

The Compass

Staying the Course Through Service and Education



Volume XII, Issue 2, Summer 2010

CALAOMS Members Help Californians At RAM Los Angeles

During April 27 – May 3, 2010 over 40 CALAOMS members volunteered their services to provide dental care to thousands of patients at the Sports Arena in Los Angeles with Remote Area Medical (RAM). The response by our members was very much appreciated by CALAOMS and, especially, by RAM. It was truly one of the most

wonderful and amazing experiences. RAM, with the assistance of the local Los Angeles dental and medical societies, along with thousands of volunteers, ran a streamlined and well-organized project that provided much needed medical, dental, surgical, vision, and veterinary care to those in need.

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CALAOMS members with RAM founder in the LA Sports Arena from left to right: Russell Webb, DDS; Moris Aynechi, DMD, MD; Stan Brock, RAM; Ted Feder, DDS; Sanford Ratner, DDS; George Maranon, DDS; and Robert Relle, DDS.

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Editor's Corner



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

Issues in California *Underinsured Patients*

Although many people can define the term “uninsured,” not many know how to define the term “underinsured.” Underinsured patients have some form of health insurance, but lack the financial protection needed to cover out-of-pocket medical care expenses.

A more formal definition of underinsured individuals includes patients who are insured all year, but have at least one of the following qualifiers:

- Medical expenses greater than 10 percent of their annual income
- An annual income less than 200 percent of the federal poverty level, and medical expenses greater than 5 percent of their annual income
- Health plan deductibles equal to or greater than 5 percent of their annual income

Compared to adequately-insured adults, the underinsured have limited access to care similar to the uninsured. The number of American adults who had inadequate health insurance to cover their medical expenses rose 60 percent from 2003 to 2007, from 16 million to more than 25 million people.

WHY ARE PEOPLE UNDERINSURED?

Several factors contribute to the increasing number of uninsured and underinsured. Welfare-reform initiatives have limited the ability of many unemployed, low-income individuals to access Medicaid coverage. Low-income individuals may lack health insurance because they are unemployed, because their employers do not offer insurance as a benefit of employment, or because they cannot afford it. Even people who are insured may find that their ability to access needed medical services is inhibited by significant cost-sharing requirements.

Overall, approximately 35 percent of adults in the United States are under- or uninsured. Both under- and uninsured adults are more likely to forgo needed care than those who have adequate coverage. Rates of financial stress for the underinsured are similar to those for the uninsured. As the population of under- and uninsured patients has grown, the burden of caring for medically indigent patients has fallen primarily on state-supported or university-referral hospitals, community health clinics, and other government-supported healthcare facilities.

IS COST-SHIFTING INCREASING THE NUMBERS OF UNDERINSURED?

The health insurance industry is in the midst of significant change. Employers and health insurance companies are looking for ways to moderate premium increases by offering new insurance products that shift more of the financial burden of health care to the individual. Ever-increasing healthcare costs and insurance premiums have spurred a move away from more comprehensive insurance benefits for the population younger than age 65. Trends instead point

toward plans with higher deductibles, patient cost-sharing, and more restricted benefits. These shifts could increase the number of patients whose exposure to high medical costs is greater than their income, posing a greater financial risk for patients who have insurance but lack the financial resources to absorb these cost shifts.

Faced with several consecutive years of double-digit premium increases and the demise of managed care options, small businesses, in particular, have moved to insurance plans with sharply higher deductibles. Larger firms are also moving toward high-deductible plans.

Relatively recent federal policies have also accelerated the move toward increased patient cost-sharing with the establishment of tax-protected health savings accounts (HSAs), available only to individuals whose insurance policies have deductibles of at least \$1,000 per person. Although the United States already stands out among industrialized countries for the high share of medical costs its citizens pay out-of-pocket, trends point to still greater patient and family exposure to medical care costs in the future.

Efforts to redesign the health insurance industry have proceeded with little regard to patients' or their families' ability to pay, or the consequences of exposure to financial risk. Increasing patient cost-sharing may leave insured adults without adequate financial protection in the event of illness and may result in an increase in the number of underinsured Americans. If inadequate protection erects barriers to appropriate care, market trends could undermine the central goals of health insurance: to facilitate timely access to care when needed, and to protect patients from costs that would be catastrophic relative to their income.

STARTING A DOWNWARD SPIRAL?

The adverse effects of increased cost-sharing on patient access to timely care can be particularly acute for low-income populations. Plans rarely adjust cost

exposure based on income. Moreover, higher cost-sharing, by design, shifts costs to sicker populations. The combination of poor health and low income increases the risk of access barriers and financial stress.

A recent Canadian study of the impact of increased patient copayments for prescription drugs for the elderly and welfare recipients found that both populations cut back their use of essential drugs, which, in turn, led to higher rates of serious adverse events and emergency department visits. A study of copayments for medications among Americans with chronic illnesses similarly found that as copayments increased, patients reduced their use of drugs; among patients with diabetes, the use of anti-diabetic drugs dropped by 23 percent.

These studies indicate the need to proceed with caution and awareness when changing the design of health insurance plans to avoid putting patients—particularly the poor and sick—at increased financial risk.

THE IMPACT ON HEALTHCARE POLICY

Concerns that inadequate insurance can contribute to reduced access to care and financial hardships have long been recognized. The extent of the underinsured problem among non-elderly U.S. adults, however, has not been well identified. Policy makers need to address the needs of the growing number of uninsured and underinsured patients in the United States by conducting periodic national updates on the number of underinsured Americans and by monitoring the impact on access to care.

Patients with inadequate or no healthcare insurance face difficulties accessing care and are less satisfied and less confident about the quality of care they receive. Although greater cost-sharing has been proposed as a way to decrease the escalating cost of medical care and help moderate healthcare cost inflation by encouraging people to become more prudent consumers of healthcare services, little

Continued on page 7

From the President's Desk



*A. Thomas Indresano, DMD
President, CALAOMS*

What is Life?

As oral and maxillofacial surgeons, we have been blessed with a profession that offers us many challenges, satisfaction, and an abundance of riches. We get to not only use our minds, but also our hands. It can be an extremely gratifying life. Yes, we all work hard, and many of us have families that also bring us great joy and, at times, even further challenges. We have it all...so it seems.

Given our natural tendency as humans, we continue to seek the meaning of life. Most notable philosophers would answer that search with one word—giving. Fulfillment comes from helping others.

What can we do to help our fellow man? Obviously, there are many outlets for giving of our time, talent, and treasure. I want to bring your attention to three avenues available to you, as CALAOMS members, if you are looking for that philanthropic outlet.

