly	SC	10 days
Semaglutide (Ozempic®, Wegovy®)	Type 2 diabetes, weight loss	0.5 mg once weekly	SC	7 days
Semaglutide (Rybelsus®)	Type 2 diabetes, weight loss	10 mg once daily	PO	7 days

Potential Anesthetic Risks

How can we safely manage our general anesthesia patients in the oral and maxillofacial surgery setting?

What potential challenges or risks do GLP-1 agonist medications present?

A concerning risk that GLP-1 agonist medications present is regurgitation and pulmonary aspiration during sedation or general anesthesia. GLP-1 medications delay gastric emptying and can increase the residual gastric volume even if preoperative fasting recommendations are followed. Patients who were prescribed GLP-1 medications had a 33% higher chance of experiencing aspiration pneumonia than those who did not take these medications before upper endoscopy.[9] The overall risk of post-endoscopy pneumonia is 0.83% in the GLP-1 patient population.

Guidelines from the American Society of Anesthesiologists (ASA) to reduce the risk of pulmonary aspiration in adults generally recommend fasting from heavier foods for 8 hours and clear liquids for 2 hours prior to general anesthesia. The ASA Task Force on Preoperative Fasting issued new guidance on perioperative GLP-1 receptor agonist management. The Task Force recommends that in patients undergoing elective procedures, GLP-1 receptor agonists dosed weekly should be held for a week prior to surgery, or the day of the procedure if administered once daily. If gastrointestinal symptoms are present the day of the procedure (e.g., nausea, vomiting, dyspepsia, abdominal distention), procedural delays should be considered. These symptoms are predictive of residual gastric contents.[10] Several case reports have described pulmonary aspiration of gastric contents in patients who had been fasting for over 18 hours. Many anesthesiologists are also routinely performing preoperative abdominal ultrasounds to evaluate for residual stomach contents.

ASA Fasting Guidelines		
Minimum Fast	**Ingested Meal**	**Includes**
2 hours	Clear fluid	Water, soft drinks, black coffee, clear tea, medications with a sip of clear liquid as prescribed
4 hours	Milk	Human, infant formula
6 hours	Light meal	Fruits, juice with pulp, non-human milk, toast, non-fatty/light meal
8 hours	Regular meal	Fatty meals, meats

The limited data that has been published has shown that the ASA Fasting Guidelines are not adequately protecting patients who may have delayed gastric emptying.[11] It appears that it would be prudent to increase the duration of *fasting from all foods from 6-8 hours to 12 hours* prior to anesthesia. Clear liquids may be continued up to 2 hours prior to procedures because clear liquids have been shown to improve gastric emptying and reduce residual gastric contents. GLP-1 agonists should be resumed at the next scheduled dose after the procedure.[12]

Patients who take GLP-1 medications for diabetes management and blood sugar control may experience changes in their blood sugar levels due to holding their medication. Prior to anesthesia, the patient's blood sugar should be checked to have a current value and to be treated as necessary. Consultation with the primary care physician or endocrinologist may be necessary in some diabetic patients when medications are modified or held.

Potential Surgical Risks

Do oral and maxillofacial surgeons need to modify their surgical approach?

What potential challenges or risks do GLP-1 medications present to surgery?

GLP-1 medications appear to be relatively safe surgically in the oral and maxillofacial surgery setting. As the popularity of these medications grows and the duration of their use increases, complications or side effects may become more apparent. There has been an article published that reported a 266% increased risk of deep vein thrombosis (DVT) in patients taking semaglutide with type 2 diabetes. The association is thought to be due to dehydration while taking semaglutide and increased blood viscosity which increases the risk of deep vein thrombosis.[12] Increased risk of DVT does not appear to be confirmed with additional studies to date.

I personally have noticed crestal bone loss and less-than-ideal bone healing with immediate implant placement in patients taking GLP-1 medications. The implants integrated but there was greater initial inflammation than expected and eventual crestal bone loss. My personal findings with immediate implant placement may be coincidental as the number of patients was limited, but I wanted to bring attention to this potential finding. Otherwise, I have not experienced any other significant issues with soft tissue or bone healing in my practice.

Today, our patients have renewed optimism in their pursuit for better health. GLP-1 agonist medications demonstrate remarkable effectiveness for health and weight with minimal side effects. Obesity has been a plague on society, negatively affecting every aspect of many of our patients' lives. GLP-1 agonists are quickly becoming one of the most popular medications prescribed, so a consistent and safe approach is important for oral and maxillofacial surgeons. The most serious challenge for the oral and maxillofacial surgeon appears to be vomiting and the risk of aspiration under anesthesia. GLP-1 medications should be held 1 week prior to surgery and the patient should hold food for 12 hours prior to surgery. I would also recommend attempting to minimize the depth of anesthesia to stage 1 to keep reflexes intact if possible. These anesthetic recommendations should minimize the risk of vomiting and aspiration but unfortunately, they will not completely eliminate it, so the oral and maxillofacial surgeon should be prepared when this emergency presents.

