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Your Dentist is Advocating for Your Best Oral Health



By Barry J. Taylor,
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The opinions expressed in this editorial are solely the author's own and do not reflect the views of the Oregon Dental Association or its affiliated organizations.

WELCOME TO YOUR OREGON DENTAL ASSOCIATION MEMBER

dentist's office.

The ODA is a voluntary membership organization that your dentist has chosen to join. The ODA is the largest dental association in the state. As a member of the ODA, your dentist is also a member of the American Dental Association and, more locally, he is a member of a local component. At all levels, the ODA is an advocate for improving oral health not just for you but also for the community at large.

The ODA has always been dedicated to advancing the dental profession in order to provide better oral health care, and also promoting the highest standard of oral health.

Your dentist is well informed and is constantly taking continuing education courses to learn new techniques, skills, and how to improve the care they are providing you. This is such an important thing that the Oregon Board of Dentistry (**see page 24**) requires dentists to complete a minimum of 40 hours of continuing education every two years. The ODA hosts the Oregon Dental Conference, which is one of the 10 largest state dental conventions in the U.S. The Oregon Dental Conference provides more than 50 courses for your dentist to participate in. In addition to the Oregon Dental Conference, your dentist may also participate in other courses offered by many other dental associations.

One of the most important things that the ODA does is advocate for improvement of oral health for the residents of Oregon. Our mission is to improve the oral health for all residents of Oregon regardless of ethnicity, economic situation or where they live. Within the past year, the ODA has been a proponent for several legislative items in Salem (**see page 18**) that would

benefit Oregon residents. We called this initiative the "Oregon Action for Dental Health Initiative".

Recent graduates of dental school have an average debt of over \$250,000, and a debt of \$400,000 is not uncommon. To encourage new general dentists, including pediatric dentists and primary care physicians, to practice in rural areas, the ODA, along with Oregon Health & Science University, has advocated for the "Medicaid Primary Care Loan Repayment Program." This program offers loan repayment assistance to doctors who serve Medicaid patients in underserved communities.

The ODA also is an advocate for providing tax credits (\$5,000) for dentists and other medical providers who practice in rural areas of Oregon. This includes 10 rural counties and cities with a population of less than 5,000 with another dentist not within 25 miles. In addition to location, the participating dentist must accept Medicare and Medicaid patients. In Oregon, 98 percent of all children who rely on public dental programs live within 30 minutes of a dentist who accepts Medicaid. This tax credit is just one small way in which dentists are encouraged to practice in these rural areas to maintain this access to care. Built into the legislation was a 10-year maximum of receiving the credit and a person income cap for taking advantage of it.

Over the past two years, the ODA has introduced legislation encouraging, and advocated for, oral health screenings which would require school districts to make sure that all children under the age of 7 who are entering school for the first time. Our goal was to help make sure that all children had a "dental home" in which to receive care. The ODA would like for this information to

“Our mission is to improve the oral health for all residents of Oregon regardless of ethnicity, economic situation or where they live.”

be available so that we can better advocate for children’s oral health and dental care.

Although it did not pass in Salem, the ODA along with the OHSU School of Dentistry proposed the Native American Health Scholarship Program. This program would have provided free tuition and fees to attend dental school at OHSU for an individual who was a member of a federally recognized Indian tribe. In return the student would agree to work at a tribal healthcare service site for an equal time that was spent at OHSU. The ODA will continue to advocate for better oral health care for all populations of Oregonians.

One of the highlights in Salem this year for all health care providers was a new law raising the legal limit to purchase and sell tobacco and e-cigarettes to the age of 21. Tobacco is a significant contributor to gum disease and also is a contributing factor to oral cancer along with other oral health problems. This was just one more example of how the ODA is advocating for better oral health care and dental care for all residents of Oregon.

In addition to legislation, the ODA also has many other avenues in which it is advocating for better oral health care and dental care. One example of this

is its support of the MODA Tooth Taxi (**page 10**) which travels the state providing free dental care to children. In addition to volunteering on the Tooth Taxi, your dentist may also volunteer on other dental vans and in events in the community that provide free dental care.

There are many reasons that your dentist has made the choice

to be a member of the Oregon Dental Association. It may be for the continuing dental education, the camaraderie with their colleagues, or their support for the ODA advocacy for Oregonians oral health. Regardless of their motivation, you can be guaranteed that your ODA member dentist wants to provide you with the best dental care available. ●

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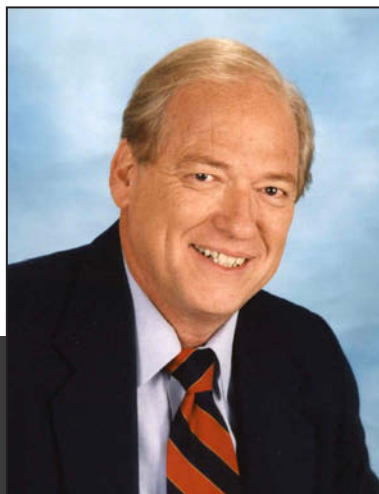
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The Science of Smiles



By Paradigm Dental

PARADIGM DENTAL

Reprinted from Paradigm Dental's Blog

IN NEARLY ALL OF HUMAN HISTORY, WE

have tried to comprehend the complicated cause of human happiness. Ancient philosophers like Aristotle tried to find explanations for the differences between pleasure and pain. For most of this venture, as Harvard psychology professor Daniel Gilbert said in an interview with *Harvard Business Review*, we've approached happiness from a philosophical approach: What is happiness?

It's only recently that we've taken a scientific approach. Our discoveries have led to some fascinating conclusions. It turns out the science of smiling has a lot to do with our happiness.

Studying something as seemingly subjective as happiness may seem futile. However, when you consider the question, "How are you?" you'll find that you always have an answer. People typically know if they're happy or not. Today, we can even measure brain activity to objectively determine whether a person is happy.

On paper, happiness and a smile may be obviously linked. We smile when we laugh and are pleased. Examining the actual science of smiling, however, offers concrete data to prove the connection between the two.

Various organizations have conducted studies on smiling.

UC Berkeley once conducted a landmark study on how smiling is linked to success. The group looked at photos in an old high school yearbook and actually measured the size of people's smiles. Over 30 years, they measured the well-being and happiness of those pictured. By the

conclusion of the study, the group could predict how long someone's marriage would last, how highly they would score on a standardized test of well-being and happiness, and how inspiring they would be to others.

Those with the widest smiles consistently ranked the highest in all of the above.

In 2010, Wayne State University conducted an experiment where they looked at baseball cards from MLB players in the 1950s. Players with the widest smiles in their pictures lived about eight years longer than those who didn't smile at all!

Other evidence has presented itself over time that proves humans are a naturally smiling species.

In 2011, Ron Guntman, the founder and CEO of HealthTap, did a TED Talk where he showed 3D models of babies still in the womb. He stated that babies appear to be smiling even before birth, and many newborn babies continue to smile in their sleep and when they hear a human voice.

As it turns out, the natural habit of smiling continues long into childhood. On average, kids smile up to 400 times a day.

When it comes to adults, 30 percent of us smile more than 20 times a day, and 14 percent of us smile less than five times a day.

Thank goodness for kids, then.

As Uppsala University in Sweden found, it's very difficult to frown while looking at a person smiling. When we looking at people grinning, it suppresses our control of our facial muscles, compelling us to smile.

So what does smiling really have to do with happiness? For

Charles Darwin, everything. In his book *The Origin of the Species*, he hypothesized with his Facial Feedback Response Theory that smiling actually makes us happier.