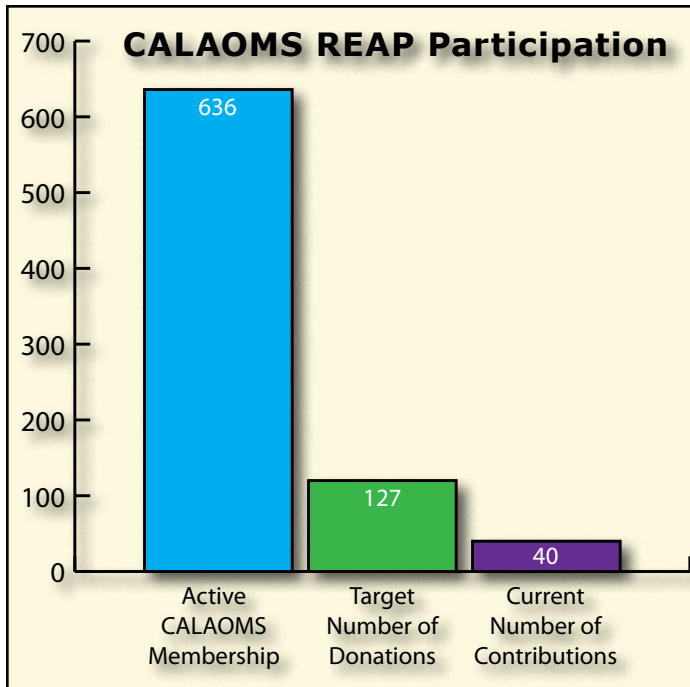
First, consider the Remote Area Medical (RAM) program, which we at CALAOMS supported this

past year through donation of time and resources in the form of manpower. Our Executive Director, Pam Congdon, helped schedule scores of CALAOMS members to assist in this initiative which took place in Los Angeles, where we were able to provide oral health care to thousands of underserved patients. Within the next year, we anticipate that there will be another RAM event to be held in The Bay Area and Sacramento. You can volunteer your time to treat these needy patients who otherwise have no way of getting basic medical/dental care. Please contact Pam if you are interested, and she will gladly take your name and contact you when more details are known. It truly is a great way to help others in need.

Additionally, you could donate your time and knowledge to your local oral and maxillofacial surgery (OMS) residency program, dental school, hygiene program, or dental assisting program in some way to promote the education of our esteemed profession. In these hard economic times, we all know that educational programs are hurting for faculty and would truly appreciate your efforts to help. Help perpetuate our breed! Call your local dental school or OMS residency program and offer your time. I promise you—it will make you feel great!

Finally, and most certainly not least, you could give to the OMS Foundation. As AAOMS members, we are asked to donate each year to the REAP campaign (Research and Education Advance Patient Care). This money fills the pot that finances the research which brings new techniques and disciplines directly to our specialty. If we don't care enough to give, then who will? This is a foundation by OMSs for OMSs.

There are over 600 members in CALAOMS, but only less than 1% of us have donated in the past. I set a goal of 20% participation by our members for this year. The benchmark donation is the equivalent fee for one set of third molars in your office, but any amount is greatly appreciated! As a state body, we are up to 6% (40 total gifts as of July, 2010) now. Let's try



to hit 20% (120 total gifts)! Giving—that’s what rings our bell. Try it, and you will see that it really is more blessed to give than to receive. ●

Editorial - Continued from page 5

attention has been paid to the downsides of such an approach. Advocates of insurance redesign often envision coupling high deductibles with employer-funded or personally-funded HSAs that could be used to pay front-end costs. But in the current marketplace, insurance policies rarely include adjustable patient cost-sharing or out-of-pocket limits, depending on income.

Rising healthcare costs and access to affordable insurance are prominent issues and will continue to be the focus of much debate during the upcoming mid-term elections. Overall, new policies and research are needed, focusing on the current health insurance cost-sharing designs and the effects they may have on the growing number of underinsured patients. Policymakers need to pay attention to the adequacy of healthcare insurance and the effectiveness of the care patients receive. Otherwise, an increase in the number of underinsured Americans could undermine our nation’s health, productivity, and financial security. ●

RAM LA - Continued from page 1

According to RAM staff, the Dental Section numbers were the highest they have had at any event on a day-by-day basis. There were 15,302 medical services rendered. In the Dental Section, 2,483 extractions and 4,342 fillings were performed. There were 5,359 volunteers. The Total Value of Care given during the week was \$3,027,034.00.

Currently, I am discussing with RAM how we can bring their expedition to Sacramento and the Bay Area. I was told that 60 percent of RAM’s care efforts are provided in the United States. Recently, RAM has also been a significant help in the demolished countries of Haiti and Guyana.

HISTORY OF RAM

The vision for Remote Area Medical® (RAM) developed in the Amazon rainforest, where founder

Stan Brock spent 15 years with the Wapishana Indians. He lived with the pain and suffering created by isolation from medical care, and witnessed the near devastation of entire tribes by what should have been minor illnesses. When he left South America to co-star in the television series, “Wild Kingdom,” he vowed to find a way to deliver basic medical aid to people in the world’s most inaccessible regions.

RAM was founded in 1985. Many years of research and planning have yielded this vast, carefully developed network of men and women who have come together to make RAM a highly mobile, remarkably efficient relief force. Volunteers are doctors, nurses, technicians, and veterinarians who go on expeditions at their own expense, and treat hundreds of patients each day under some of the worst conditions.

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RAM LA- Continued from page 7

At RAM/LA this past spring, we had over 40 CALAOMS members volunteer to provide services. All of us who volunteered were proud to give, and were amazed at the volunteer support and the appreciation shown by the patients.



CALAOMS members turn out at RAM/LA in force. Pictured from left to right: David Rainero, DMD; Parvaz Farnad, DDS; and Gerald Gelfand, DMD.

DAVID RAINERO, DMD – *“I think one of the most memorable moments for me was seeing the contrast between two consecutive patients. The first was an unemployed aerospace worker who found himself without health insurance benefits, in chronic pain, and with no extra money for his own dental needs. He told me that he couldn’t believe that he ended up at RAM, but was tremendously grateful for our services. Immediately following him was a pleasant homeless woman, who was used to going to the free clinics in and around LA, but was also just as grateful for the services that RAM provided to relieve her dental pain. It made me think that the services provided were done so— without any questions asked— to anyone in need. The playing field was leveled by the fact that we were there just to help. I think that the volunteers gained as much from this experience as the patients. I hope that RAM can come to Northern California. Let me know if I can help in any way.”*

GERALD GELFAND, DMD – *“It’s always rewarding to help people who need it and the patients were overflowing with gratitude. I received more “bless you(s)” than a years worth of sneezes. Many of these people had been in pain for a long time with nowhere to turn and I’m sure every one of the volunteers was happy to help out.”*



GABRIEL GABBAYPOUR, DDS, MD – *“RAM was a wonderful experience and clearly showed how our profession can reach out to people who cannot get care otherwise. I truly enjoyed the experience, and look forward to participating again.” - pictured with patient.*



TONY CHI, DMD – *“This is our turn to give back. We are specialists and we should be here helping.” - pictured from left to right: John L. Lytle, DDS, MD; Ronald Kaminishi, DDS and Toni Chi, DMD.*



David Hochwald, DDS – *“I would do this again. This is a great deal and so many can’t get dental care. If they can stand in line and are willing to wait, I can provide what little I can do to help.”* - pictured with assistant Bernadette Rapati.