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Promote Access To Facility-Based Dental Procedures

In 2023, CMS implemented a new facility code (G0330) for hospitals to report dental services requiring monitored anesthesia and the use of a hospital's operating room, which was paid at a rate of $1,722 per case – up from $200 that was previously paid for hospital-based dental procedures. This code and increased rate provided a pathway to better access to hospital operating rooms for rendering complex dental procedures to pediatric, adult, or disabled patients.

For 2024, CMS not only increased the hospital's payment rate for G0330 to $3,071, but it also added more than 240 dental procedure codes to the list of payable hospital outpatient services and added nearly 30 dental procedures to the ambulatory surgery center (ASC) Covered Procedures List (CPL), including HCPCS code G0330. With individually assigned rates to each procedure code, hospitals and ASCs will have even more methods to bill for facility costs and resources (e.g., surgical equipment and supplies, clinical staff, use of the operating room) associated with certain Medicare-covered dental procedures.

Infographics on hospital and ASC access have been posted on AAOMS.org (*See Following Two Pages.*) Members are encouraged to utilize these resources and promote the codes with their local hospitals, ASCs, and Medicaid payment systems.

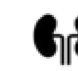
Increase in Facility Fees for Hospitals

Effective 2024, hospitals may collect facility fees of up to $5,585 per procedure ($3,071 for G0330) for costs associated with necessary hospital-based outpatient dental surgical care.

Why is facility access to dental surgical care necessary?

Thousands of children, adults with special needs and disabilities, and the frail elderly suffer from significant dental decay and require extensive dental treatment.

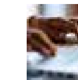
The complexity of the dental work – combined with the fragile condition of the patient – may require these services to be conducted in a hospital or ambulatory surgical center (ASC).



Medicare recognizes the need for facility access and recently expanded coverage for oral exams and treatment for certain medically compromised patients when treated in outpatient settings.

Many states also mandate medical coverage for anesthesia rendered in conjunction with dental procedures in a facility setting for children and adults who are developmentally disabled or medically compromised.

What has changed to enable hospitals to be reimbursed more for dental services?



Effective Jan. 1, 2024, CMS has assigned facility fees to 243 dental procedures, including Healthcare Common Procedure Coding System (HCPCS) code G0330 that took effect in 2023, for hospitals to report dental services that require monitored anesthesia and the use of a hospital's operating room.

The hospital outpatient facility fee for G0330 will be $3,071 (up from $1,722 in 2023). Facility fees for most other dental procedures on average range from $840 to $3,071, with a few as high as a $5,585 per service. When multiple procedures are performed, hospitals can bill multiple facility fees cumulatively, while multiple procedure reductions may apply.

Ask of Hospitals

Utilize G0330 and CDT Codes on the Hospital Outpatient List

to enable OMSs and pediatric dentists much-needed access to hospital-outpatient services for their patients while **significantly increasing facility payments for the hospital.**

- Successful patient outcomes are dependent upon hospital access for certain patients.
- A coalition of organizations – AAOMS, the American Dental Association and the American Academy of Pediatric Dentistry – lobbied CMS for establishment of the G0330 code and addition of CDT codes to the hospital outpatient lists.
- The coalition is working with state Medicaid agencies to support adoption of the facility code and CMS's assigned APCs by Medicaid.

Oral and maxillofacial surgeons:
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Facility Fees for ASC-Based Dental Procedures

Effective 2024, an ambulatory surgical center (ASC) may bill facility fees for costs associated with many dental surgical procedures, enabling access to necessary patient care.

Why is facility access to dental surgical care necessary?

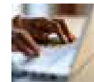
Thousands of children, adults with special needs and disabilities, and the frail elderly suffer from significant dental decay and require extensive dental treatment.

The complexity of the dental work – combined with the fragile condition of the patient – may require these services to be conducted in a hospital or ASC.

Medicare recognizes the need for facility access and recently expanded coverage for oral exams and treatment for certain medically compromised patients when treated in outpatient settings.

Many states also mandate medical coverage for anesthesia rendered in conjunction with dental procedures in a facility setting for children and adults who are developmentally disabled or medically compromised.

What has changed to enable ASCs to be reimbursed for dental services?