So if you're ever feeling sad or angry, just trying smiling. It may actually make you happier.

Obviously, we're less compelled to grin when we're not confident in our smiles. You should never be afraid to showcase a smile because, as we know now, it has incredible emotional benefits. If you've ever been self-conscious of your teeth, it's time to invest in your happiness.

You should always consult your dental specialist before making a dramatic change in your oral health. Most dentists offer a wide range of treatments, from at-home care to in-office procedures, all aimed at bettering your smile. Teeth whitening, braces or Invisalign, or veneers are all excellent methods to maximize your smile's potential. Schedule an appointment with your dentist today to start working toward your best grin. ●

Dr. Douglas A. Rust and Dr. Brian T. Rust are the father-son team of Paradigm Dental in Beaverton, Oregon, and are both graduates of OHSU. At Paradigm Dental, patient comfort and satisfaction is the foundation of their care philosophy. Paradigm Dental of Beaverton believes in treating patients with familiarity and dignity, providing them with the best procedural options and latest technology, and letting them take a deciding role in how we proceed with treatment.

The Dental Foundation of Oregon



By Jacki Gallo,
ED, LLM

OUR MISSION: IMPROVING ORAL HEALTH FOR OREGON'S children. Our Tooth Taxi Mobile Dental Clinic delivers FREE dental care and oral health education to children who are uninsured or under-insured. We partner with local schools to provide their students with comprehensive dental care and education. With the dental epidemic in Oregon continuing to increase, we serve those children who need dental care the most by eliminating economic, geographic, and transportation barriers. We currently provide services to more than 3,000 low-income/uninsured children each year. In addition to comprehensive dental services, our program also provides oral hygiene and nutrition education classes to classrooms. Each child in the class receives a hygiene kit (toothbrush, toothpaste, floss, timer and an educational brochure) to take home.

Oregon children have among the worst oral health in the nation. Because of poverty, lack of access to care and other social and economic issues, children in Oregon suffer

more dental pain and infection than children in almost any other state. Kids in pain get sick, miss school, fall behind academically and are in turn not set up for successful futures. In fact, Oregon educators estimate that on any given day, more than 5,000 children are suffering from substantial dental pain or infection. Poor oral health affects overall health. When decay goes untreated, children may face even greater problems as adults, including chronic conditions that contribute to lung disease, stroke and bacterial pneumonia. In rare cases, oral infections have even led to death.

Research shows that more than 90 percent of all systemic diseases (diseases involving many organs or the whole body) have oral manifestations, including swollen gums, mouth ulcers, dry mouth and excessive gum problems. Such diseases include diabetes, leukemia, oral cancer, pancreatic cancer, heart disease and kidney disease. Oral health is connected to the health of one's body as a whole.



Preventative care (both in the mouth, and oral hygiene education) has been shown to significantly affect children, in particular, because it allows their newly developing adult teeth to come in strong and healthy. Dental sealants and topical fluoride treatments help prevent decay in children's teeth. Dental disease is 100 percent preventable. The Tooth Taxi provides preventative care, education, as well as comprehensive dental care for Oregon's children in need. We provide service to children in need across the entire state of Oregon.

The Tooth Taxi employs a full-time dentist, a program director and two dental assistants. The Tooth Taxi serves school-based sites (and community centers) for a week at a time, providing dental screenings, fluoride varnishings, cleanings, sealants, extractions, root canals, fillings, crowns and other comprehensive dental care to those children most in need who would not otherwise receive any care.

We are always in need of volunteers (dental professionals and others) to help in many different ways on the Tooth Taxi. If you or someone you know is interested in volunteering on the Tooth Taxi, please reach out to us; we'd love to work with you.

Additionally, we are funded by gracious donors and by our event fundraising. We continue to work to raise monies needed to fund the Tooth Taxi program. Whether a donor is a business, an individual, a private foundation or a participant in our fundraising event, we welcome all donors. If you have a great idea to share with us on how you would like to help the Tooth Taxi, or to make a donation, please reach out to us and we will be happy to engage with you in order to help make a difference for Oregon's children. Find us on Facebook @DentalFoundationofOregon or our website www.SmileOnOregon.org.



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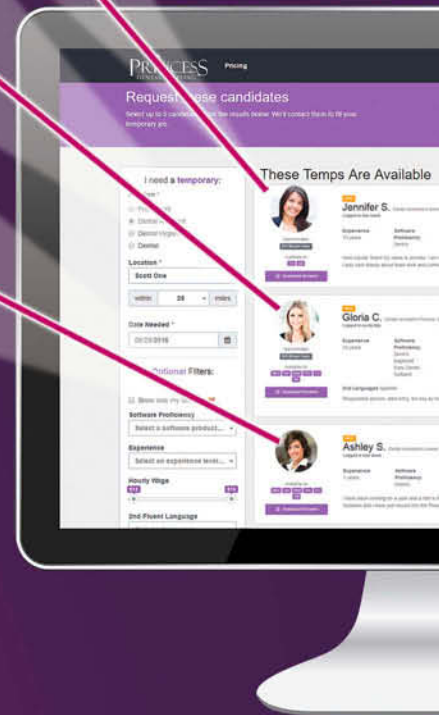


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Dental Patients Ask: “Why the X-rays?”

Going beneath the surface can help avoid painful tooth maladies, dentist says

X-RAYS

By Dr. Tara Paluska

Reprinted from The Register-Guard newspaper

MY NEW PATIENT WAS EXPRESSING DOUBT ABOUT

the need for dental radiographs — X-rays — as part of her appointment to have her teeth cleaned.

“It’s just a cleaning,” she said. “Why do I have to get all those X-rays? I had some taken last year, and I don’t want that radiation exposure.”

Her reaction isn’t uncommon, especially for patients who remember the early days of dental radiology. Back then, lead aprons were required to protect patients from radiation.

Today, however, dental X-rays don’t expose patients to that same level of radiation. Dentists use digital processes now, and our equipment has continually improved over the years. Patients receive less radiation at a dental visit than they get spending a day at the beach or flying on an airplane. X-rays are safe for pregnant women. Yes, we still use the aprons; they are comforting, but they aren’t considered necessary anymore.

My dental assistants are good about giving this information to patients. Sometimes, however, the patients are still hesitant and want to talk to the dentist. One of the points I make to patients is that I am required by the Oregon Board of Dentistry to diagnose a dental condition before treating it. To aid in diagnosis, I use X-rays, among other methods. I could face discipline if I practice below the standard of care, and this standard includes obtaining appropriate dental radiographs as needed.

For my patients, avoiding X-rays could mean needless suffering from dental conditions. Radiology is important because surface inspections

alone don’t reveal what lies inside the tooth or bone. Abscesses, cavities, bone loss, resorption of teeth — all of it should be treated and is detectable with X-rays.

- I use three types of X-rays:
- ▶ Panoramic, providing views of the upper and lower jaws and sinuses;
 - ▶ Periapical films, showing the roots of teeth; and
 - ▶ Bitewings for views between the teeth and evaluating the bone level.

The bitewing and periapical X-rays are tailored to an individual’s risk of dental disease, and the interval falls within a one- to three-year time frame in an effort to stay current on my patient’s dental conditions. The panoramic X-ray generally is taken about once every five years, or as oral findings dictate, but it is important. I have referred a patient to an oral surgeon in the past because the panoramic X-ray revealed a possibly cancerous defect.