LORETTA GILMORE, DDS – *“It is an honor to participate. The patients were so grateful. The organization and teamwork promoted by RAM is amazing. The whole effort was just beautiful and I am grateful for the opportunity. Just let me know when I can be of service in any way I can.”*



Barry Johnsin, DDS – *“This program is the greatest thing for patients. I want to be more involved with RAM’s projects.”*

The following are a few quotes from patients that were treated by CALAOMS Members.

PATIENT – *“We were treated like royalty; can’t say enough good about what RAM is doing.”*

PATIENT – *“RAM is a blessing.”*

I think that the most poignant quote was by Darryl Maze, unemployed patient, and a deacon at his church: *“America, RAM, and all the volunteers show we can work together when the climate of the country’s problems is at its lowest. We are Americans, and we won’t let the dream die.”*

I hope that all of you will consider volunteering with CALAOMS and CDA at the next RAM event. I will keep you posted on the date and time. Thank you to all of you who donate your time and talent to those less fortunate.

by Pamela Congdon, CAE, IOM - Executive Director, CALAOMS

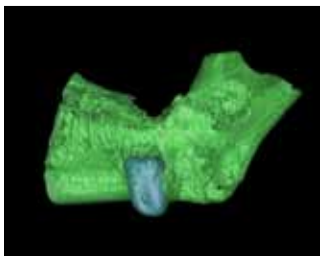
Technical Articles



Peter Krakowiak, DMD, FRCDC(C)

A TAD to the Left.... Or to the Right?

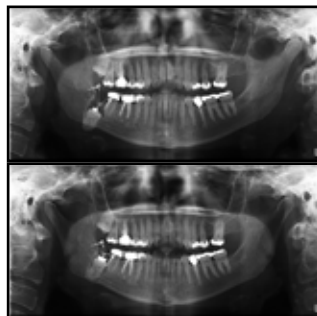
Temporary anchorage devices (TADs) are increasingly becoming more valuable in enhancing our ability to correct anterior dental relationships and even vertical skeletal discrepancies, especially those involving anterior open bites in the late adolescent and early adult patient population. They also have the ability to allow various tooth movements or positional corrections without reactive anchorage segment movement. In this era of office-based oral and maxillofacial surgery (OMS) practice, the knowledge and application of this modality should be of great interest to all of us. After all, most of us have extensive experience



Img. 1



Img. 2



Img. 3



Img. 4

with endosseous implants and rigid fixation, which are all precursors to the concepts of stable and controllable orthodontic anchorage.

TADs, by definition, are temporary. They are mechanical, being in the form of smooth titanium screws; and they are biological in that they are retainers for active force components of either fixed or removable orthodontic appliances. They work with fixed edgewise appliance designs, as well as acrylic platform splints. They can be splinted or individually placed. They can be loaded directly, or they can also connect to standard dental anchorage segments. Force arms can be attached to alter the vector of forces being applied to them, as well.

The concept of orthodontic anchorage was first introduced in the 17th century; however, it was not until 1923 that Louis Ottofy defined it as “the base against which orthodontic force, or reaction of orthodontic force, is applied.” The definition was recently clarified by Daskalogiannakis as applying to “resistance to unwanted tooth movement”

The subsets of simple, stationary, reciprocal, intraoral, extraoral, and intermaxillary have been also been defined since. However, the nomenclature and classifications are still under development.

The use of TADs is a relevantly recent clinical technique, but their applications, as well as evidence-based supportive literature, are growing steadily. The main treatment indications for their use are: space closure, impacted canine eruption, anterior open bite closure, molar uprighting, molar distalization, intrusion, extraction, occlusal cant correction, as well as protraction and retraction of segments. They are contraindicated in patients with metabolic bone diseases, severely compromised

immune function, history of significant jaw irradiation, or intravenous bisphosphonate use.

Treatment planning is performed in conjunction with the patient's orthodontist, and great benefit can be gained with pre-operative radiographic evaluation, which may include the use of a cone beam computed tomography (CBCT) scan.

Placement of TADs is usually performed with local anesthesia. Depending on bone density or system design, a pilot hole can be made, and then the anchorage screw is inserted interradiarily into the dentate skeletal segments. Either a 90-degree or 45-degree of insertion can be used, depending on the thickness of the bone and root anatomy. In the maxilla, screws used for anterior-posterior movement can be placed into the attached gingiva, but for vertical movements they ought to be positioned apically into mobile mucosa to allow for greater range of vertical orthodontic movement. Both buccal and palatal placement is possible in the maxilla. The palate tends to offer larger placement space between the roots of teeth in the molar segments. The zygomatic buttress may also be utilized for anchorage screw placement, but tissue tends to grow over the TADs, causing more soft tissue irritation at these sites. An alternative to screw anchorage in this area is a fixation plate or a skeletal fixation wire.

The best site to place TADs in the mandible is the buccal alveolus. Of course, the mental foramen area should be avoided. Placement with a 20-degree angle to the occlusal plane provides the best bone anchorage and minimizes the risk of root perforation.

For anterior retraction or posterior protraction, TADs should be positioned at the center of resistance of the moving segment. For intrusion, the placement at the mucogingival junction

is the most ideal. The mandibular buccal shelf is also a suitable area for implant placement for tooth uprighting and retraction.

There are numerous TAD designs available from several manufacturers. Most have a diameter range of 1.5 to 2.5 mm. The screw head can have either a button-top or a bracket-top connector. More aggressive thread pitch and wider implants are usually used in type 3 bone of the maxilla. The length of the TADs range from 5-12 mm. There are self-tapping and self-drilling designs available. Preliminary research data on stability-loss incidence of TADs has ranged from 9-30% in the literature. Patients must be advised of

Continued on page 12

Image Reference

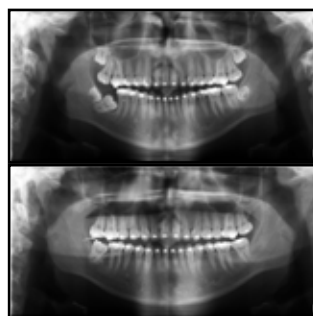
- Img. 1** *Third molar transport case, initial lingual CBCT view.*
- Img. 2** *Double TAD set-up for vertical third molar transport.*
- Img. 3** *Top: Panoramic view of initial position and TAD placement. Bottom: Final location of transported third molar before extraction.*
- Img. 4** *Top: TAD use to intrude molars with elastics. Bottom: Final occlusion after molar intrusion.*
- Img. 5** *TAD use with bite plane appliance and elastics.*
- Img. 6** *Transpalatal arch used to stabilize tipping with buccal TAD application.*
- Img. 7** *Top: Panoramic view of pre-TAD assisted uprighting site. Bottom: Post-uprighting panoramic view of second molar now ready for leveling.*
- Img. 8** *CBCT images used to evaluate TAD placement.*
- Img. 9** *TAD with NiTi coil placement for second molar uprighting (following page.)*



Img. 5



Img. 6



Img. 7



Img. 8

TAD Continued from page 11

this relatively high rate of anchorage loss prior to initiation of treatment.