Effective Jan. 1, 2024, CMS has added 26 dental surgical procedures (including the G0330 dental rehabilitation code), each with their own facility fees, to the ASC Covered Procedures List (CPL). This means, as of Jan. 1, these services may be payable by Medicare (and possibly some commercial medical plans) when rendered in the ASC.

The facility fee for G0330 in the ASC setting will be $1,318.93. The facility fee paid to ASCs for each of the other assigned dental procedures will range from $364.98 to $2,760.89. When multiple procedures are performed, ASCs may bill multiple facility fees cumulatively, although multiple procedure reductions may apply.

Ask of ASCs

Utilize G0330 and/or CDT Codes on the ASC-CPL

to enable OMSs and pediatric dentists much-needed access to ASCs for their patients while **securing appropriate facility payments for the ASC**.

- Successful patient outcomes are dependent upon ASC or hospital access for certain patients.
- A coalition of organizations – AAOMS, ADA and the American Academy of Pediatric Dentistry – lobbied CMS for establishment of the G0330 code and addition of CDT codes to the ASC CPL.
- The coalition is working with state Medicaid agencies to support adoption of the facility code and CMS's assigned dental codes by Medicaid.

University of the Pacific Dental Students Participate at California CareForce Clinic in Indio

by Shiv Patel, student dentist,
University of the Pacific Arthur A. Dugoni School of Dentistry

For 13 years, California CareForce has been providing free medical, dental, and vision services at over 35 clinics across the state. Following approval from the Dental Board of California, Dugoni students had the opportunity to volunteer for the first time at the Coachella Valley Clinic in March 2024. With permission for a 6 to 1 student to faculty ratio, University of the Pacific Arthur A. Dugoni School of Dentistry students provided care to hundreds of dental patients on March 8-10, 2024.

Five 3rd year students and 2 supervising faculty worked with the California CareForce team, mainly in the Oral Surgery and Restorative sections. As this was the first time our school has worked with this organization, there were some logistical challenges and we had to ensure that the participants and faculty were cleared to volunteer at the clinic. This included utilizing the recently-passed CALAOMS-sponsored legislation, Assembly Bill 936, which has expanded the eligibility of dental students in their clinical training years to provide free dental services. In addition to setting up the entire clinical environment, providing the necessary supplies and instrumentation, and recruiting patients in need of care, California CareForce also provided accommodations for the student and faculty volunteers. The 3-day clinic beginning on Friday took place at the Empire Polo Grounds in Indio and served the entire Coachella Valley. Volunteers were assigned roles such as triage, taking radiographs, assisting, and direct patient care. Our team was tasked with providing restorative and oral surgery services including composite fillings and simple and complex surgical extractions.

Throughout the three days of clinical operations, dental care was provided to 425 patients, including 303 extractions, 189 fillings, 28 stay plates, and 89 cleanings. In addition to dental, 1178 patients were treated for their medical and vision needs by the other volunteers. The UOP students were utilized to provide mainly surgical services. It is noteworthy that in future trips, more students would be able to participate in providing restorative procedures for patients. Supplies including handpieces, antibiotics, pain medications, surgical instruments, and toys for children were procured through various sponsorships. Stay plates were provided by Riverside Dental Lab and Glidewell Laboratories. Pharmaceutical supplies were provided by La Botica Pharmacy.

Left to right: Dr. Aaron Sulaeman, Dr. Ned Nix, Vineet Gangadharan, P. Joseph Perez, Shiv Patel, John Huan, and Desmond Ding

The 2024 clinic in Indio was successful in the outreach to the local communities of the Coachella Valley with a focus on patient education and surgical services. In order to continue this momentum of community outreach, the student leaders for the trip have paved the way for future participants, providing guidelines for upcoming trips and to improve upon the previous experience. This will include more in-depth participation by UOP students, both dental and hygiene, with more faculty to provide a broader range of services to the community. California CareForce provides clinics across California; and as we continue building this relationship, more opportunities will arise for UOP dental students.

Acknowledgements: Dr. Ned Nix, Prof. Eve Cuny, Dr. Peter Scheer, Dr. Brian Diep, Dr. David K. Lam, Cyndi Ankiewicz, California CareForce.

A few of the CALAOMS Members that volunteered at the California CareForce Coachella 2024 clinic from left to right are: Peter M. Scheer, Nima S. Massoomi, George Maranon, Ned L. Nix, David R. Cummings, and Robert L Bass.

Retired CALAOMS OMS Dr. Craig Y. Bloom and his wife Arlynn (pictured in red with grateful patients in the dental section

Dr. Peter M. Scheer and his assistant with dental patient being prepared for an extraction.

