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2017 Oregon Dental Conference Preview

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Membership Matters

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Membership Matters is an official publication of the Oregon Dental Association in support of its core purpose to advance the dental profession and promote the highest standard of oral health and oral health care.



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By Barry J. Taylor,
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FACD, CDE

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20 Years of ODC Maturity

THE 2017 OREGON DENTAL CONFERENCE WILL FEATURE OVER 80 SPEAKERS

presenting over 75 courses. The courses cover more than 25 topics. The Exhibit Hall will be filled with 200 exhibitors. Nine other dental organizations have partnered with the ODA in presenting the courses. Over the course of the weekend, there will be ten additional organization lunches and dinners. **Dr. V. Kim Kutsch** and the other members of the Annual Meeting Council have worked hard putting together a great meeting. ODA staff members Lauren Malone and Anna Velasco have been working full time over the course of the year to organize this event.

When you have children, their maturity is slow (with young boys it has been like a slug going through peanut butter, as someone recently also described the ADA House of Delegates), but there are those moments when all of the sudden you realize they are actually growing up (he did get into college!). When I reflect back over the 20 years of attending the Oregon Dental Conference, it is amazing to see the growth. Both of my parents were also exhibitors at the conference for many years so my memories actually go back 40 years when it was at the downtown Portland Hilton. Yes, my childhood memories luckily include the excitement of my father coming home from the conference and opening up his briefcase to give us brand new toothbrushes. Now I purchase USB connected electric toothbrushes for my two sons (which does not improve their motivation to brush any more than a toothbrush in 1976) at the conference.

I thought I remembered much about that first conference I attended in 1997, but it appears there is some revisionist history (just as I remember middle school being uneventful for my oldest son). I remember attending the House of Delegates, continuing education courses, and the President's party over a four day weekend. Aside from the House of Delegates and location of the meeting, it seems similar to the conference I will attend in 2017. Actually, I am forgetting a lot (similar to when I forgot to watch my youngest son as he crawled out our front door at age two).

1997 (themed, "Strategic Partnerships: Patterns of Success beyond 2000) was the last year that the entire conference was held at the Lloyd Center Red Lion Hotel, a location where the Exhibitor Hall was located in the parking garage. The House was held in conjunction with the scientific meeting at that time. The House had twice as many delegates compared to 2017 and there was very spirited debate in reference committees over the many resolutions (although the ODS Tower discussion is now a moot point). The House was a suit and tie meeting (I am sure **Dr. Richard Garfinkle** was wearing a Hawaiian shirt) and the ODA's **Dr. Dennis Reed** President's party on Saturday evening was a black tie affair. The only other onsite event was the Annual OHSU School of Dentistry Alumni lunch. With the House ending on Friday, I attended CE courses on Saturday and Sunday.

I was curious as to the course selection in 1997 so I requested from the ODA's Lauren Malone a copy of the 1997 course catalogue. It was not a catalogue. All 14 course descriptions fit on to one page. Only four of the courses were related to direct clinical patient care. One of those clinical courses was about the "potential superiority" of ultrasonic instrumentation in periodontal therapy. The legendary (showing my age) **Dr. Harry Albers** was presenting a two-day, fourteen-hour course on "adhesive tooth colored restorations." I had just graduated in 1995 and posterior adhesive tooth colored restoration was still a controversial topic to teach at the OHSU School of Dentistry. (And the new Chair of the dental school's Department of Biomaterials and Biomechanics, **Dr. Jack Ferracane**, was giving a three hour CE course at the adjoining dental assistant's conference entitled, "Dental Materials Update.")

The School of Dentistry's popular pharmacology instructor, **Dr. John Smith**, was lecturing about "Analgesics update: Opioids, NSAIDs and Beyond," a course description that hasn't changed in 20 years. **Dr. P. Allen** from Baylor University was presenting the most technical lecture of the weekend, "Plastic Reconstructive Periodontal Surgery of Esthetics." In hindsight, this may have been

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.

the most advanced course as it covered topics such as treatment of implant sites and localized alveolar ridge augmentation and preservation. The course list also provides evidence that the highly respected **Dr. Steven Beadnell** actually hasn't given a course on medical emergencies at every ODC as there were no courses on the topic that year.