Forces applied to TADs can reach 900 grams, but most orthodontic literature recommends 300 grams, or less, of force per fixture. Less force is advocated for intrusive movements (50-200 grams). Forces can be generated by NiTi coils or elastic mechanics. Transpalatal bars are often utilized for intrusion of upper molars to prevent buccal tipping when only buccal TADs are used. With palatal TADs, the use of crisscross elastics or NiTi coils, stabilized with bands and cement, can be utilized. Also, acrylic posterior bite appliances can be used to intrude molar and bicuspid segments, while allowing the (relative) extrusion of anterior dentition.



Img. 9

TAD removal following therapy is uncomplicated due to the lack of osseointegration of the smooth titanium surfaces. Smaller diameter screws may have a greater chance of fracture, particularly in dense bone. It is advised to initiate removal by applying a small amount of clockwise rotation prior to counterclockwise rotation screw removal.

Complications associated with TAD use involve root contact. Most often, this is realized during placement, as the fixtures become more difficult to advance upon initial passage through the cortex. If this occurs, remove the TAD and reposition it. Initial reports suggest that root surfaces can easily repair small superficial cementum defects with no apparent long-term vitality or resorptive changes. However, follow-up is warranted at these sites. Sinus perforations are possible, but appear to have limited consequences, as with most fixation hardware or endosseous implants. Paresthesia is possible with implants placed near the mandibular nerve or the greater palatine foramen. Knowledge of the anatomy and site selection can help avoid these problems. Soft tissue “bunching” and irritation is common with TADs placed outside of keratinized gingiva in the dynamic vestibular mucosa. Chlorhexidine rinses can minimize the extent and severity of these problems. In some cases, the soft tissue can grow over the head of the fixture, and either a local soft

tissue excision or use of orthodontic wax can stabilize the sites during the remaining course of treatment.

In my experience with TADs, I have found them to be of great use in uprighting mandibular second molars, closing open bites, and correcting relative occlusal plane issues. I have also treated several deeply impacted teeth with extrusion to reduce the surgical risks of mandibular nerve injury. The key on all of the molar cases was achievement of a stable bond to the impacted molar, and then the choice of the right length of NiTi coils to ensure maximum length of force application.

The most unique application of a TAD came to us when we transported a linguallally-impacted extracorporeal third molar in a patient who had previously been seen by two OMSs and an ENT surgeon, who all recommended an extraoral surgical approach. We elected to extrude the (initially) inaccessible tooth over three months through the mandible to a position where a conservative sectioning of the crown— using standard intraoral crestal approach— was possible. The patient was quite pleased with the lack of neurological disturbance, along with not having to undergo hospitalization or extraoral scarring, as initially suggested.

In my community, I have been fortunate to work with several great orthodontists who were happy to include us in their efforts. Our interactions have been very positive, and have helped to reinforce our professional association. In addition to already providing support services for impacted dentition, orthodontic extractions, third molar extractions, and, of course, orthognathic surgeries, OMSs are uniquely qualified for the placement of TADs. There is, however, a growing trend among orthodontists to perform these procedures on their own patients. Making them aware of our specialty’s unique capabilities and expertise in this area is paramount to retain our position as the primary surgical dental specialist.

For anyone interested in this technique, there are courses available from the vendors/manufacturers, such as Rocky Mountain Orthodontics and Ortho Technologies. Most of our membership will find the surgical aspect of the courses elementary, but they do offer some insights into potential mechanics and orthopedic principles not always readily apparent. Also, CALAOMS will have a speaker on this topic in the upcoming annual meeting in 2011. ●

The Use of Ultrasonic Instruments in Oral and Maxillofacial Surgery



Wendy P. Liao, DDS



*Piezosurgery® 3
Ultrasonic Instrument by
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Ultrasonic instrumentation has gained significant ground in the surgical world. Particularly, within the dental community, Piezosurgery® brand has become the most popular ultrasonic surgical device.

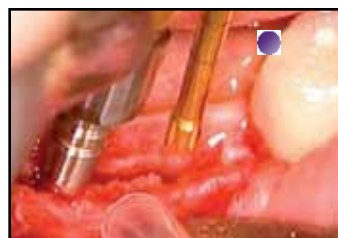
I became interested in the technology when one of the attending oral and maxillofacial surgeons at the University of the Pacific, Dugoni School of Dentistry purchased a Piezosurgery® unit a few years ago. In the oral and maxillofacial surgery setting, this ultrasonic instrument is used most frequently for sinus lift/augmentation, dental implants, bone grafting procedures, as well as nerve repositioning surgeries. It has three settings – root, bone, and implant. The root setting is used primarily for endodontic and periodontal cases. The bone setting can be further subdivided according to the type of bone encountered.

The claim to fame of the Piezosurgery® device is its ultrasonic micro-vibratory movement that leads to more precise hard tissue cutting without injuring the underlying soft tissue. The set comes with 52 tips which allows for different configurations and angulations in order to accommodate different clinical uses. However, this convenience comes with a fairly steep price tag – the base unit alone costs over \$10,000. The different tips cost between \$150 to \$250 each, while the implant tips are \$450 each. Most of the tips can be used 25-35 times before needing to be replaced. The implant tip can be used 50-70 times before being replaced. It is also important to mention that the current implant tips only prepare osteotomies up to 4mm in diameter and do not prepare any wider platform sizes. You can also purchase an elite package for \$16,000 which comes with the base unit and 20 tips.

It is a luxury to have the Piezosurgery® device, in my opinion, since many of the aforementioned procedures can be performed without the unit, as long as the surgeon has the necessary skills and experience. However, Piezosurgery® has clear benefits of precision, safety, and surgical efficiency if one has the disposable budget to afford one. ●



Sinus Lift



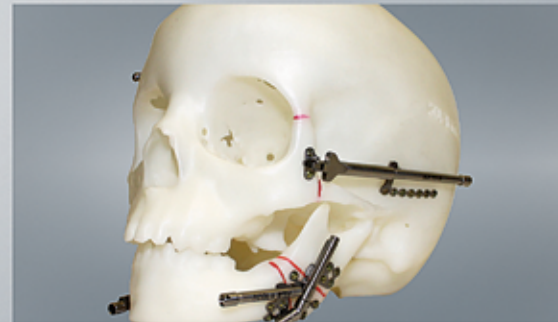
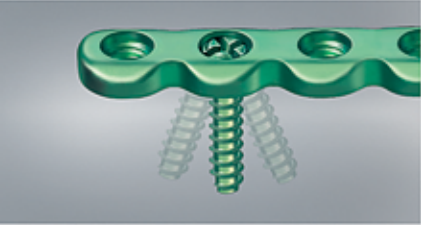
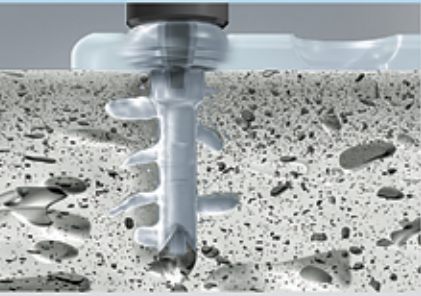
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Lateralization of Nerves



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Humanitarian Efforts



Carlos Moretta, DDS

Bangladesh, has proven to be both physically and mentally challenging. This isn't quite the mission trip into which you can squeeze a vacation where you see patients in the morning and scuba dive in the afternoon!