RISK MANAGEMENT

Why It's Vital to Choose a Doctor-Owned Medical Malpractice Insurer

by Robert E. White Jr., President, The Doctors Company and TDC Group

Choosing a medical malpractice insurer involves more than just reviewing the cost of premiums—physicians must consider which insurer has their best interests at heart. Consolidation in the industry has led to shareholder-owned companies acquiring doctor-owned companies and vice-versa. When an acquisition brings a doctor-owned company into the hands of shareholders, physicians have a prime opportunity to ask: Is this the type of insurer I want protecting my reputation?

A doctor-owned company offers benefits—intangible and tangible—that shareholder-owned companies can't match.

- **Doctor-owned companies have an affinity of interests with those they insure.** This simply doesn't exist when the insurer is a shareholder-owned company. A doctor-owned company can fight for doctors through legislative advocacy and when a physician is sued without interference from outside influences. On average, physicians will spend more than 10 percent of their careers facing an open, unresolved medical malpractice claim.[1] Those protecting physicians at a doctor-owned company know that a claim payment reported to the National Practitioners Data Bank will follow the doctor around for the rest of their life.
- **Doctor-owned insurers have only one person to account to: The doctor who holds the policy.** On the other hand, investor-owned companies must produce every quarter the predicted earnings per share. Shareholder-owned companies remind their leaders and employees every quarter what the target is, and if they don't hit that number, their stock price will be adversely affected. While individual employees in shareholder-owned companies may do their best to support insured physicians, overall, the company's claims resolution process is determined by their ownership structure and their primary obligation to produce earnings for investors.
- **Doctor-owned insurers give their members a financial stake in the company.** Loyalty programs like The Doctors Company's Tribute® Plan, which offers a substantial financial award upon retirement, are tangible manifestations of what it means to be an owner. Programs offering annual dividends are another financial benefit that only doctor-owned companies can offer, because shareholder-owned companies are obligated to direct profits to one place and one place only: their shareholders.
- **Doctor-owned insurers offer depth of expertise and service.** Physicians can see and feel the positive impacts to their practice when they receive best imaginable service. It's solo and small practices, especially, where the physicians personally interact with the insurer and take advantage of patient safety and risk management programs, but these differences impact practices, regardless of size. Doctor-owned insurers are governed by people who are from the practice of medicine, and when a company is by doctors, for doctors, this impacts not just the handling of claims, but all the ways an insurer caters to the needs of its member doctor.
- **Shareholder-owned companies will settle a case when it makes financial sense for them**. Attorneys file many malpractice suits with no basis in law—80 percent of claims against our members, for instance, result in no indemnity paid to the plaintiff. Yet for fear of a negative verdict, a publicly traded company may decide to settle, versus defend, even if the doctor wants to defend themselves in court. This is especially true in states with low policy limits and bad-faith laws that work against an

Doctor-owned insurers give their members a financial stake in the company.

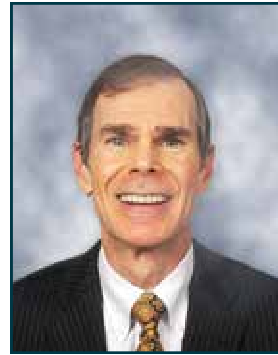
insurance company; insurers are worried that if they risk trying a case, they'll get hit above policy limit, and they may settle rather than risk taking a big verdict. Sadly, it's the doctor who has to carry those consequences. A doctor-owned company, on the other hand, could take that same case all the way through trial to protect member doctor.

The majority of physicians will face at least one medical malpractice claim in their career, which makes choosing a malpractice insurer one of the most important decisions they will make. Choosing an insurer that is dedicated to defending and protecting their reputation can bring physicians peace of mind and allow them to focus on what they do best—practicing medicine.

Reference

Seabury S, Chandra A, Lakdawalla DN, and Jena AB. On average, physicians spend nearly 11 percent of their 40-year careers with an open, unresolved malpractice claim. *Health Affairs* 2013;32(1):1-9. doi:10.1377/hlthaff.2012.0967

MEANING IN ETHICS



by Richard Boudreau, MA, MBA, DDS, MD, JD, PHD, PSYD

An Ethical Polity

There is a point of tension between contractarians and compact theorists that is ultimately a discussion about the texture of our ethical polity (L-*politia* 'citizenship'). The point of tension seems to be less the recognition of the individual's debt to the whole of society than the vindication of the function of agencies, like family, schools, and religious communities that mediate the moral identity of the self. The latter cannot be construed simply as the product of a self-defining individual facing the complexity of a pluralistic world from a position of neutrality. Philosopher/ethicist/theologian Stanley Martin Hauerwas observes: "Set out in the world with no family, without a story of and for the self, we will simply be captured by the reigning ideologies of the day" (*A Community of Character: Toward a Constructive Christian Social Ethic).*

Yet a pluralistic civic order would seem to require diversity on the level of families as well as institutions which, in turn, promote and give rise to different moral identities and visions of the good. A host of questions opens up here concerning the public function of moral agencies such as families, schools, and religious communities. What is the relationship between democratic theory and practice, and ethos inspiring those agencies?