Sometimes, patients are concerned about the cost of X-rays and may want to use previous bitewings or transfer X-rays from a former dental office. If the X-rays are diagnostic and within an acceptable time frame, they can be used; however, X-rays can age out, making it impossible for me to use them with any confidence. It’s worth checking with your dental insurance, should you have that coverage, because preventive or diagnostic X-rays often are covered at 100 percent.

A child’s first panoramic X-ray should be taken around age 7. I want to be certain that all teeth are present, in the right location and developing correctly. Sometimes, teeth are hiding



in the palate. If this is not detected in a timely manner, it can lead to tooth loss.

Patients also wonder why my staff and I ask for detailed medical histories. It’s because I am a health care professional, ready to respond in an emergency. If my patient begins to have chest pains and his chart indicates use of erectile dysfunction medicine, for example, it changes the medications I can administer safely. In addition, I may spot oral conditions that are related to systemic disease, and these should be addressed by the patient’s physician.

Kaiser Permanente opened its Lane County dental office in early 2016, and I have seen a steady stream of new patients since then. Even if they question dental radiology, I am heartened that everyone wants the same thing: good oral health. 🌟

Dr. Paluska is a general dentist in Eugene with Kaiser Permanente Dental. She enjoys helping patients improve and maintain their oral health. She focuses on the importance of preventive care and teaching patients good oral hygiene habits.

Are My Child's Teeth Developing Normally?



By Erica Crosta,
DMD, MS

AS AN ORTHODONTIST I DEAL WITH THE facial and dental growth and development of children. The developing adolescent mouth can be a daunting and intimidating place if you don't know what you are looking for. A child's dentition is ever-changing, and it can be confusing as a parent to keep track of what is normal and age-appropriate.

Humans have two sets of teeth: primary "baby" teeth and permanent "adult" teeth. Primary tooth development normally begins around five weeks in utero. The last permanent teeth (third molars or wisdom teeth) typically complete development between the ages of 17–21 years of age. The important thing to always remember is that there can be large timing variations between individuals, and this is totally normal! Early development and late dental development have not been linked to any other developmental milestones and can vary dramatically between individuals.

A child will typically begin erupting their first baby teeth around 6 months of age; these teeth are typically lower central incisors. Over the next 24 months of your child's life, they will erupt all 20 primary teeth, 10 on the upper arch and 10 on the lower arch. As your child grows and develops with this full complement of baby teeth, you may notice some spaces in between them; this can sometimes alarm parents. Please let me assure you, most of the time this is totally normal!

From age 2½ to age 6, there will not be much visible change in the primary dentition. However, many permanent teeth will be developing and changing in the jaw bones. Around the age of 6, the first permanent molars will usually begin erupting behind the last primary teeth. Because these permanent molars do not replace any primary teeth, they can go unnoticed.

Also around this time, your child may begin experiencing his or her first loose teeth, typically the lower primary central incisors (remember, this was the first tooth to erupt when your child was 6 months old). From age 6–8, children will usually experience the loss of approximately eight primary teeth (four upper incisors and four lower incisors). Their subsequent permanent central and lateral incisors will replace these primary teeth. This is typically the age when your child should be seen by an orthodontist. Your orthodontist can help determine if the changes at this age are normal or abnormal. At this age, we can sometimes identify developing impactions, crowding, jaw discrepancies and potential functional problems. Sometimes children at this age will need interceptive orthodontic treatment to try and prevent problems that are not as easily corrected in the future.

Ages 8–10 are a transitional period when your child will generally not experience much visual change in his or her dentition. This period is called the mid-mixed dentition because children have 12 permanent teeth and 12 primary teeth. Around age 10 (give or take 6–12 months on either side), they will start to lose the remainder of their baby teeth. This period will typically last around two years and commence with the eruption of upper permanent canines and upper and lower second molars; also known as 12 year molars. The last teeth to appear are the third molars (wisdom teeth) between ages 17–21. These teeth are extremely variable and typically need to be extracted due to lack of room in the mouth and their potential for impaction.

Additionally, girls generally develop earlier than boys and lower teeth typically erupt before their upper counterpart. There can be large amounts of variation; a delay or acceleration of 12 months

“The important thing to always remember is that there can be large timing variations between individuals, and this is totally normal! Early development and late dental development have not been linked to any other developmental milestones and can vary dramatically between individuals.”

from the average timetable is still considered normal and falls within the normal range.

The American Association of Orthodontists recommends taking your child to the orthodontist for evaluation around age 7. Eruption sequence and timing will be evaluated as well as facial growth and development. Your orthodontist may recommend early, interceptive treatment if there is an indication for it. ●

Dr. Crosta is an orthodontist in Bend. She attended Oregon State University for her Bachelor of Science, and progressed to Oregon Health & Science University for her Doctorate of Dental Medicine. She earned her Master of Science and certification in orthodontics from the University of Nevada, Las Vegas.

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Fluoride: Nature's Cavity Fighter



By Kurt Ferré, DDS

FLUORIDE IS NATURE'S CAVITY

FIGHTER. It is the 13th most common element in the Earth's crust and is found at varying concentrations in all drinking water and soil. Dr. Fredrick McKay, a young dentist, discovered the miracle of fluoride in the early 20th century. He had recently moved to Colorado Springs and observed that although many of his patients had unsightly spots on their teeth, they had far fewer cavities than his patients back in the eastern United States, where he was trained.

With the help of dentist pioneer Dr. G.V. Black, they discovered that the low decay rate was related to the naturally occurring fluoride in the water. The problem was that in Colorado Springs, the concentration was 10 parts per million, which caused the unsightly spots called fluorosis. Dr. McKay and Dr. Black hypothesized that if the concentration were lower, then the protective benefit of fluoride could still be achieved without the unsightly spots on the teeth. After years of observational studies of water supplies around the country, they arrived at the concentration of one part per million (ppm). Today, the optimal level has been lowered to 0.7 ppm.

In January 1945, Grand Rapids, Michigan, was the first city in the United States to add fluoride (called fluoridation) to its public

water supply. The results were dramatic. In 10 years, the cavity rate dropped by 65 percent for 12-year-old children! It is estimated that fluoridation has saved over \$40 billion and countless hours of pain and suffering for Americans.

So, how does fluoride work? Studies have demonstrated that fluoride has both a pre-eruptive (systemic) effect and a post-eruptive (topical) effect. Therefore, after teeth have erupted into the mouth, the primary action of the fluoride is topical for both children and adults. When we eat sugars and other carbohydrates, the acid-producing germs in our mouths make acid, which drips on the teeth and causes a microscopic breakdown (demineralization) of the enamel. But if fluoride is present, it will gather up the dissolved minerals (calcium and phosphorous) and reattach with the fluoride, and this new structure is more resistant to further acid attacks. This enamel breakdown and reattachment to the tooth surface occurs multiple times every day.

So, how does a cavity occur? It occurs when the "acid-sugar challenge" is so great that the fluoride present in the mouth is overwhelmed by the amount of acid in the mouth.

Sadly, since many if not most Oregonians do not enjoy the public health benefit of fluoridation, it is important that you obtain nature's cavity fighter in other ways: toothpaste, rinses, fluoride rinses and, for children under 14 years of age, fluoride supplements. Please discuss fluoride with your hygienist and/or your dentist. 🍷

Dr. Ferré has more than 30 years of experience as a practicing general dentist. While he is now retired, he is a past president of the Multnomah Dental Society and does weekly volunteer work in the Portland metropolitan area.