Honestly, I cannot remember anyone who has ever told me they have gone to Bangladesh for vacation. Yet this small country has an abundance of need, providing a wealth of learning opportunities for students, residents, and faculty alike. Of course, you have to be willing to sweat a little - actually a lot given the 100 degree temperatures with 100% humidity on any given day. The location is very rural. The amenities are...well...who needs amenities? This is a trip for the truly dedicated; where I can assure you that you will leave your very best effort on the field...it actually is a field!

Global Impact Initiative

The mission field has always provided a unique opportunity for care providers to develop and grow. The patient pool and interesting surgical cases are among the wonderfully diverse variables to consider in mission service. In 2009, I had the opportunity to participate in mission trips to Honduras, Peru, Philippines, and Bangladesh.

BANGLADESH

It is fascinating to see patients present with some of the rarest lesions only read about in text books. Patients travel on foot for many days just to be seen by a doctor. To see how truly appreciative they are for the slightest attention and care is simply a blessing. However, often the setting for definitive care is not ideal and many patients must be turned away. For the last three years, traveling to Jalchatra,

There are times, however, when patients present with conditions that are just beyond our capacity to treat, given the facilities and equipment that we have available. And despite the fact that they often traveled for days to get to us, they still show gratitude for the consultation. You can only imagine the potential for interesting cases with approximately 160 million inhabitants on a piece of land that is roughly the size of Iowa. That's more than half of the U.S. population! Each year we have developed our mobile clinics to provide comprehensive care including internal medicine, pediatrics, ophthalmology, optometry, dentistry, dental hygiene, general surgery, oral and maxillofacial surgery, and general anesthesia all of these in one of the most unvarnished settings imaginable.



HAITI

Two weeks after the devastating earthquake in Haiti in January, 2010, we had the opportunity to visit the area. We have been on many mission service trips, but none of them to provide disaster relief. This trip was different. The need was so profound. It was hard to imagine this much poverty so close to the borders of the United States.

Haiti posed unique logistical challenges. What services could we offer, and could we really be helpful to anyone? At the two-week post-earthquake time of our arrival, those who had sustained maxillofacial injuries were either dead or had already been treated. We were determined to do whatever needed to be done. If the need arose, we were there to provide help. During our time there, we made animal balloons for the children, extracted teeth, laid down PVC pipe from an artesian spring in the mountain two miles down to Hospital Adventiste D'Haiti (which had run out of water), and helped set up a primary care clinic for the treatment of those needing non-urgent care. We found that the most fulfilling task we performed that had the deepest impact was laying down PVC pipe! I forgot to mention that the pipe ran through mosquito-infested swamp fields with patches of human excrement - like I mentioned, not your usual mission trip!

One month later, we returned to Haiti, this time to an orphanage in the northern region, where we established an exodontia clinic among other primary care clinics. Despite our best efforts to fill every need, we felt that we had merely scratched the surface by the time we left to come home.

Mission service not only provides a chance to provide the best care to those who have no care, but it also enables the providers to reap the rewards from what they sowed. There is a tremendous sense of blessing and gratitude harvested from mission trips. Relieving human suffering in any form is admirable. We, as oral and maxillofacial surgeons, relieve suffering on a daily basis in our offices and clinics, whether by surgery, prescription, or just our words.



Our efforts may not be perfect, and we usually fall short of being able to treat every single person in need; but upon our return home we all realize that the patients whom we felt we would be affecting actually affected us more. We set out to leave a lasting impact on them, but return only to find that we, in fact, are more affected.

Through the years, Loma Linda University has made a global impact, providing healthcare to the poor and underserved in third-world countries. With hospitals, clinics, and public health initiatives implemented on six continents, Loma Linda University is constantly attempting to fulfill their mission, "...to make man whole." For this reason, we have developed the Loma Linda University Oral and Maxillofacial Surgery (LLU OMS) Missions Committee, whose plan involves creating an inventory of equipment and supplies which allows us to provide services regardless of location. We perform several service trips each year and make the experience available to faculty, staff, residents, students, alumni, and friends of the LLU OMS residency program. If you would like to contribute with your time, money, or any used/new equipment, please feel free to contact Dr. Carlos Moretta at 909.558.4671, or email at koolrosky@yahoo.com.



“Dead” Children Can Now Find a Life

*by Jeffrey J. Moses, DDS, FAACS
President and Founder, Smiles International Foundation*

Years ago, the Soviet withdrawal from Ukraine left medical centers without sufficient medical equipment or instruments to perform vital procedures for their patients. Children born with craniofacial deformities, such as cleft lip and palate, were left severely compromised in their options for care. The government was forced to inform the mothers of these unfortunate babies that their children had little chance of survival and would likely die as a result of feeding difficulties. Babies were then placed into one of the “State Baby Houses” until they passed away, and the mothers were told to “try again” for a normal baby. (“Baby Houses” contained hundreds of these children orphaned by deliberation or circumstance.) The Chernobyl incident’s effect would lead to increased incidences, as well.

This is a story about a region of the Ukraine and how the people found an unlikely solution to this tragedy. It started at a meeting which took place early in 2005 between Salah Hassanein, the Chairman and Founder of the Variety Children’s Lifeline Foundation, and I. This topic arose in conversation, and, at Mr. Hassanein’s request, I decided to go to the Ukraine to explore the facts and formulate a solution.

Carolyn McMurtray, a Christian missionary friend of Mr. Hassanein, had discovered hundreds of orphan children lacking human touch, with many of them possessing facial deformities which led to

inhumane ridicule, and, ultimately, prevented their adoption. The surgical attempts by the local surgeons, hindered by lack of proper pediatric instrumentation, left the children even further compromised.

We prepared a site visit complete with a full surgical team specialized in cleft and craniofacial care. We brought instrumentation to demonstrate modern pediatric surgical techniques. We arranged clinical symposia for the host doctors and hospitals through the Foundation’s credentials, which taught modern surgical techniques that were not previously accessible behind the Iron Curtain. The concept of a full-team approach to the care of the children was demonstrated. Various disciplines, such as speech, audiology, orthodontics, otorhinolaryngology, surgery, dentistry, and even genetics were employed in this team approach.

We then helped to build up the regional hospital and staff with equipment, educational support, and supplies. We also provided world-class surgery experts to demonstrate techniques and work side-by-side with the Ukrainian doctors, exchanging techniques using the modern equipment in an ambassadorial fashion.

Once this process stabilized and the children were receiving proper care throughout the year, Smiles International transferred the care to the



Dr. Moses (center) joins the hands of Prof. Dr. Anatoly Komok (left) and Dr. Pushkar Mehra (right) to signify the transfer of “Mission Smiles of Ukraine”

Boston University team for long-term relationship maintenance. This way, as specialized techniques advanced over time, the regional center's surgeons would be kept current, and the ambassadorial relationship would be maintained.