The latter question concerns especially the issue of the family's relation to the larger society. Family relations and responsibilities appear to be the best way to create human beings with a developed capacity to give ethical allegiance to the principles of a democratic society. Because democratic citizenship relies on self-limiting freedom of responsible adults, a mode of child rearing that builds on basic trust and a sense of commitment is necessary. We do not choose our relatives. They are given to us and, as a result, we learn what it means to have a history.

That is why we need a moral language that helps us articulate the experience of the family and the loyalty it represents. Such a language, as Stanley Hauerwas suggests, "must clearly denote out character as historical beings and how our moral lives are based in particular loyalties and relations. If we are to care for others, we must first learn to care for those we find ourselves joined to by accident of birth."

The intense obligations and moral imperatives nurtured in families may clash with the requirements of public authority, for example, when young men refuse to serve in a war they claim is unjust because it runs counter to the beliefs, civic or religious, of their families. This, too, is vital for democracy.

Keeping alive a potential locus for revolt, for particularity, for difference, sustains democracy in the long run. It is no coincidence that all twentieth-century totalitarian orders aimed to destroy the family as a locus of identity and meaning apart from the state. Totalitarian politics strives to require that individuals identify with the state rather than with specific others, including families and friends.

Family authority within a democratic, pluralistic order does not exist in a direct homologous relation to the principles of civil society. To establish an identity between public and private lives and purposes would weaken, not strengthen, democratic life overall. Children need particular, intense relations with specific adult others in order to learn to make choices as adults. The child confronted prematurely with a "right to choose" is likely less capable of choosing later on.

To become a being capable of choosing alternatives, one requires a sure and certain place from which to start. For this reason, theorists representing the communitarian or social-compact perspective are often among the most severe critics of contemporary consumerism, violence in streets and media, the decline of public education, the rise in numbers of children being raised without fathers, or mothers, and so on.

They insist that a defense of the family, that is, a defense of a normative ideal of mothers and fathers in relation to children and to a wider community, can help to sustain a variety of ethical and social commitments. Because democracy itself turns on a generalized notion of the fraternal bond between citizens, it is vital for children to have early experiences of trust and mutuality. The child who emerges from such a family is more likely to be capable of acting in the world as a complex moral being, one who is a part of, and yet detached from, the immediacy of his or her own concerns and desires.

In Western bioethics, the notion of solidarity has recently emerged as the category able to strike a balance between the alternatives of collectivism and individualism. Such a notion plays an important function in a variety of issues spanning from reproductive rights to fair distribution of health care resources to medical research and experimentation.

A bioethics inspired by the notion of solidarity calls for a genuinely pluralist normative system that recognizes and sustains a mode of thinking equally distant from excessive privatization, on the one hand, and overweening state control, on the other. Solidarity thinking pleads for a notion of democracy that entails a vision of tolerance and understanding of the importance of cultural traditions, the realization that the essence of democracy is the freedom which belongs to citizens endowed with a conscience.

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2025 Meetings

- OMSA Course On-line — Open Year Round
- January Meeting Webinar — January 18, 2025
- CALAOMS 25th Annual Meeting — Hayes Mansion, San Jose - April 26 & 27, 2025

2026 Meetings

- January Meeting Webinar — January 17, 2026
- CALAOMS 26th Annual Meeting — The Weston Long Beach - May 2 & 3, 2026

Vendor Spotlight

CALAOMS Wishes to Thank the Following Vendors That Graciously Sponsored CALAOMS' Meetings In 2024

- **The Doctors Company -** Webinar Sponsor, January 2024 Meeting.
- **The Doctors Company -** Speaker Sponsor, 24th Annual Meeting.
- **OMSNIC/HUB International -** Residents Sponsor, 24th Annual Meeting.
- **US Oral Surgery Management -** Luncheon Sponsor, 24th Annual Mgt.
- **Beacon Oral Specialists** - Breakfast and Breaks Spon., 24th Annual Mgt.
- **H & H Company -** WiFi Sponsor, 24th Annual Meeting.