In 2017, the Conference no longer costs just \$95 as it did in 1997. In 1998, the meeting was moved to the new Oregon Convention Center and in 2000 the House of Delegates was separated from the conference. My sons are now mature responsible teenagers; they weren't always that way. The conference is now almost as non-recognizable as Sage and Carl. Now in addition to Dr. Beadnell's Medical Emergency course, there is a choice of continuing education that is not even comparable to the meeting 20 years ago. I look forward to the changes over the next 20 years. 🍷

Calling All Aspiring Writers!

The July/August Issue of *Membership Matters* will be an Office/Patient Issue. This issue will be designed for members to have in your office for patients to peruse at their visits. We are looking for all dentists interested in contributing to the issue. From dental tips and specialty procedures to what to expect when you come in for a routine cleaning, submit your idea or an article for review.

Please submit all questions and articles to *Membership Matters* Editor, Barry Taylor, DMD, FAGD, CDE, at barrytaylor1016@gmail.com by May 17.

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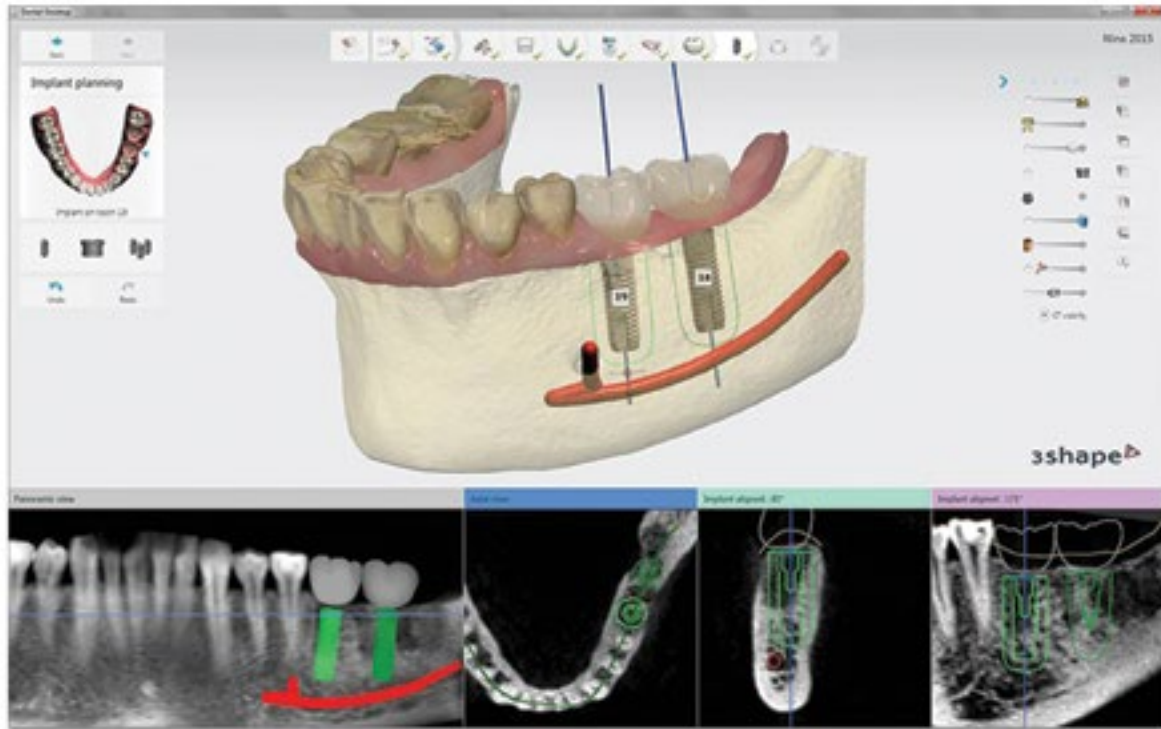
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Events & Education