Over the following three and a half years, ten surgical, didactic, and supply-delivery mission clinics were accomplished. Hundreds of pediatric facial deformities were operated on and repaired. Equipment, supplies, and clinical services, valued at several hundred thousand dollars, were donated and received with gratitude. The benefit:cost ratio was over 7:1 with tremendous leverage of the actual donated dollar. This support came from many different sources, including Rotary International, Smile Train, Variety Children's Lifeline, and the Smiles International Foundation.

In the spring of 2009, the Ukrainian newspapers and television news stations hosted a news conference honoring the success of the Mechnikov Regional Medical Center and the first children's hospital. They recognized the established relationship with the United States' surgical team which had made themselves available for surgical correction of children's facial cleft deformities. The Dnepropetrovsk Regional Minister of Health was in attendance to present a Meritorious Award to us. He also spoke to the general public, as well as the delivery room doctors and personnel who had rescinded the previous government

regulations which requested mothers turn their babies with cleft deformities over to the state Baby Houses.

Photographs were shown at the news conference of some of the children we operated on with "before" and "after" images, including names. An emotional and surprising outcome of this portion of the news conference came when a mother of a patient recognized the name and photograph of her daughter. She then contacted the Center and was able to reclaim her daughter to reunite their family.

The Boston University team adopted the mission site in Dnepropetrovsk which relies primarily on the surgical skills and continuing leadership of Drs. Pushkar Mehra, James Bertz, and David Hoffman. Their collaborative surgical missions have continued into 2010 and will continue forward.

No longer will children born in the region of Dnepropetrovsk and Dneprodzerzhinsk, Ukraine, be taken from their mothers to face the "failure to survive" diagnosis. In the future, children will have the hope of entering society with normal facial features, speech, and eating ability. Children in the orphanages now have a better chance of adoption. ●

"Vision, hope, and faith of a few individuals can make a difference if applied to the opportunity placed before them."

— JJ MOSES



Craniofacial child pre-op



Child post-op Phase I & II Ready for Phase III

Risk Management Corner

The Doctors Company/SCPIE Responds to Some Recent Customer Concerns

The Doctors Company Patient Safety Department staff responds to hundreds of questions or concerns from their insureds every year. The following are a few topics which have been of recent interest to oral surgeons.

REPORTING TO THE DENTAL BOARD

The California Business and Professions Code §1680(z) mandates reporting to the Dental Board when a patient is hospitalized for a period exceeding 24 hours following dental treatment. This reporting applies for "...any patient to whom oral conscious sedation, conscious sedation, or general anesthesia was administered, or any patient as a result of dental or dental hygiene treatment." While there is no special report form to facilitate this process, failure to report can be considered unprofessional conduct and could possibly result in fines or revocation of license.

Sometimes a patient may be transported to an emergency department (ED) due to uncontrolled bleeding or perhaps a cardiac event during a procedure. If the patient is discharged following evaluation and/or treatment in the ED, then reporting is not required.

A dentist must also "...report to the board all deaths occurring in his or her practice, with a copy sent to the Dental Hygiene Committee of California, if the death was the result of treatment by a registered dental hygienist, registered dental hygienist in alternative practice or registered dental hygienist in extended functions."

WHAT TO DO WHEN THE DENTAL BOARD CALLS

A Dental Board investigation is a very serious matter. Your professional reputation and career are on the line so you should take at least the same care to protect that career as you would take if a trial lawyer threatens you with a malpractice lawsuit. One should always keep in mind that the California Dental Board serves two roles: investigator and prosecutor. Its purpose is to protect consumers and it initiates investigations because of reports it has received through complaints or other matters such as resolution of legal claims. Contrary to popular myth, there is no need for the Board to have probable cause prior to conducting an investigation of an oral surgeon.

It is natural to feel anxious when you receive notification from the Dental Board, but the number one rule is don't panic --- but don't relax either. All inquiries from the Board must be appropriately responded to or it may conclude that the allegations of the patient evidence serious failing in your practice.

Although you may be thinking to yourself that you can deal with the Board on your own since you "did nothing wrong," it is strongly advised that you seek professional counsel upon the initial inquiry. The Doctors Company will be able to assist you in your first response. It is crucial that appropriate counsel be involved from the beginning.

Be sure that you are completely truthful about the information that you share with your attorney.



These conversations are subject to the attorney/client privilege that prohibits disclosure of information that you two share together. By no means should you speak to fellow practitioners or anyone else other than your counsel about the issue. If you do, these conversations will potentially be discoverable during any interview or other proceedings.

Finally, under no circumstances should you contact or attempt to contact the patient about the complaint. You will only make matters worse.

RECORD REQUESTS FROM THE DENTAL BOARD

Effective February 1, 2010, the California Dental Board began to cite and fine licensees who failed or refused to comply with the Board's request for dental records. According to California Business and Professions Code §1684.1(a)(1), a licensee who fails to comply within 15 days of receiving both a request and patient's written authorization for release of records to the board, shall pay to the board a civil penalty of \$250 per day for each day that the documents have not been produced. The fine can range up to a maximum of \$5,000 unless the licensee is unable to provide the documents within this time period for good cause.

THE USE OF FACEBOOK

Tools like Facebook can make on-line communications with family and friends easy and instantaneous. The perception of privacy, however, may be false. In May, Facebook users were told that chats and emails previously thought to be private in several hundred thousand profiles were, in fact, visible to others. Qualities that make Facebook simple to use can create risk issues for your practice. Before

connecting your personal profile to your work practice, consider the following:

- Assume all your comments on the Internet are public, permanent, and discoverable in litigation.
- Prevent the unintended use of your comments, links, and thoughts. Facebook uses programs that actively link any postings, profile information, and links to external sites. These links and their activity may not be obvious, or in some cases detectable.
- Avoid "friending" patients, unless they were your offline non-patient friends before Facebook. Draw a line between your personal and professional life and avoid postings and links which may not reflect favorably on your profession.
- Guard your reputation with relentless intensity.

RED FLAGS RULES COMPLIANCE

The Federal Trade Commission has delayed once again the enforcement deadline for its Red Flags Rules. The previously announced deadline of June 1, 2010, has now been extended to December 31, 2010, unless Congress passes legislation on the rules with an earlier effective date. With the proliferation of medical identity theft, steps have been taken to try to prevent such occurrences within healthcare practices. The Red Flags Rules require doctors and hospitals to adopt written plans for tracking and responding to indicators of identity theft in their billing operations. An Identity Theft Prevention Program must be developed for all practices with 20 or more employees.

While these topics are of recent interest to oral surgeons, should you have additional patient safety or risk management questions, please do not hesitate to call The Doctors Company's Patient Safety Department at 800-421-2368, extension 1243.



Legislative Arena



*Ned L. Nix, DDS
Immediate Past President, CALAOMS*

Update on AB 2637 Dental Sedation Assistant

CALAOMS has been a leader in dental assistant (DA) education in California, as well as across the nation. CALAOMS' oral and maxillofacial surgery assistant (OMSA) curriculum has set the example for our national organization, AAOMS, as they have adopted a program using our course as a model, the oral and maxillofacial surgery anesthesia assistant program (OMAAP). CALAOMS has once again taken the lead in dental assisting education by establishing the Dental Board of California (DBC)-approved curriculum leading to qualification for examination and licensure for the dental sedation assistant (DSA) permit. This adds an additional licensed practitioner, strengthening the OMS anesthesia team model, and it also makes a DSA available for the appropriate permittee's conscious sedation team.