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

Bay Area: Oral & Maxillofacial Surgeon California Partner Opportunity. Part-time or Full-time Oral Surgeon in Northern California. IMMEDIATE OPENING! We are a well-established, high-tech, modern dental practice in the prestigious area of San Jose/ Milpitas with excellent patient population, fee-for-service, and looking for a licensed, outstanding Oral Surgeon. Offering option to buy and room for growth, excellent income, flexible schedule, sign-on bonus and competitive base salary. Please contact via email at: bayarea.ospractice@gmail.com

East Bay Area: Part time opportunity available. Busy practice with two locations and four surgeons. Mondays and Fridays available immediately. Full time will become available in the fall. Traditional practice: extractions, bone grafting and implants, biopsies, sedations. Please contact osjob2023@gmail.com

Central Valley & Bay Area: Kids Care Dental & Orthodontics is on the move… come join our incredible Doctor Group.!.! KCD&O has part-time and full-time opportunities for oral and maxillofacial surgeons in the Sacramento, Stockton, and San Francisco East Bay regions.

KCD&O is a doctor-led and patient-centered pediatric practice that offers multi-disciplinary services across pediatric dentistry, orthodontics, and OMFS. We are the premier pediatric group in the state of California and currently have practices throughout Northern California. You will work with an experienced practice management staff, PALS-certified assistants, and have the opportunity to collaborate and share insight with our orthodontists and pediatric dentists. The scope of practice includes routine dentoalveolar surgery, benign pathology, etc. We can assist with hospital privileges for those interested. We accept fee-for-service or PPO's. This is a phenomenal opportunity, our surgeons enjoy competitive compensation with high earning potential, a path to equity/ownership for full-time providers, and group benefits including health, dental, vision, life/AD&D and professional liability insurance, and a 401(k) savings plan. Requirements are a CA license and a GA permit. If you are interested, please contact us at 916-661-5754 and send your CV to drtalent@kidscaredental.com

Lake Tahoe: Dream opportunity to build an oral surgery career in the Lake Tahoe area. Our thriving, two-office practice has a reputation for taking great care of people and has excellent relationships with our referring offices in Truckee and Lake Tahoe. The practice scope is primarily dentoalveolar and implant-based, with very occasional trauma and hospital cases. Current doctors work three days a week with full-time income. Offices are all-digital with CBCT, X-NAVs, intraoral scanners, and updated equipment in both locations. Looking for an ABOMS certified (or active candidate for certification) associate leading to partnership. Must be personable, caring, and interested in making this area your forever home. Tahoe Oral Surgery is a proud supporter of 1% for the planet.
Please email inquiries to rachel@tahoeoralsurgery.com

Northern California: Sierra Foothills, well established practice seeking an associate leading to partnership. Very desirable community with opportunities for an active outdoor lifestyle. Send inquiries with letter of interest and CV to bizdocjay@mac.com and nfantovrn@aol.com

Napa & Sonoma: Seeking a motivated and hard-working OMS with excellent interpersonal skills. We have a well-established dentoalveolar/implant practice with room for growth and opportunity to perform additional procedures. Candidates would be expected to establish and maintain relationships with existing and potential referring doctors in the community. This is a great opportunity for new graduates or experienced oral surgeons to join our established and busy practice with a pathway to partnership. We have two locations: Sonoma and Napa. Please contact Sandra@oralsurgerydentalimplants.com

Orange County: We are currently seeking a motivated, compassionate surgeon to join our growing practice in the greater Orange County area. We have a two in one oral surgery office fully equipped in the beautiful city of Huntington Beach, CA. All current staff surgeons are board-certified with extensive experience in Dentoalveolar, implant, orthognathic, and trauma surgery. Currently both in the past and present all surgeons held or hold leadership positions in the local dental societies as well as local academic appointments. Primary surgeon is on staff at 3 local hospitals but no ER coverage is required with this position unless associated prefers. The scope of the practice includes but not limited to: dentoalveolar, orthognathic surgery, trauma, pathology, grafting, IV sedation.

Our position is for a unique individual who is caring of patients with exceptional interpersonal skills. Included with employment: salary, health coverage, 401K, CME reimbursement, mentorship with other surgeons, and more. All single or double degreed candidates will be considered as well as BE and BC. Currently this practice only has one doctor owner and seeking a well-qualified and skilled colleague with eventual partnership opportunity. Please contact Ofc managers- Rod or Mary 714-766-6560 or 949-514-8714 or send us an email: socalomfsdds@gmail.com

Roseville, CA: Immediate full-time oral surgeon needed to join our team. Practices a full scope of oral and maxillofacial surgery with expertise ranging from corrective jaw surgery to wisdom teeth extraction to teeth-in-an-hour/ Dental Implants. Diagnoses and treats facial pain, facial injuries and TMJ disorders, and performs a full range of dental implant and bone grafting procedures.
Please contact- Courtney
Phone: 916-783-2110
Email: courtney@drantipov.com

Sacramento: Exciting Associate Opportunity! Sacramento Surgical Arts is looking to add a surgeon, seeking a partnership track, to support the growth of 3 practice locations!