Oregon Action for Dental Health: Building an Initiative from the Ground up to Improve Access to Care

IN OREGON, 91 PERCENT OF CHILDREN ON public health insurance live within 15 minutes of a dentist who accepts Medicaid, and yet the state's children have among the worst oral health in the nation. Schools estimate that more than 5,000 children suffer from dental pain or infection on any given day.

Adults face a similar situation. Although 99 percent live within a half-hour of a dentist, as many as 1 in 5 say their mouths and teeth are in poor condition.

In a state with more than enough dentists available to provide dental care, why are we facing this problem? Are there social and economic issues at play, or is geographic access a primary factor?

To begin addressing these questions, the Oregon Dental Association launched an initiative in early 2017 called Oregon Action for Dental Health: a multipronged, multiyear effort that seeks to improve access to oral health care for every Oregonian, to strengthen the public-private safety net for those unable to afford essential care and to expand education and disease prevention programs in underserved communities.

There are many varied and complex factors that prevent people from getting to the dentist, but the Oregon Dental Association is committed to ensuring that every Oregonian has access to a high-quality, licensed provider regardless of race, income or geographic location.

Diagnosis first, and then a cure

You can't determine the right treatment without a diagnosis. Knowing this,

the ODA commissioned a study by the Health Policy Institute to better understand the extent to which geography creates gaps in access to dental care, whether for children in urban or suburban neighborhoods, or for residents of the state's rural and tribal communities.

"We wanted to dig deeper and develop a more accurate picture of access to dentists, especially in rural areas," said ODA President Dr. Gregory Jones, whose dental practice is in Redmond.

Past studies found that cost was the No. 1 factor keeping Oregonians from seeing dentists, followed by general fear or discomfort around dentists or inconvenience. However, questions remained as to whether dentists were as accessible in rural communities as other areas across the state, and whether the number of new dentists would keep up as older practitioners retired.

The 2017 study, which was peer-reviewed by Portland-based ECONorthwest, looked at the geographic location of dentists and whether they accept public insurance such as Medicaid, generating a heat map showing which areas had access to dentists and which did not.

Number of providers is not the problem

The new research showed that Oregon has enough dentists now and entering the workforce in the future to provide care for all residents through at least 2035. This analysis was based on current data along with projected population growth, estimates of dental

school graduates and trends such as retirement or movement of residents.

"We now know that we have enough dentists to serve the entire state," said Jones. "We just need to ensure other barriers aren't keeping people from receiving the care they need."

The next question focused on geography. If there are enough dentists to serve everyone who needs one, are they located in the right areas, and are they accessible regardless of the type of insurance a person has?

The study showed that 98 percent of children who rely on public insurance for dental care live within 30 minutes of a dental care provider who accepts Medicaid patients. Of Oregonians overall, 99 percent of residents live within 30 minutes of a dental care provider.

Dr. Marko Vujcic, Chief Economist and Vice President of the Health Policy Institute at the American Dental Association, presented the findings and other recent research to the Oregon House and Senate Health Care Committees in the spring.

"The geographic coverage of dental care providers is actually quite extensive," Vujcic said. From the policy perspective, he noted: "There needs to be somewhat less focus on increasing the number of providers and much more focus on connection interventions, making sure the population knows where dental care providers are who accept their coverage, easier navigation services and improving dental reimbursement rates in Oregon, which are quite low compared to other states."

91% OF PUBLICLY INSURED CHILDREN LIVE WITHIN 15 MINUTES of a Medicaid dentist.



89% of publicly insured children live in areas where there is at least one Medicaid dentist per 2,000 publicly insured children within a 15-minute travel time.



88% of the population live in areas where there is at least one dentist per 5,000 population within a 15-minute travel time.

DISTRIBUTION OF POPULATION ACCORDING TO POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

Publicly Insured Children per Medicaid Dentist		Population per Dentist	
<500	74%	<2,500	74%
500-2,000	15%	2,500-5,000	14%
>2,000	2%	>5,000	7%
No Medicaid dentist within 15-minute travel time	9%	No dentist within 15-minute travel time	6%

Sources: Based on ADA Health Policy Institute analysis of the 2015 ADA office database and 2011-2015 American Community Survey. For full methodology, see Nasseh K, Eisenberg Y, Vujcic M. Geographic access to dental care varies in Missouri and Wisconsin. *J Public Health Dent.* 2017 Jan 11. Note: Percentages in table might not add up to 100% due to rounding.

For more information, visit ADA.org/HPI or contact the Health Policy Institute at hpi@ada.org.

Using the findings to guide next steps

While the HPI study provided valuable insight into the availability and geographic location of dentists accepting the Oregon Health Plan, it raised additional questions about affordability, the ability of dental practitioners to accept Medicaid patients and patients' access to dentists who accept public insurance.

"While there's still work to be done, we now have concrete data showing that we don't face a challenge when it comes to our workforce and supply of dental care providers," said Oregon Dental Association President-Elect Dr. Bruce Burton, a dentist in Hood River. "Knowing that means we can focus our resources where they're needed most: ensuring professional dentists are available and affordable to all Oregonians."

During this year's session in Salem, the ODA supported legislation that

would ensure all Oregonians have access to a qualified, licensed dental professional.

This included voicing strong support for renewing the Rural Medical Practitioners Tax Credit, which encourages dentists to locate their practices in underserved communities, and funding the Medicaid Primary Care Loan Repayment Program to help dentists who choose to practice in rural areas pay back student loans. Other legislative efforts included an oral health school screenings law, which would require schools to report data on students' dental screenings.

The ODA also partnered with OHSU School of Dentistry and Oregon tribes to promote a Native American Health Scholarship Program. This program would provide free tuition and fees for qualifying Native American health professional students, including dental students, who agree to work in a tribal service site after graduation.

This bill is only the beginning of conversations between the ODA and Oregon's tribes. ODA representatives and the Legislative Commission on Indian Services met in Salem in May. Additionally, the ODA, in conjunction with OHSU representatives, participated in a successful dialogue on access to dental care with the Confederated Tribes of Grand Ronde in June.

"Good dental health is fundamental to the well-being of our communities, and we hope to work together with Grand Ronde leaders on policies and programs that improve oral health care in Indian Country," said Conor McNulty, executive director of the Oregon Dental Association. "We know that Oregon has a unique relationship with its federally recognized tribes, and we would like to continue that tradition through solid communication, education and respect for tribal sovereignty."

Equity is important

Following the 2017 legislative session and in the years to come, the ODA will continue to focus efforts on equity and access to oral health care for all Oregonians. As access to care in other states has come into question, some have essentially created a lower tier of care for lower income or rural residents. To the ODA, this is not an acceptable solution for Oregon.

The organization hopes to go beyond a Band-Aid approach and focus on long-term solutions that ensure equitable dental care for all Oregonians.

"While the issue of access to care is not one that can be solved in a month, or even a year, there are small things that we can do right now to help ensure equitable access to dental care for all Oregonians," said Dr. Calie Roa, a dentist practicing in Medford, "regardless of what they look like, how much money they make or where they live." ●

Do You have the Most Widespread Disease in the World?



By Michael Matsuda,
DDS

YOU MAY TRY YOUR BEST TO EAT

healthy, exercise, and even follow Dr. Oz, but there's a good chance you are suffering from the most common disease on the planet: gum disease.

Periodontal, or inflammatory gum disease is a silent epidemic in our country, affecting a whopping 50 percent of adults over the age of 30. So it is no accident we are seeing "inflammation" in the news more and more these days, along with the importance of healthy gums.