Provided by Mehdi Salari, DMD

FEBRUARY 2017

14	Continuing Ed., 1.5 Hours	<i>Periodontics: Soft Tissue Grafts & Frenectomies Presented by Dr. Mahdad Nasiri</i>	@ West Salem (Roth's)	Contact Sabrina H. mpdentalce@qwestoffice.net
16	Continuing Ed., 2 Hours	<i>New Dentist Symposium Presented by Dr. John Rosenthal, Chris Verbiest, Jess Bogumil, CPA</i>	@ Milwaukie (Moda Plaza)	www.multnomahdental.org or lora@multnomahdental.org
22	Continuing Ed., 2 Hours	<i>TMD From a Physical Therapist's POV Presented by Sarah Stuhr, RPT</i>	@ Milwaukie (Moda Plaza)	www.multnomahdental.org or lora@multnomahdental.org
28	Continuing Ed., 3 Hours	<i>Medical Emergencies & Nitrous Oxide Presented by Dr. Brian Humble</i>	Oregon City @ (Providence Willamette Fall Comm. Center)	executivedirector@ clackamasdental.com

MARCH 2017

7	Continuing Ed., 2 Hours	<i>Opioids—The Role of Dentists Presented by Gary Allen, DMD, MS, Amy Fine, DMD, and Jennifer Webster, MA, MPH</i>	@ Eugene (Lane Comm. College)	lanedentalsociety.org
10	Board of Trustees Meeting		@ Wilsonville , Oregon	
14	Dental Day		@ Oregon State Capitol (900 Court St NE, Salem)	Register at http://bit.ly/dentalday2017
14	Continuing Ed., 1.5 Hours	<i>Obstructive Sleep Apnea: Recognition & Treatment Algorithms for Dental and Surgical Teams Presented by Pamela Huges, DDS (OHSU)</i>	@ West Salem (Roth's)	Contact Sabrina H. mpdentalce@qwestoffice.net
15	Continuing Ed., 2 Hours	<i>Sleep Apnea Presented by Dr. Patrick Hagerty & Dr Pamel Huges</i>	@ Portland (OHSU SOD)	www.multnomahdental.org or lora@multnomahdental.org

Events are subject to change. Please consult the sponsoring group to confirm details. To add your component's continuing education event, please email bendsalari@gmail.com. Please send all other events to Cassie, cleone@oregondental.org.

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Welcome New ODA Members!

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Clackamas County Dental Society

Juliana B. DaCosta, DDS, MS
Multnomah Dental Society

Alyssa Franzen, DMD
Multnomah Dental Society

Lillian G. Harewood, DMD
Multnomah Dental Society

Sung Yeon Ji, DDS
Multnomah Dental Society

Brian Lee Wilson, DMD
Southern Willamette
Dental Society

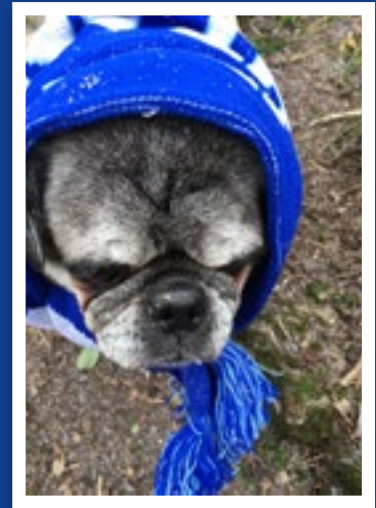
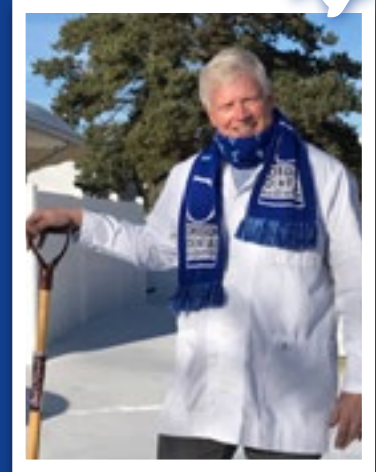
Simon Yakligian, DDS
Lane County Dental Society





Join the Molar Movement #FightEnamelCruelty

Oregonians were faced with quite the winter storms in December and January! The Molar Movement Scarf was there to save the day!