We are a full scope oral surgery private practice, providing a variety of services from advanced oral and maxillofacial surgery to non-surgical cosmetic procedures.

Sign on bonus; competitive base annual salary; quarterly production bonus; partnership opportunity; benefits; retirement. CV's and inquires can be directed to tkackley@mosaicdentalcollective.com.

San Diego: Well-respected oral surgery practice located in central San Diego. 25 years in practice and one of the most successful, busy practices in the city. Very active Seattle study club sponsor for over 21 years with 50 members. Scope of practice includes all dentoalveolar surgery, implants, bone grafting, PRF/PRP active use, orthognathic and TMJ surgery, sleep apnea treatment with MRD and bi-maxillary advancement and facial trauma. In house OR capable of supporting single jaw orthognathic/TMJ surgeries. Active hospital practice for more complex cases.

We are looking for a board certified/eligible surgeon with active skills in orthognathic/TMJ/Trauma surgery comfortable with outpatient anesthesia and dentoalveolar surgery that is interested in becoming a partner in this practice. Comfort with public speaking is a big plus. Outgoing personality with excellent patient care skills is mandatory. Interested parties, please contact via email at info@mvoms.com, or office phone at 619-298-2200 and ask for Kim, office manager

San Francisco - Union Square: Excellent private practice is looking for a full or part time oral surgeon to join our wonderful and professional team. Please send CV and letter of interest / inquiries to: sfomfsjob@gmail.com

Santa Barbara: OMS Associate wanted to practice in Santa Barbara. Leading to partnership/owner position. Please contact Yvonne at 805-692-8500 or Email at drwelsh.oms@gmail.com

Southern California: Opportunity to work with a well-established office. Southern California location close to the beach. Looking for an oral surgeon focused on ethical patient care.
Contact: oralsurgeonjob1@gmail.com.

Southern California's Inland Empire
Immediate full-time oral maxillofacial surgeon wanted in Southern California's Inland Empire. We promote a workplace with a supportive and efficient staff, individual growth and personal achievement. The right individual should demonstrate creativity, interpersonal skill and have a team player attitude. We emphasize dentoalveolar surgery, dental implants, and pathology but also practice orthognathic, TMJ and trauma surgery. Compensation includes competitive salary, incentive bonus system, health insurance stipend, and relocation advancement. Interested applicants should call (909) 331-0227 or email MDudziak@ieomfs.com.

DOCTOR SEEKING POSITION

UCSF Fresno OMFS Graduate looking for an associateship/partnership position in Southern California, with potential for buy-out down the road. omidniav@gmail.com 714-624-7634

San Diego: An Army OMS looking to join a well-rounded practice as a partner or associate to partner.

Currently, I am the Chief of Oral and Maxillofacial surgery at Winn Army Community Hospital on Fort Stewart, GA and have a very active dent-alveolar practice as an independent contractor.

I am separating this coming summer and would love an opportunity to come back home to San Diego. Please contact me for a CV or to schedule an interview. Sergey Gazarov, DDS sgsergey@gmail.com or 858-382-2254

PRACTICE FOR SALE

Bakersfield: Long established OMS practice located in a new office in the heart of town. This busy practice is perfectly located in the middle of Bakersfield with all major highways intersecting within a few blocks from the office. Within 10 minutes of both Mercy and Adventist Health hospitals, the office is also surrounded by many dental offices for referrals. I am currently doing 7-8 surgeries a day, and there is an extra room ready for a surgical suited making it easy to produce more surgeries a day if needed. The community is growing quickly, so you can't go wrong with this practice. Call 661-835-7389 or email genehughesdds.oralsurgery@gmail.com

Irvine: Newly renovated oral surgery practice located in Irvine, CA. Located in a very desirable area near Hoag Health Center in a high rise medical building. The office is large enough to support multiple doctors with 3 operating suites and 3 consult rooms. All new state of the art equipment was added during the top to bottom renovation. The practice is currently in growth mode, which makes this a perfect time to purchase and turn this into a thriving practice for many years to come! Will provide transition support.