A bit of bleeding in the sink after brushing may seem fairly harmless, but this early sign of gum disease is a red flag that should be acted upon. Why? Because *Healthy Gums Don't Bleed*, and even the faintest trace of blood means that bugs by the millions (oral bacteria) living in your mouth gain access to the circulatory system—a recipe for disaster, since the bloodstream is a direct pipeline to your vital organs.

Studies are showing direct and indirect links between gum disease and a number of chronic diseases and conditions such as diabetes, heart disease, Rheumatoid arthritis, lung disease, pre-term birth/low birth weight babies, Alzheimer's disease, and certain cancers. (The mouth IS very much connected to the body!) For this reason

alone, the health of your gums should be top priority in your efforts to attain health.

If you have already noticed puffy gums or bleeding, it's not too late to reverse the disease if it is confined to the gums. Early intervention is key because, left untreated, the disease can spread to the bone beneath the gums and cause irreversible destruction.

Periodontists are dentists who have specialized training in the treatment of gum disease and conditions involving the gums and underlying bone that anchor our teeth. Periodontal care aims to preserve and maintain these supporting structures so that you will have your teeth long after you need them. For a tooth that is lost or missing, periodontists can place dental implants that restore both function and natural esthetics.

The third area of expertise periodontists specialize in is esthetic or cosmetic procedures that restore the natural beauty of your smile. Gums frame the teeth with symmetrical curvatures. When the amount of gum tissue is in balance and harmony with the teeth it surrounds, the result is a beautiful and confident smile. There are many esthetic conditions that a periodontist can assist you in correcting or improving. Our goal is to give you the happiest, healthiest smile possible.



Crown lengthening and veneers treat a gummy smile and short-looking teeth



Connective tissue grafts can regenerate lost gum tissue and give you back your youthful smile.



If you have periodontal disease, there are ways a periodontist can help you treat and manage your condition. When you come in for your appointment, the doctor will examine you and discuss treatment options with you. Periodontal offices have highly skilled hygienists who perform regular maintenance cleanings as well as deep dental cleanings that are done with the gums comfortably numbed up.

Periodontal specialists constantly learn about new ways to enhance treatment outcomes for our patients. Our education is ongoing throughout our careers to learn advancements in the field and enhance our knowledge base. Examples of these advancements include the use of stem cells, biologics/growth factors and therapeutic lasers.

As a periodontist, my goal is to educate people and provide them with the tools they need to start winning the war against gum disease. Oral health is directly linked with

overall health, and I am passionate about helping people achieve their best outcomes.

For more information about periodontal disease and what services are offered in a periodontal practice, please visit the American Academy of Periodontology's website at: www.perio.org/consumer/patient-resources. They also have lists of all the board certified periodontists in your area. ●

Dr. Matsuda graduated from University of the Pacific Arthur A. Dugoni School of Dentistry, completed his residency in periodontics at Oregon Health and Science University, and is a board certified diplomate of the American Board of Periodontology. Dr. Matsuda currently serves as president of Oregon Society of Periodontists, is president-elect of Western Society of Periodontology, and also serves as a Clinical Assistant Professor at OHSU Department of Periodontology.

“If you have periodontal disease, there are ways a periodontist can help you treat and manage your condition.”



A protective gum graft can prevent bone loss and recession, which will help prevent tooth loss.

“Not As Bad As a Root Canal”



By Douglas C Boyd, DMD

THIS IS THE MOST COMMON CLICHÉ HEARD in social media, movies, and public conversation for years. Root canal treatment seems to be the public gold standard of unbearable pain comparisons. I specialize in root canal therapy (endodontics), and I find this saying not only damaging to the dental profession but obsolete and untrue. Root canal therapy can be likened to an appendectomy on your tooth, where the offending tissue that is causing a problem is removed, i.e., the nerve of the tooth.

When your tooth has adverse symptoms to hot, cold or pressure discomfort when you chew, you may have the first signs that your nerve is going bad and root canal treatment may be needed. However, there may be no symptoms. Your general dentist may see a problem in an X-ray image of a tooth, even one that has had a root canal. Root canal therapy is started by giving a local anesthetic which allows the interior of the tooth to be cleaned. Most likely, this will leave you pain-free. If you still experience discomfort after a root canal has been started, you may need to repeat this process with your dentist to make sure every microscopic space inside the tooth is clean and disinfected.

Once the canals are cleaned completely, a filling material is placed in the canal(s). Long-lasting pain after a root canal is rare; short-term mild discomfort may be present.

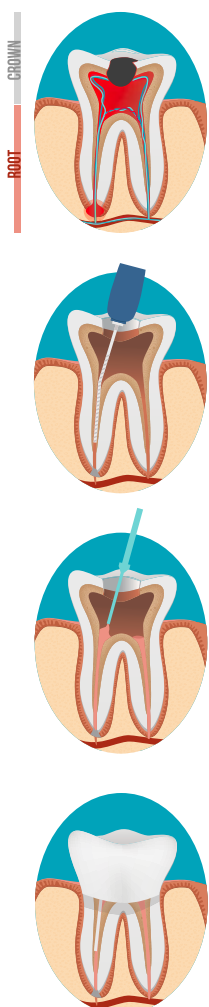
Most of the root canal treatments done in the United States are by general practitioners. Root canal specialists, like myself, should be considered part of your

“Root canal therapy can be likened to an appendectomy on your tooth, where the offending tissue that is causing a problem is removed, i.e., the nerve of the tooth.”

dentist’s treatment team. There are some teeth, usually your molars, that are difficult to treat because of their complex root canal anatomy. These are the types of teeth requiring advanced specialty skills. General dentists, trained in team interdisciplinary care, tend to refer these challenging cases to root canal specialists. Also, if a past root canal is failing, an endodontist is usually referred to for retreatment.

In summary, modern root canal therapy should not be considered the favored analogy of horrific pain. That analogy is exaggerated and inaccurate. Patients suffer the most prior to treatment, and that is why patients usually seek root canal treatment. The mild discomfort experienced after treatment and easily controlled by pain medication is simply the sore surrounding bone and soft tissue supporting the tooth in question. It may take 24 to 48 hours for this “bone pain” to go away, and the prescribed pain medications will allow most patients to return to work and live their lives normally afterward. Usually an over-the-counter anti-inflammatory pain medication like Advil, Aleve or Motrin is adequate. Antibiotics are sometimes needed if an infection is suspected. ●

Dr. Doug Boyd graduated from the University of Idaho in 1967, with a B.S. degree and earned his dental degree from the University of Oregon Dental School in 1971. After dental school, Doug served a dental internship at Wilford Hall Medical Center, U.S.A.F. hospital. He was stationed at Hanscom Air Force Base as a general dentist from 1972–1974. In 1976, after completing his certification in endodontics and earning a Masters degree at the University of Oregon Health Sciences Center, Doug served as endodontist from 1976–1979 at Sheppard Air Force Base Hospital. In 1979, he started his own private practice in the Portland area.



What is a Prosthodontist?