For more information, or to email your photo to us, contact ODA Membership Manager Kristen Andrews at 503-218-2010 x110 or kandrews@oregondental.org.

Images Courtesy of Fred Bremner, DMD, Clackamas County, James McMahan, Eastern Oregon, and Mark Miller, DMD, Yamhill County



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Editor

General Guidelines for Mutual Aid Agreements

Preparing for the Unexpected with a Mutual Aid Agreement

Content reprinted from the ADA website at <http://success.ada.org/en/practice-management/general-guidelines-for-mutual-aid-agreements>

NO ONE EVER EXPECTS ANYTHING TO HAPPEN TO THEM, ESPECIALLY IN THE PRIME OF THEIR CAREERS, but if a major illness befalls you, or if you die unexpectedly, what will happen to your practice and your patients? Setting up a mutual aid agreement right now will give you peace of mind that whomever takes over your practice in your time of need will be able to do so legally and seamlessly.

What is a Mutual Aid Agreement? A mutual aid agreement is a formal contract with colleagues whereby in the event of the sudden illness, injury or death of a dentist-signer to such an agreement, the other signers promise to temporarily cover for the stricken colleague until either his/her recovery, or up until the time when a deceased dentist's practice is sold.

Because of numerous inquiries from dental societies and the membership regarding mutual aid agreements, the Council on Dental Practice in cooperation with the Division of Legal Affairs at the ADA has developed general guidelines to assist in the preparation of such arrangements.

When preparing a mutual aid agreement, the following elements should be considered:

- ▶ Purpose of agreement
- ▶ Who is eligible to participate
- ▶ Term of agreement (number of years or expiration date)
- ▶ How to handle amendments
- ▶ Meetings of participants
- ▶ Expenses
- ▶ Establishing the officers
- ▶ Committees
- ▶ Terms of coverage
- ▶ Statement of services
- ▶ Time commitment
- ▶ Patient and business information confidentiality
- ▶ Guidelines on accepting patients or hiring staff from the stricken dentist's practice

How to handle billing? A non-paid volunteer dentist working temporarily in the office of a stricken participant in order to complete cases should sign claim forms for any billable service using his/her own name and information. The ADA claim form allows one field for the billing entity and a separate one for the treating dentist. This would allow payments to be sent to the practice of the stricken participant. ■

For a full description of each of the above elements, download the complete document from the ADA's Council on Dental Practice: http://ebusiness.ada.org/productcatalog/2270/Center-for-Professional-Success/Flexible-Benefit-Plans/CPS_PR028.

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- Benjamin Whitted DDS, Molalla, OR

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Business Associate Agreements and Data Breach

Oregon's data security laws are more stringent than Federal HIPAA rules and require faster notification times! For example, if you are a HIPAA covered entity and one of your business associates is not HIPAA compliant and has a data breach involving patient information, you could be held liable. It would be the responsibility of the dental office to send notifications required under the Federal Breach Notification Rule.



By Lori Lambright

ODA Member
Compliance Coordinator

503-218-2010, x104
llambright@oregondental.org

Q Do all providers need a HIPAA Business Associates Agreement?

&
A

Business Associates Agreements are a HIPAA requirement if a provider falls under the definition of a covered entity.* Covered entities must have a written agreement in place with any person/company who provides services and/or functions that involve the use of your patient's Protected Health Information (PHI). These might include: software vendors that maintain or store PHI on their server; billing services; law firms; CPAs; collection agencies; marketers on your behalf; and electronic claim clearinghouses.

Provider staff are exempt from the rule as are other health care providers that treat the same patient. However, if a provider establishes a business relationship with another provider for some other purpose (e.g. training office personnel that involves the use of PHI), a business associate agreement would be required.