Located in Southern Orange County, Irvine is one of the nation's largest planned urban communities and encompasses more than 65 square miles. Irvine's central location—45 miles from Los Angeles, 85 from San Diego, and 15 minutes from Disneyland Resort—makes it a popular hub for Southern California travelers. There's a lot to love right in Irvine proper. From kid-friendly outdoor activities to full-service shopping, the little big city has something for everyone. Please contact:
jstraw@edoralsurgery.com 916-990-3644

North San Diego County: OMFS practice in North San Diego County for sale. Expanding community, office located next to lake and golf resort. Office is modern, clean with up-to-date equipment. Traditional dentoalveolar and implant practice, strong referral base, 47% overhead in 2022, excellent cash flow. Retiring after 29 years as single practitioner. Would like to finalize contract in 2023, new owner to take possession July 1st, 2024. No DSOs please. If interested, please call and leave message at (760) 744-1320.

Northern California: Established OMS Practice for sale in Northern California. Very desirable area. Please respond to nfantovrn@aol.com for inquires.

Santa Monica: Full scope OMS practice is offered for immediate sale or transition to sale, 35+ years established in distinguished medical building with long standing, stable referral base. The emphasis of the practice is dentoalveolar surgery and dental implants. The practice is fee for service and insurance patient based. Located in close proximity to two major medical centers, Santa Monica UCLA Medical Center and St. John's Health Center. The office consists of 1 operating room, 2 equipped operatories and recovery room. Please send your CV and contact information to: se.needle@gmail.com

Silicon Valley: Oral Surgery Practice seeks buyer to continue a decades long tradition of providing quality OMS services to a traditional referral base in San Jose, Los Gatos and Saratoga. Interested prospects can send a CV to molinelli@aol.com or call 650-347-5346.

South San Francisco Bay Area: Excellent private practice opportunity in a very attractive South San Francisco Bay Area community. This is a well-known and respected practice with a 32-year history of providing the highest level of patient care. Our facility is a free-standing, 3,000+ square foot building located in a very desirable location. We are accredited by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). Anesthesia services are readily available as part our close, 11-year, relationship with the premier anesthesia group in our area.

Our surgeon is looking to transition his practice to a highly competent and deeply committed doctor who is willing to do what it takes to provide the standard of care our patients deserve. Practice transition options are available including clinical and/or business mentoring as desired. Please send preliminary inquiries to: oms.transition.2022@gmail.com

WOULD LIKE TO BUY

Greater Sacramento Area. I am looking to purchase a practice with transition in Sacramento or surrounding areas. I am currently practicing in Northern California and I am looking for an OMFS practice with an emphasis on Dentoalveolar and implant surgery. Please contact me at omfspractice43@gmail.com if interested

Southern California: I am currently out-of-state and would like to relocate to California. I am looking for an OMS practice for purchase with transition. Southern California preferred (Greater Los Angeles, Inland Empire or Greater San Diego) / mid-size city or suburban community. 1,500-2,000 sq. ft. 2-3 operatories. Please email me @ surgeryoms@gmail.com

West Los Angeles oral surgery practice. Well Established, Excellent reputation and relationships within the community and amongst the Dental referral base. The office is 2,200 square feet in a multi-tenant building and has been remodeled with updated equipment and technology, including Cone Beam. 2 Consult Rooms, 3 Surgical Suites, Full surgical Area with Recovery, Nurses Station and Sterilization Center. Very well designed for Oral Surgery flow. This practice has been in the same location for 20+ years. $2.1M Annual Revenue, Operating Expense below 55%, with $1.0M net. Please contact Jason Owens at 855-546-0044 or jowens@ddsmatch.com for a confidential conversation about this opportunity.

OFFICE SPACE FOR SALE OR LEASE

San Francisco Peninsula: Oral Surgery Equipment and Office Building for Sale. 139 Arch Street, Redwood City is a beautiful, modern oral surgery building with equipment for sale (building and equipment can be sold separately).

The 3,808 sq. foot building is seller occupied, and will be delivered vacant at close of escrow. This makes it ideal for an existing dental practice to move right in.

The main unit has three fully equipped surgery rooms, two exam rooms and a three bay recovery area. Equipment and physical space have been continually updated. The oral surgery office is approximately 2,700 sq feet. There are two additional units in the building on month to month leases which can be made available for future expansion or leased to provide supplemental income for the new owners.

Parties interested in the oral surgery equipment can send a letter of interest to peninsula.oms@gmail.com.

Parties interested in purchasing the building may reach out to brett.weber@kidder.com

Dr. Anthony Spina of Chicago Surgical Specialists, Chicago, IL

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