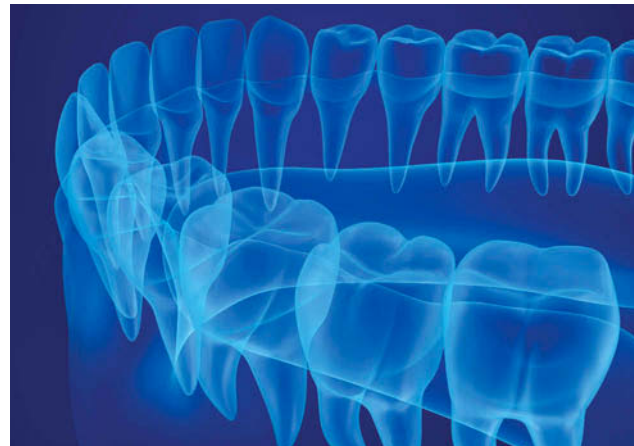
By Scott R. Dyer,
DMD, MS, PhD

“To this day, I continue to marvel at the interaction of art and science that are required to restore the smiles and lives of my patients.”

WHEN I WAS 14 YEARS OLD, I began carving and making teeth in the dental laboratory of my father and grandfather. I marveled at the interplay of art and science that was necessary to create teeth for dentists and their patients. That fascination led me on a path to dental school. During my dental training, I became aware of many dental specialization areas. All of them were interesting, but one resonated clearly with all the things that led me to become a dentist, prosthodontics.

What is a “prosthodontist”? The term “prosthodontist” means replacement and prosthetic while “-dentist” means dealing with teeth. Essentially, prosthodontists are the recognized experts when anything needs to be replaced or reconstructed in the mouth. This can range from a single tooth, multiple teeth, or all teeth and gums in the mouth. While many other dentists can do some or all of these treatments, prosthodontists are the specialists dedicated to this type of care.

Prosthodontists expertly restore and replace teeth. They have trained three additional years after completing dental school including advanced-level courses, clinical and laboratory experience, patient care and research. Prosthodontists are considered the “quarterback” of the dental treatment team, coordinating dentists, specialists, technicians, artists and other health professionals to develop solutions for our patients. This rigorous training and experience provide prosthodontists with a special understanding of the dynamics of a smile and the preservation of a healthy mouth including: esthetic and cosmetic dental restorations, full mouth reconstruction, maxillofacial prosthetic procedures like oral cancer reconstruction, traumatic injuries, snoring and sleep disorders, cleft palate and other congenital conditions that affect the mouth.



To this day, I continue to marvel at the interaction of art and science that are required to restore the smiles and lives of my patients. I feel very lucky to have found a career like dentistry and the specialty of prosthodontics. A few years ago, I read a quote that continues to inspire me to push on my own path of learning and development, pursuing excellence. “After a certain high level of technical skill is achieved, science and art tend to coalesce in esthetics, plasticity, and form. The greatest scientists are artists as well.” (Albert Einstein) 🍷

Dr. Scott R. Dyer is a board-certified prosthodontist and maintains a private practice limited to fixed, removable and implant prosthodontics in Tualatin, Oregon. He is an adjunct professor at Oregon Health & Science University in the Department of Restorative Dentistry in the divisions of Biomaterials and Biomechanics, and Prosthodontics. He received his D.M.D. from Oregon Health & Science University and a Certificate in Prosthodontics with a Master’s of Science from the University of Texas Health Science Center at San Antonio. Dr. Dyer earned his Ph.D. from University of Turku, Finland, with his work regarding the design of dental prosthetic structures.

The Oregon Board of Dentistry



By Stephen Prisby,
Executive Director
of the Oregon Board
of Dentistry

THE OREGON BOARD OF DENTISTRY (OBD) WAS created by an Act of the Legislature 130 years ago, in 1887. Our agency is empowered to regulate the dental profession and protect the citizens of our state. It is universally agreed that oral health is essential to one's general health and well-being, and our state agency is one of many entities in Oregon helping to facilitate that. The ten members of the board, comprised of dentists, hygienists and the public, are appointed by the governor and confirmed by the Senate.

As executive director, I serve at the pleasure of the governor and carry out the administration of the board's duties and directives. I lead a staff of seven, which is split between administration/licensing and the investigative staff. The OBD licenses dentists and dental hygienists and certifies certain functions of dental assistants. The Dental Practice Act contains the statutes and rules regarding the lawful practice of these professionals in our state, including very specific rules regarding sedation and permitted levels of anesthesia. The OBD's



investigators handle the complaints that our agency receives. It is ultimately the ten board members who decide whether an individual licensee will be disciplined or not, which they vote on at board meetings during public session.

The Oregon Dental Association (ODA) was formed soon after the OBD back in the 1880s. The association is the professional voice for Oregon dentists. The ODA promotes the profession and works well with our state agency to communicate important news, rule changes and other issues that impact safe practices in the state. We are two distinct entities. The ODA also has a peer review process as an alternate path from the OBD complaint process, in which ODA member dentists are required to participate, for an equitable resolution of patient complaints about dental treatment. It is always best to first speak with your dentist to resolve an issue before contacting the OBD or the ODA's peer review process.

The following are some of the most frequently asked questions (FAQs) we receive from the public. Every patient and situation is unique, so please contact us for more assistance or clarity as needed. We are very proud to help the citizens of our state and respond promptly to all concerns and questions, with a phone call or through email. Our website at www.oregon.gov/dentistry is the best way to review all OBD-related information and our phone number is 971-673-3200. 📞

Stephen Prisby is originally from Chicago. He has a B.S. in Mass Communications from Illinois State University. He has over 10 years experience in higher education, with positions in admissions and as a campus director. He joined the OBD in July 2012 as the office manager and has been involved in almost every aspect of its operation. He now serves as the executive director.

FAQs at the Board of Dentistry

Can I get my dental records from a dentist?

Board regulations require that a licensee provide *copies* of a patient's records, including X-rays, within 14 days of written request made by the patient or patient's guardian. (OAR 818-012-0030(9)(a) & OAR 818-012-0032).

What should I expect when the dentist proposes treatment?

If the dentist makes recommendations for treatment, don't be afraid to ask for more information.

- ▶ Are other treatment options available? How do the options differ in cost? Which solutions will last the longest? Do all the options solve the problem?
- ▶ Among the dentist's recommendations, which treatments are absolutely necessary? Which are elective? Which are cosmetic? Which procedures are urgently needed and which ones are less urgent?
- ▶ Ask for a written treatment plan before you agree to treatment. Most treatment plans should suggest alternative treatment options. When extensive or major dental work is proposed, such as implants, crowns, or bridges, seeking a second or even a third opinion may be appropriate.
- ▶ How much will the proposed treatment cost? What method of payment does the dentist accept?

Check with your insurance company or managed care plan about the services covered and the amount reimbursed for the treatment. Your dentist can submit a "Preauthorization Plan" for the insurer's review. The insurer will inform you of the costs that will be reimbursed under your particular plan.

What can I do if I have a problem with my dentists?

We always encourage patients to speak directly with their dentist (to mutually resolve problems), not the office manager or other staff members. Some issues not within the jurisdiction of the board can be resolved through the peer review process facilitated by the Oregon Dental Association. While peer review proceedings are not intended to be solely dispute resolution services, professional review often can resolve some types of disputes between patients and dentists. The process is confidential, and is available provided the complaint falls within the peer review guidelines. For more information about this process and its guidelines, contact the peer review director of the Oregon Dental Association at 1-800-452-5628, or visit the ODA web site at www.oregondental.org.

If you feel that the issue involves unacceptable patient care or other issues under the jurisdiction of the Board of Dentistry, you have the right to file a complaint with the board. All written complaints filed, that are within the board's jurisdiction, are investigated.

How do I know if a dentist has been disciplined?