Aside from Business Associate Agreements, providers should also make sure their privacy, security and breach notification processes are up to date. Encrypting your email is easily the simplest measure you can take to prevent breaches. ■

**Covered Entities are defined in the HIPAA rules as (1) health plans, (2) health care clearinghouses; and (3) health care providers who electronically transmit any health information connected with transactions for which Health & Human Services has adopted standards.*

This column is intended to help you to be better informed of the **rules** and **regulations** that are required of running a dental practice in Oregon.

i Find this information online at:

HIPAA Business Associate Agreements: <http://tinyurl.com/hhs-hipaa-business>

Submitting Breach Notifications: <http://tinyurl.com/breach-notification>

The ADA Practical Guide to HIPAA Compliance has tools to help dentists comply with privacy and security rules:

<http://tinyurl.com/hipaa-compliance-kit>

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Hope for Civil Discourse with the Inauguration of a New Oregon Secretary of State

By Rickland G. Asai, DMD, *Trustee, ADA 11th District, Past-President of Oregon Dental Association, asair@ada.org*



I HAD THE OPPORTUNITY TO ATTEND THE INAUGURATION CEREMONY FOR DENNIS RICHARDSON as our new Secretary of State on December 30. These are not the sort of events I normally attend, but I heard it was going to be something different. My curiosity was piqued, so I emailed my RSVP and was flattered to be seated in the Senate Chamber. The inauguration itself was in many ways nothing special, but a formality of the transition into elected office. It was not hidden away in some back office out of sight and out of mind. And I kind of liked that.

My reflection on the ceremony driving home was this could be a great start to our

legislative year. I hope as the legislature gavel to session February 1, we see and hear more respectful and dignified debates. That reporting in the media focuses on substance and not sound-bites. I look forward to the possibility of creative dialogue and even more to innovative solutions to many of the challenges facing our citizens and government now. My wish for 2017 would be for civility in speech, respect for each other, and the art of negotiation and compromise for the betterment of the citizenry. The Inauguration Ceremony for Dennis Richardson sets a tone I hope will go a long way this year and beyond in achieving just that. 🇺🇸

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The Oregon Dental Association benefits from a robust and dedicated volunteer infrastructure that sustains the activities of the organization. As ambassadors for the Association, our volunteer leaders are essential to our sustainability and growth.

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Contact your local component society if you are interested in becoming a delegate!

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Oregon Dental Day at the Capitol

A Day of Education, Engagement & Empowerment

ON TUESDAY, MARCH 14, 2017 over one hundred dentists, OHSU General Practice residents, and OHSU School of Dentistry students will come together to learn about and engage state legislators and staff on the major issues impacting Oregon dentistry and its patients. Those issues include:

- ▶ Renewing and expanding the rural health provider tax credit
- ▶ Strengthening the school oral health screenings law
- ▶ Enacting 90-day public notice of de-fluoridation
- ▶ Supporting funding for healthy scholars and Medicaid Primary Care Loan Repayment programs

There may well be other important issues that come up as ODA reviews over 2,500 introduced bills for relevance and impacts to Oregon dentistry. The day activities will include:

- ▶ Bus charter to/from Salem originating at OHSU-SOD and ODA building
- ▶ Full breakfast, guest speakers, and issue briefing at the Salem Convention Center
- ▶ Small group meetings with your local state senators and representatives
- ▶ Opportunities to observe committees and floor sessions
- ▶ Tours of Capitol Building

All expenses are paid—your time is invaluable. Your impact will be measurable in ODA's success in advocating legislation strengthening the Oregon dental profession and patient care, while defeating bills that threaten both. 📌

Please register today! Go to oregondental.org or contact Lori Lambert at llambert@oregondental.org or at 1-800-452-5628.

JOIN YOUR COLLEAGUES FOR A DAY OF ADVOCACY & ACTION!

Dental Day 2017

Oregon State Capitol
Tuesday, March 14, 2017



REGISTER AND CONFIRM THE DATE *NOW* to join your ODA colleagues in a day of advocacy at the state capitol educating yourself, legislators and their staff on critical issues impacting dentistry, including oral health care policy and funding, workforce, education and training.

Tuesday, March 14, 2017

Oregon State Capitol (900 Court St NE, Salem)

ODA member issues briefing, followed by meetings with your local legislators from 8am–4pm.*

Please register ASAP at <http://bit.ly/dentalday2017> so ODA can plan an effective day of action. For more information or questions, email Lori Lambright at llambright@oregondental.org or call 800-452-5628 ext. 104.