When CALAOMS was approached by the California Dental Association (CDA) and the Dental Assisting Alliance in 2002 to help develop a license that strengthened the career path of dental assistants in California, organized

nursing, organized dental assisting, CDA, and CALAOMS developed the duties of a prospective dental sedation assistant (DSA). This was done over a six-year period with discussion and debate from the dental community.

In 2004, SB 1546 (Figueroa) was passed by the legislature and signed by the Governor to establish the registered surgical assistant (RSA). Sponsored by CDA, SB 1546, along with subsequent clean-up legislation, was designed to create a new career path for dental assistants by, among other things, creating three new specialty licensure categories of registered restorative assistant, registered orthodontic assistant, and registered surgical assistant. After several years of postponements of the effective date of the new categories while the Dental Board tried to develop consensus regulations governing the educational and training requirements, in January of 2008, the Board concluded that the proposed structure had proven to be more complicated than anyone had anticipated, and decided to suspend its regulatory process while the interested parties discussed substantially revamping the entire proposed structure. CDA then commenced an intensive round of discussions with the Dental Assisting Alliance in an effort to reach consensus on an alternative to the SB 1546 structure. Those discussions fairly quickly resulted in an alternative framework, which became contained in AB 2637 (Eng) to create the dental sedation assistant (DSA).

AB 2637 deletes nearly all of the changes to dental assisting licensure laws that had been made by SB 1546 and its follow-up bills. Instead of creating three new dental assisting licensure categories, AB 2637 streamlines the structure by instead creating two new permit categories: an orthodontic assisting permit and a dental sedation permit, with specified educational and examination requirements for each. The bill also places into law some additional functions for existing dental assisting categories, which it is hoped will further enhance the career opportunities for dental assistants without making the process overly burdensome for assistants or dentist employers. In spite of late opposition from the California Nurses Association to the dental sedation permit provisions of the bill, AB 2637 was passed easily by both houses in August, and was signed by the Governor on September 28th. Its provisions,

including the two new permit categories, went into effect on January 1, 2010.

In the arena of ambulatory sedation and general anesthesia, the medical model suggests a second licensed provider be present on the anesthesia team. These procedures are only done in a hospital where nurses are employed and given responsibility above and beyond that provided for in AB 2637. To be specific, procedures permitted by the AB 2637 law are only to be performed under the DIRECT AND IMMEDIATE SUPERVISION OF THE LICENSED DENTIST.

Medical anesthesiologists are licensed by the DBC to deliver ambulatory sedation and general anesthesia (GA) in the dental office. To date, there is no requirement for an additional licensed provider to be present on the anesthesia team. Currently, state law requires three health care providers be present in the room during dental surgery with conscious sedation (CS) or GA.

Not only does the DSA establish a license for our dental assistants, it increases the hours of anesthesia training available through CALAOMS from 32 to 110 hours.

AB 2637 and the DSA Permit:

- Provides for an additional license for California dental assistants.
- Increases education possibilities for our anesthesia assistants in the OMS office.
- Improves the safety of our OMS anesthesia team model.
- Establishes continuing education (CE) requirements for licensure maintenance, improving the future education and training of our dental anesthesia assistants.

Facts about CRNAs (clinical registered nurse anesthetists) and AAs (medical anesthesiologist assistants):

- 1) CRNAs require a Registered Nurse (RN) degree and 24-36 months of post-RN training, offering a master's degree, making them eligible for certification as a CRNA. There are 108 CRNA programs in the United States. This certification is recognized under the Medical Practice Act of California.

- 2) An anesthesiologist assistant (AA) must first earn a 4-year bachelor's degree. Then, complete a 2-year Anesthesiologist Assistant master's degree program that has been accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). Anesthesiologist assistants can also earn professional certification from the National Commission for Certification of Anesthesiologist Assistants. There are 5 AA programs in the U.S. This licensure is NOT recognized under the Medical Practice Act of California.
- 3) These providers deliver general anesthesia in hospitals under the supervision of medical anesthesiologists. These providers are left alone in the operating room to deliver anesthesia care under minimal supervision of the M.D. They are, in effect, serving as the sole anesthesiologist delivering the general anesthetic care. Comparing the training of a dental sedation assistant and a CRNA (or AA) is like comparing "apples to oranges." ●

SAVE THE DATE

*Marsh Robinson Academy Of
Oral & Maxillofacial Surgery
39th Annual Meeting*

When: Saturday November 13th 2010

*Where: Los Angeles Downtown Marriott
333 Figueroa Street, Los Angeles CA*

This year's guest speaker will be Dr. Jay Malmquist, Past President of AAOMS.

He will present on "Contemporary evidence based bone grafting for implant site development"

**Anyone interested may contact MRA at
(213) 479-9349 or (951) 471-3334
for registration information.**

Dr. Russ Webb Candidate for ADA President-Elect

by Jeffrey A. Elo, DDS., MS

California's own Dr. Russ Webb, a long-time CALAOMS member and former medal-winning Olympian is a candidate for ADA President-Elect. The election will be held during ADA's annual House of Delegates in Orlando, Florida, on October 11, 2010. With four candidates running for this position, the race is expected to be extremely competitive.

In preparation for the election, Dr. Webb has been traveling the nation at a maddening pace, meeting dentists and discussing topics pertinent to his candidacy. So far this year, Dr. Webb has traveled to scores of dental meetings, in addition to carrying out his substantial duties as a member of the ADA Board of Trustees.

Dr. Russ Webb has a strong history of distinguished service in organized dentistry. He began his service in 1986 as a CDA delegate, representing the Tri-County Dental Society, and served as his component society President in 1991-1992. He then served for five years as a member of the CDA Board of Trustees, followed by a year of service as CDA President. Currently, he serves as the 13th District (California) representative on the ADA Board of Trustees, a position he has held since 2006. He also served from 1997-1999 as a Regional Representative on the Board of Directors of the Southern California Association of Oral and Maxillofacial Surgeons.

Dr. Webb serves on the Board of Counselors of the UCLA School of Dentistry, and is a past Governor of the UCLA Foundation. He is a current member of the following organizations: CALAOMS, AAOMS, the International Congress of Oral Implantologists, the American College of Dentistry, the Academy

of General Dentistry, the International College of Dentistry--which awarded him the 2010 Leadership Award, the Academy of Dentistry International, and the Pierre Fauchard Academy.

Dr. Webb obtained his undergraduate degree from UCLA. He then attended UCLA School of Dentistry. Following this, he completed his oral and maxillofacial surgery residency at UCLA in 1981. He continues to practice part-time in his office in Upland, and is a part-time faculty member in the implant department at the University of the Pacific Arthur A. Dugoni School of Dentistry.