On the OBD website (www.oregon.gov/dentistry), we have a LICENSEE LOOKUP feature. Board actions taken against the licensee will be posted, or in certain cases, a note will ask you to contact the board office for more information. Complaints are not public information; Oregon statute dictates that we keep that information confidential. If you cannot find a licensee on our Licensee Lookup system and you believe he or she should be listed, please contact us. This information is updated constantly, and every effort is made to assure that it is accurate.

Pediatric Sedation



By Andrea N. Beltzner,
DMD

I LOVE MY JOB AS A PEDIATRIC dentist. One of my biggest responsibilities is to help kids grow up with a positive attitude toward dentistry. This is not always easy, but it is so rewarding when I can watch an anxious youngster at my dental office begin to feel comfortable in the dental chair over time. We all know that many adults avoid visiting a dentist until they are in pain because they are so anxious about dental treatment. I know that my most important job as a pediatric dentist is to help children feel at ease so that as adults they can look forward to seeing their dentist and get the care they need.

As a pediatric dentist, I have a lot of tools in my tool belt to help each child feel comfortable in the dental office. Some of those tools include simple non-pharmacologic things like positive reinforcement, lots of praise, the promise of stickers and tokens for the prize machine at the end of the visit, distraction, having an older sibling model a positive visit, multiple short and easy visits to desensitize a very anxious patient and the tell-show-do technique. For the vast majority of young patients, these methods work really well and are all that is needed to help put a child at ease at the dentist.



Of course, there are times when our non-pharmacologic tools are not enough to allow a very young or anxious child or a child with special needs to tolerate and be comfortable for dental treatment. For these patients, I will evaluate if we can delay treatment by guiding the parent to develop a good oral hygiene routine at home and will also give recommendations for diet modification, in addition to seeing them more often in the office when monitoring areas of decay. I may recommend silver diamine fluoride to help stop or delay the progression of cavities to buy some time for the child to mature and become more comfortable in the dental office.

If there is dental treatment that must be completed in a very young, pre-cooperative child or for a child with severe anxiety or certain special health care needs, we may recommend the use of nitrous oxide, oral conscious sedation, or even general anesthesia to be able to complete the child's dental treatment comfortably and safely. For a fairly cooperative child who may be mildly anxious, I may recommend nitrous oxide for their dental treatment to help ease their anxiety, particularly for a child who may need a longer appointment or multiple visits. Nitrous oxide is a gas (that is mixed with oxygen) that the patient breathes during dental treatment. It helps patients to feel very calm and relaxed and is generally very safe with very few side effects. The level of nitrous oxide can be titrated depending on how anxious the child is, and it takes effect quickly and is also out of the child's system very quickly when turned off at the end of the procedure.

For the pre-cooperative or highly anxious child with extensive decay, the child might benefit from oral conscious sedation or, in some cases, even general anesthesia. Oral conscious sedation may sometimes be combined with the use of nitrous oxide gas.

There are many different agents that are used for oral conscious sedation and many factors for the dentist to consider when recommending oral conscious sedation. Some of these factors include the child's medical history and the duration and invasiveness of the dental procedures. In general, oral conscious sedation in children administered by a pediatric dentist with the proper training is extremely safe. As dentists, we know that patient selection is of the utmost importance when recommending oral conscious sedation or general anesthesia. A careful medical history, including consulting with the patient's physician for a child with any medical concerns or things that may be unclear when reported by the child's caregiver, is essential. A careful physical assessment of the child, including calculating the BMI from the child's height and weight and evaluating the airway including the size and position of the tonsils and the size and position of the lower jaw are also essential. In addition to these things, I often ask the child's caregiver if he or she snores at night or has any history of sleep apnea. Children with elevated BMIs and large tonsils are at a higher risk of respiratory distress due to airway obstruction during oral conscious sedation. It is also helpful to know how the child does drinking oral medication at home to know if oral sedation is even a possibility. A dentist never should administer additional medication if a child spits out the oral sedation medicine, because it is impossible to know how much of the medication the child actually ingested. As a general rule, I will only recommend oral conscious sedation for children over age 3 and over 30 pounds. Patients must also refrain for eating or drinking anything for eight hours prior to the sedation appointment. Careful monitoring of any patient during oral conscious sedation is a must! Monitoring includes continuous measurement of the

child's breathing and heart rate with machines like pulse oximeters and also capnography, which continuously measures the child's exhaled CO₂. The dentist must always have a plan in place that has been rehearsed with the dental team in case of the very rare medical emergency that could occur in the dental office. With careful patient selection and careful monitoring of patients during procedures with sedation, complications from oral conscious sedation in children during dental treatment are very rare. The benefits to be able to provide dental treatment comfortably to children that will prevent or alleviate a painful dental infection are enormous to the overall mental and physical well-being of the child.

Providing high-quality dental treatment to children safely and in a comfortable environment is my goal for each of my patients. I am thankful that I have many options available to me when considering the best course of treatment for each individual patient. It is important for the dentist to discuss all recommended treatments thoroughly, including alternatives to the recommended treatment, risks associated with treatment and to take time to answer any questions that the child's caregiver might have. ●

Dr. Andrea Beltzner received her dental degree from Harvard in 2005 and then completed a pediatric dental residency program at the University of Connecticut. She received her board certification in pediatric dentistry in 2007, and is a Diplomate of the American Board of Pediatric Dentistry. She chose pediatric dentistry as a specialty not only because she loves children, but also because she values being able to help children develop a positive attitude toward dental care that will last them a lifetime, by making dentistry fun and comfortable for them while they are young.

Oral Surgery: Beyond Wisdom Teeth



By Thomas A. Kolodge,
DDS, MD

WHEN MOST PEOPLE HEAR ABOUT ORAL SURGERY, they probably think of having wisdom teeth removed. While removal of wisdom teeth is among the most common services provided by oral surgeons, the range of training and procedures included in the specialty of oral surgery is much more extensive.

Oral and maxillofacial surgery (often shortened to “oral surgery”) is a specialty of dentistry, and thus all oral surgeons are dentists. Training programs include a minimum of four years of additional training after dental school, typically in a hospital-based environment. Approximately half of the current oral surgery residency programs are six years in duration and include the integration of medical school, allowing trainees to acquire medical degrees as well. All oral surgery programs include comprehensive education in a wide range of disease processes and treatments involving the maxillofacial (relating to the jaws and face) region. Following completion of training, many providers restrict their practice to only some of these areas, while others continue to practice the full spectrum of the specialty. Still others complete fellowships to further specialize their area of expertise.

Dentoalveolar procedures are the most commonly performed surgeries for the majority of oral surgeons. This includes removal of teeth, facilitation of orthodontic treatment and preparation of the jaws and soft tissues for various tooth replacement options. While general dentists do perform oral surgery procedures, patients are often referred to an oral surgeon if the procedure is more complicated or involves additional risk. Reconstruction of the dentition with the placement of dental implants is also a very common procedure carried out by oral surgeons. This often involves procedures

to maintain jaw bone and soft tissues after extractions or regeneration of bone and soft tissue after significant loss, in anticipation of the placement of dental implants.

Oral surgery also involves management of head and neck infections, which are often caused by infected teeth. Many times, oral surgeons are called on for treatment of facial trauma. This can include treatment of dental trauma, facial fractures and soft tissue injuries of the head and neck regions. Oral surgeons are able to help patients suffering from temporomandibular joint (TMJ) problems or other facial pain. This includes both nonsurgical and surgical treatment of various conditions including jaw joint dysfunction.