**ODA will arrange meetings with your local legislators for you. You do not need to stay until 4pm if meetings are earlier in the day. Transportation will be prearranged from Wilsonville. Details to follow.*

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The 2017 Oregon Dental Conference® is an event for the **entire dental team.**

The Oregon Dental Association (ODA) is proud to present their 125th annual session. This conference is the concurrent meeting of the ODA, the Oregon Academy of General Dentistry (OAGD), the Oregon Academy of Pediatric Dentistry (OAPD), the Oregon Dental Assistants Association (ODAA), the Oregon Dental Executives' Association (ODEA), the Oregon Dental Hygienists' Association (ODHA), the Oregon Society of Oral & Maxillofacial Surgeons (OSOMS), the Oregon Society of Periodontists (OSP), the Oregon State Association of Endodontists (OSAE), and our new partner group, Oregon Association of Dental Laboratories (OADL).

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Early registration deadline: **March 3, 2017** | www.oregondentalconference.org

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Print the form, complete it, and return via fax or mail with your payment. Please be advised that there is a \$25 processing fee for faxed or mailed registrations.



On-Site at ODC

Registration will be available in Pre-Function A at the Oregon Convention Center during the hours listed below. Dentists who are not members of ODA will need to show their ADA card to receive the ADA member rate.

Thursday, April 6	7 AM – 6 PM
Friday, April 7	7 AM – 6 PM
Saturday, April 8	7 AM – 1 PM



Registration materials

Confirmation of registration will be sent to individual registrants after processing. A packet containing name badges for all participants will be mailed prior to the conference to all primary registrants who register by March 3, 2017. Those registering after March 3 may pick up their name badge in the Holladay Lobby of the OCC during registration hours.



Refunds, transfers, and cancellations

All refund, transfer, and cancellation requests must be submitted in writing. If cancellation occurs after preregistration materials have been mailed, badge(s) must be returned with the written request. A \$25 handling fee will be charged for all refunds. Refund requests will not be granted, for any reason, **after 11:59 pm on March 24, 2017.**

Early Bird Deadline: March 3, 2017

Register by March 3 for early bird pricing and to receive your conference materials prior to ODC.

Mail/Fax Deadline: March 24, 2017

If you are registering after March 24, you must register online at oregondentalconference.org, or on-site in Pre-Function A of the Oregon Convention Center, April 6–8.

Dentist Registration Categories & Fees

	Conference Badge		Exhibits-Only Badge	
	EARLY Before 3/3	ON-SITE After 3/3	EARLY Before 3/3	ON-SITE After 3/3
ODA member	\$285	\$400	\$25	\$50
ADA 11th district member (AK, ID, MT, WA)	\$285	\$400	\$25	\$50
ADA retired or life-retired member	\$285	\$400	\$0	\$0
ADA direct member	\$285	\$400	\$25	\$50
Oregon specialty partner group dentist (OAPD, OSAE, OSOMS, OSP only)	\$285	\$400	\$25	\$50
Retired volunteer dentist in Oregon (with DV license)	\$0	\$0	\$0	\$0
ADA member dentist outside 11th district (not from OR, AK, ID, MT, WA)	\$315	\$455	\$25	\$50
Non-ADA member	\$810	\$960	\$200	\$400
International dentist	\$315	\$455	\$25	\$50

Non-Dentist Registration Categories & Fees

	Conference Badge		Exhibits-Only Badge	
	EARLY Before 3/3	ON-SITE After 3/3	EARLY Before 3/3	ON-SITE After 3/3
Hygienist; Assistant; Administrative Staff; Laboratory Tech	\$100	\$190	\$25	\$50
Student (dental student; dentist resident; pre-dental student; hygiene student; assisting student; lab tech student)	\$0	\$0	\$0	\$0
Non-dental guest (spouses, children over 18)	\$100	\$190	\$25	\$50

Visit the Exhibit Hall for FREE! If you're an ODA member, you can visit the Exhibit Hall for FREE on Saturday, April 8.