Dr. Webb is an Eagle Scout, as well as a member of the UCLA Athletic Hall of Fame. He is also a recipient of the UCLA Alumnus of the Year Award. He credits his Olympic experience for shaping a strong appreciation of teamwork and achieving goals; and as a candidate for ADA President-Elect, he advocates collaborative leadership and a free flow of information to decision-makers.

Russ Webb's deep commitment to collaboration and teamwork took root early in his life as a member of the United States water polo team. He brought home a bronze medal from the 1972 Olympic Games in Munich, Germany, and since 1984 has been a member of the U.S. Water Polo Hall of Fame.

Time and again, Dr. Russ Webb has demonstrated his unwavering dedication to protecting the field of dentistry. He is the right man for the right job at the right time. His leadership style is borne of experience and reliant upon the "wisdom of the many" rather than the "opinions of the few." Russ Webb is the only oral and maxillofacial surgeon in this race. He will be a terrific ADA-President; and CALAOMS, CDA, and our dental colleagues from across the nation are proud to support his candidacy.

Anyone wishing to offer financial assistance to Russ Webb in this effort can do so by mailing a check, payable to "CDA - Webb Campaign" to the CALAOMS office. ●

In Memoriam

JEFFREY J. PULVER, DDS



by Sam Poidmore, DDS and Charles Hasse, DDS, MD

On June 25, 2010, Jeffrey J. Pulver, DDS, passed away, succumbing to malignant melanoma. He was surrounded by his loving family. Jeff courageously “dodged the bullet” for a remarkable 14-plus years.

Jeff was born on May 31, 1952, in Chippewa Falls, Wisconsin. He was the eldest of 6 siblings. He spent most of his childhood on the family farm in Wisconsin with his loving parents, Don and MaryLou Pulver, and 5 siblings. It was there that he developed his skills as an outdoor sportsman, and became a “green thumb farmer.”

He attended Marquette University School of Dentistry, where he graduated in 1977. Following dental school, he completed a one-year general practice residency at Detroit-Macomb County Hospital. Jeff then came to California and completed his oral and maxillofacial surgery residency at the V.A. Medical Center, Long Beach/UCI Medical Center, Orange, in 1981. Jeff and his lovely wife, Karen, then moved to Prescott, Arizona to start their family and begin practice. After living in Prescott for seven years, they

moved to Orange County, where he began a new oral and maxillofacial surgery practice. He joked that after living in Prescott for seven years, and having to pay for Karen’s regular shopping trips to Nordstrom in South Coast Plaza, it was cheaper for him to relocate his practice to Orange County. During the years that followed, he conducted a very successful practice, working side by side with his wife, Karen, a registered nurse.

Jeff developed the Center for Oral Reconstruction and Education (C.O.R.E.), which provided mentoring programs in surgical and restorative implant dentistry, as well as basic C.P.R. training for dentists and auxiliary staff. He was a qualified instructor in advanced cardiac life support, and participated in regular re-certification courses throughout California.

Jeff also lectured on numerous topics, including bone biology, orthognathic surgery, and implant surgery. He was among the first few oral and maxillofacial surgeons in Orange County to implement Accelerated Osteogenic Orthodontic (AOO) surgery. He was on staff at St. Joseph Hospital of Orange, as well as Children’s Hospital of Orange County (CHOC).

During his internship at Detroit-Macomb County Hospital, he participated as a medical team member for the Detroit Red Wings. His avid love of hockey, combined with his interest in Sports Medicine, led him to his appointment as the team Oral and Maxillofacial Surgeon for the Anaheim Ducks since its inception 17 years ago. He made special efforts to get involved in the lives and well-being of his players. He developed personal friendships with many players and members of the Ducks organization. One of Jeff’s great joys was to celebrate the 2007 Stanley Cup championship with his beloved team, with whom he proudly wore a championship ring. Characteristically a goal-oriented individual, he trained and completed two IRONMAN triathlons during his career.

Jeff and Karen spent many happy hours with family and friends on their fishing boat, anchored between Cabo San Lucas and Newport Beach. Many

of his friends will attest to the good times had by all, especially during his “guy excursions.”

Those who knew Jeff were constantly uplifted by his quick wit, endless jokes (some not repeatable), and zest for life. His unwavering love, compassion, kindness, and generosity endeared him to his family, patients, friends, and all whose lives he touched. Jeff lived every day to the fullest; working, playing, and serving. In dealing with his cancer, he was the epitome of courage, dignity, and strength--right up to the very end.

Jeff is survived by his loving wife and best friend, Karen; his daughter Kristyn, a dental hygienist; and his son, Ross, a dental student; proud parents, Don and MaryLou Pulver; five siblings, and extended family.

Jeff’s legacy of love and endearing friendships, together with his remarkable courage, will forever be remembered in our thoughts, our hearts, and daily lives. Safe harbor, dear friend. ●

PRESS RELEASE

Effective April 1, 2010, Healthsoft, Inc, publishers of the Windent OMS software, joined forces with PracticeWorks Systems, LLC, publishers of the WinOMS CS software. This merger brings tremendous benefit to Windent and WinOMS customers due to the unique ability to share software options and services. Immediate benefits to Windent users include the seamless integration with the entire line of Kodak digital equipment, the ability to integrate iPhones and Blackberry cell phones with Windent data, and the electronic online verification of insurance coverage.

Sales and support services for the Windent software continue to be provided out of the Windent offices in Richardson, Texas by existing Windent personnel. Windent looks forward to taking even better care of their customers with the added benefits offered as a result of the merger.

Upcoming 2010 & 2011 CE Events

For Doctors

Residents' Night September 22, 2010	Southern CA
ACLS November, 6 2010	Solano CA
Medical Emergencies November 3, 2010	Northern CA
Medical Emergencies November 17, 2010	Southern CA
2011 January Meeting January 15-16, 2011	Monterey CA
11th Annual Meeting May 21-22, 2011	Rancho Palos Verdes

For Staff

OMSA Fall October 23-24, 2010	Southern CA <i>Weekend Seminar</i>
OMSA Winter October 15, 2010 February, 2011	Northern CA <i>Start of Home Study</i> <i>Weekend Seminar</i>
ACLS November 6, 2010	Solano CA
Medical Emergencies November 3, 2010	Northern CA
Medical Emergencies November 17, 2010	Southern CA

Classified



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EQUIPMENT FOR SALE

DEXTA ORAL SURGICAL CHAIR, MK-25X.
One Ritter Surgical Table, Model F-Type
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EXPERIENCED, BOARD CERTIFIED OMS
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e-mail eos@cftinet.com. CV on request.

DUAL DEGREE OMFS graduate looking for
associate position or office that is available
for sale in California. Please email me
at armkotik@gmail.com for further
information and CV or call 818-388-2737.

RETIRED ORAL SURGEON of 1 year is bored.
Looking for part-time and/or vacation
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(805) 680-4887

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Must possess strong communication skills
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First year salary negotiable, with buy in
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CV and contact information to : Sam J.
Poidmore, DDS., 18152 Pamela Place,
Villa Park, Ca. 92861, or Fax # 714-
921-9667.

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- Microfibrillar

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- Compact, cordless curing light, with *Continued on page 28*
- Preset curing times of 10, 20, and 30 seconds