Some of the most dramatic and rewarding surgeries performed are those treating dental and facial deformities. Corrective jaw surgeries can be done to reposition the upper and/or lower jaws to correct congenital deformities, or to help patients with sleep apnea. Oral surgeons play an important role as members of comprehensive cleft teams in treatment of cleft lip and palate patients.

Head and neck pathology can include cysts and tumors of the jaws, soft tissue lesions inside the mouth and on the face and head and neck cancers. Oral surgeons treat all of these conditions. Treatment typically involves diagnosis of a lesion, removal of the disease process and subsequent reconstruction of the acquired defect.

Oral surgeons perform a wide variety of facial cosmetic surgery procedures. This includes treatments such as Botox and cosmetic fillers, augmentation of the facial bones, and soft tissue procedures such as a rhinoplasty (“nose job”) and facelift.

Oral surgeons have the ability to perform procedures under sedation and general anesthesia. During training, significant time

“Dentoalveolar procedures are the most commonly performed surgeries for the majority of oral surgeons. This includes removal of teeth, facilitation of orthodontic treatment and preparation of the jaws and soft tissues for various tooth replacement options.”

is spent working as an anesthesia resident, providing general anesthesia for all types of surgical procedures. With many oral surgery procedures being somewhat complicated, sedation often allows for a better patient experience and a more controlled surgical environment. I'm sure you have seen one of the many humorous videos on YouTube with a patient recovering from anesthesia after an oral surgery procedure. This happens almost daily in oral surgery offices.

All oral surgeons limit their practice to the surgical aspects of dentistry, and thus work in close relationship with restorative providers and other dental specialists to provide the best and most comprehensive care for patients. Ultimately the goal is to optimize patient experiences and outcomes through comprehensive multidisciplinary patient care. ●

Dr. Thomas Kolodge completed his undergraduate schooling at George Fox University in Newberg, Oregon and attended dental school at NYU College of Dentistry. He concluded his education with medical school and oral and maxillofacial residency at University of Nebraska Medical Center. He practices in McMinnville and Newberg, Oregon; enjoys the outdoors and the Portland Timbers along with his wife and two sons.

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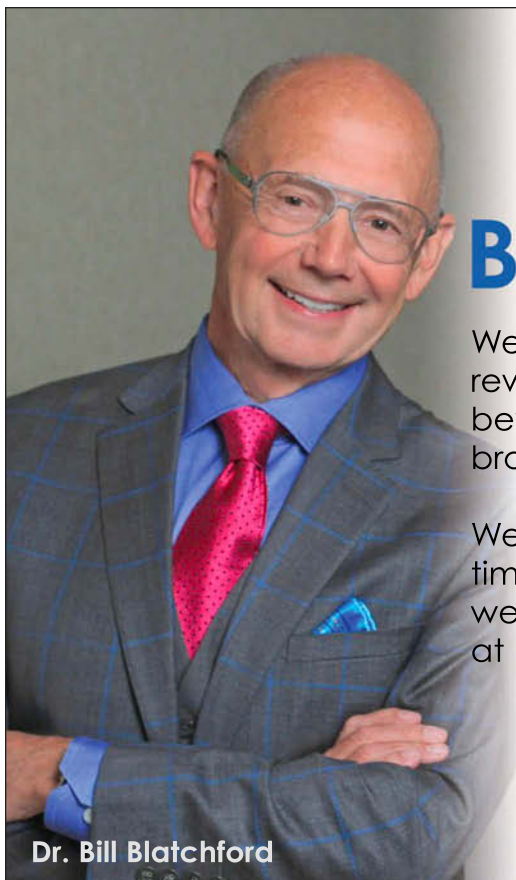
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Dr. Bill Blatchford

Numbing: the long and the short (acting) of it



NUMBING

By Seth A. Holland, DMD

YOU MAY FEEL THE NEED TO

TELL your dentist that you don't like shots, but they kind of already know. No one *likes* injections. They don't feel great going in, and the lasting numbness has been known to ruin a great meal. However, injections certainly will make your dental procedure more enjoyable, er, tolerable.

When local anesthetics are injected into the soft tissue around teeth, they block the sensory input from the tooth to the brain, i.e., discomfort. Epinephrine is often added to these injections so that the numbing has a long-lasting effect.

You may notice that right after your dentist performs the injection, your heart rate speeds up. That's the epinephrine (adrenaline) that is added to the anesthetic. Realize that epinephrine is a naturally occurring compound in your body. Your body releases epinephrine when you become surprised or fearful. When released by your glands into the bloodstream, it causes your heart rate and breathing to increase, but it also causes your blood vessels to constrict. This constriction keeps the anesthetics near the teeth longer. This allows dentist to provide care without having to give additional injections during the appointment. There are anesthetics manufactured without epinephrine which are ideal for short procedures or for patients who wish not to have epinephrine.

After leaving the dentist's office, you can expect your tooth and gums to be numb for 1–2 hours, but your tongue and cheeks may stay numb for 3–4 hours. This can be an uncomfortable feeling that makes eating, speaking and applying clown make-up difficult.

You can help reduce the numbness after a dental appointment with these helpful tips:

- ▶ Massaging or holding heat packs to the area will help stimulate blood flow, thereby helping the blood vessels to remove the anesthetic quicker.
- ▶ Vigorous activity like jogging or a brisk walk will also stimulate blood flow to help the anesthetic move through the veins faster and get processed by your liver. But please ask your dentist or hygienist if you should exercise after your procedure.
- ▶ Take a nap! This won't help process numbness, but it is less time you need to endure being numb. ●

Born and raised in rural New Jersey, Dr. Holland has lived in his second home state of Oregon since 2007. He graduated from Rutgers University in 2002 with a degree in mechanical engineering. After working in New York City as a consulting engineer he decided to switch to a career in dentistry and graduated from Oregon Health and Sciences University in 2013. He received advanced training in pediatric care, IV sedation, implants and cosmetic dentistry from the University of New Mexico in 2014. Seth and his wife Katie have one son. They all enjoy skiing, mountain biking and exploring the Cascades.

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X-RAYS,
COLOR PICTURES,
“CARIVU”

Especially in Dentistry – A Picture is Worth a Thousand Words



By Todd A. Gifford,
DMD

X-RAYS, COLOR PICTURES, AND NOW THIS AMAZING tool – “CariVu.”

The dental “X-ray” has been around for over a century. It continues to be an important tool for diagnosing dental disease. Recent advances in technology make digital X-rays safer than ever before. But X-rays have their limitations, especially when a dental problem is still in its early stages. An area of early decay can remain hidden in an X-ray by surrounding healthy tooth structure or fillings or crowns. And cracks in teeth are rarely visible with an X-ray.

When specialized cameras became the norm about 20 years ago, dentists gained the ability to clearly show their patients

exactly what the dentist was seeing during the exam. The presence of tooth decay, cracklines and other dental problems captured by these cameras help patients easily understand why their dentist is recommending treatment, even in the absence of symptoms.

That’s great. But what about teeth problems that have not progressed to the point of being visible with a camera or on an X-ray and that do not cause any symptoms yet?

In 2014, “CariVu” was introduced to address this exact problem. This diagnostic tool provides your dentist with the ability to easily detect tooth decay with amazing clarity, including decay not detectable by

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Dr. Gifford practices family dentistry in Portland, Oregon. He believes in using only premier, local dental laboratories and the best available dental materials to treat patients. He is actively involved in participation-based, hands-on, peer-reviewed, live-patient study clubs and attends a variety of lecture-based seminars and conferences.

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