Oregon Dental Conference: Courses at a Glance

COURSE TITLE	COURSE NUMBER	CE CREDITS	PRESENTER(S)	TIME	GROUP	DENTIST	HYGIENIST	ASSISTANT	OFFICE MGR.	LAB TECH
Thursday - Full Day Courses										
The 360 Experience	8102	7	Banta; et al	9 AM - 4 PM	ODA	D	H	A	OM	
Foundations of Leadership: Leading from Where You Are	8112	6	Ishimoto	9 AM - 4:30 PM	ODEA	D	H	A	OM	
Principle Based Periodontal Therapy and Treatment Planning!	8123	6	Miller	9 AM - 4:30 PM	ODA	D	H	A	OM	LT
Excellence in Dental Assisting	8124	6	Pace Brinker	9 AM - 4:30 PM	ODA	D	H	A	OM	LT
Thursday - Morning Courses										
Predictable Treatment Options in Dental Trauma	8101	3	Bakland	9 AM - 12 PM	OSAE	D	H	A		
Conquering Parafunction: The How and Why of the NTI	8104	2	Boyd	9 - 11 AM	ODA	D	H	A	OM	LT
Green Dentistry: THC and Teeth? What you Need to Know About Cannabis	8107	3	DeVincenzi; Taylor	9 AM - 12 PM	ODA	D	H	A	OM	
CPR for the Health Care Provider*	F9001	3.5	EMT Associates	9 AM - 12:30 PM	ODA	D	H	A	OM	LT
Medicine, Dentistry, and Drugs	8108	3	Fazio	9 AM - 12 PM	ODA	D	H	A		
Contemporary Oral Surgery for the General Dentist: A Simple and Predictable Approach to Minimally Invasive Oral Surgery	8113	3	Jeroff	9 AM - 12 PM	ODA	D		A		
Infection Control in Dentistry*	8114	3	Jorgensen	9 AM - 12 PM	ODAA	D	H	A	OM	LT
Merging Today's Restorative Options with Proven Principles: A Blueprint for Success	8115	3	Kessler	9 AM - 12 PM	ODA	D				LT
Adequate Record Keeping, Board Updates and the Enforcement Process	8117	3	Kleinstub; Prisby	9 AM - 12 PM	ODA	D	H	A	OM	
Clinical Approach to the Diagnosis of Oral Lesions	8118	1.5	Kratochvil	10:30 AM - 12 PM	ODA	D	H	A		
HIPAA: The Good, the Bad...and Compliance	8119	3	Lavine	9 AM - 12 PM	ODA	D	H	A	OM	
Fortify Your Life: A Guide to Vitamins, Minerals, and More	8121	3	Low Dog	9 AM - 12 PM	ODA	D	H	A	OM	LT
Practice Dentistry Pain-Free: Preventing Pain While Improving Patient Outcomes	8126	3	Valachi	9 AM - 12 PM	ODA	D	H	A		
Thursday - Afternoon Courses										
Medical Emergency Update	8103	4	Beadnell	1 - 5 PM	ODA	D	H	A		
Migraine Prevention and How a Dentist Can Be the Neurologists Most Effective Referral	8105	1	Boyd	1:30 - 2:30 PM	ODA	D	H	A	OM	LT
Basics of In-office Splint Fabrication: From Titratable FDA-cleared Apnea Devices, Parafunctional Control Splints, to Flat-Plane Bruxism Protection	8106	1	Boyd	3:30 - 4:30 PM	ODA	D	H	A	OM	LT
CPR for the Health Care Provider*	F9002	3.5	EMT Associates	1:30 - 5 PM	ODA	D	H	A	OM	LT
Periodontitis and Perio-Implantitis: The Good, the Bad, and the Ugly	8109	3	Fazio	1:30 - 4:30 PM	ODA	D	H	A		
CBCT in the Dental Office: Recommendations and Creating a Systematic Interpretation	8110	3	Gonzalez	1:30 - 4:30 PM	OSAE	D	H	A		
Identify and Overcome Fears of Practice Ownership in Today's Marketplace	8111	3	Iosif; Williams	1:30 - 4:30 PM	ODA	D				
Digital Impressions vs In-office CAD/CAM: Which One is Best for Me, My Team, and My Practice? (Workshop)	F9003	3	Juliani	1:30 - 4:30 PM	ODA	D				
Preparation Designs and Laboratory Communication—What your Laboratory Technician Needs to Provide the Best Results	8116	3	Kessler	1:30 - 4:30 PM	ODA	D				LT
Guiding You Through the Maze of Dental Technology	8120	3	Lavine	1:30 - 4:30 PM	ODA	D	H	A	OM	
Nutrition for the Dental Team	8122	3	Low Dog	1:30 - 4:30 PM	ODA	D	H	A	OM	LT
The Mouth as the Body's Mirror: Oral, Maxillofacial, and Head and Neck Manifestations of Systemic Disease	8125	1.5	Said-Al-Naief	2 - 3:30 PM	ODA	D	H	A		
Hygiene Shouldn't Be a Pain in the Neck: Ergonomic and Exercise Guidelines	8127	3	Valachi	1:30 - 4:30 PM	ODA	D	H	A		
Risk Management (part of ODC Registration)	8128	3	Verbiest	1:30 - 4:30 PM	ODA	D	H	A	OM	
Risk Management (stand alone course)	F9004	3	Verbiest	1:30 - 4:30 PM	ODA	D	H	A	OM	
Keys to Social Media Marketing Success*	8129	3	Zamora	1:30 - 4:30 PM	ODA	D	H	A	OM	

* Courses marked with an asterisk are offered more than once. See course description for details. Course numbers beginning with "8" are included with registration. Course numbers beginning with "F" require an additional fee.

COURSE TITLE	COURSE NUMBER	CE CREDITS	PRESENTER(S)	TIME	GROUP	DENTIST	HYGIENIST	ASSISTANT	OFFICE MGR.	LAB TECH
Friday - General Session										
ROCK Your Practice to the Top	8190		Madow Brothers	7:30 - 8:30 AM	ODA	D	H	A	OM	LT
Friday - Full Day Courses										
Management and Marketing That Will Make Your Practice Soar—It's Not Rocket Science!	8141	6	Huff; Morrison	9 AM - 5 PM	ODEA	D	H	A	OM	
Tips and Best Practices for Implant Success	8146	6	J. Malmquist; M. Malmquist	9 AM - 5 PM	ODAA	D	H	A	OM	LT
From Evidence to Action: Getting Patients to OWN Their Dental Health	8155	6	Wilder	9 AM - 5 PM	ODHA	D	H			
Friday - Morning Courses										
Health and Wellness for Dental Professionals—Panel	8130	3	Bone; et al	9 AM - 12 PM	ODAA	D	H	A	OM	LT
Chairside Excellence for the Dental Assistant (Workshop)*	F9005	3	Bujalski; et al	9 AM - 12 PM	ODA			A		
Hygiene Superstar*	8132	3	Czubiak; Sperry	9 AM - 12 PM	ODA	D	H			
Diagnosis and Treatment of Occlusal Problems	8134	3	DeWood	9 AM - 12 PM	ODA	D		A		LT
CPR for the Health Care Provider*	F9007	3.5	EMT Associates	9 AM - 12:30 PM	ODA	D	H	A	OM	LT
Soft Landings: An Evidence-based Approach to Minimizing CAD/CAM Catastrophes*	8137	3	Gold	9 AM - 12 PM	ODA	D	H	A	OM	
Issues in Managing the Persistent Endodontic Infection	8138	3	Hargreaves	9 AM - 12 PM	OSAE	D				
The Medicalization of Life	8143	3	Low Dog	9 AM - 12 PM	ODA	D	H	A	OM	LT
Love Dentistry, Have Fun, and Prosper!	8145	3	Madow Brothers	9 AM - 12 PM	ODA	D	H	A	OM	
Power Up Hygiene: Utilize Technology to Improve Clinical Outcomes and Energize Your Career (Workshop)	F9009	3	Miller	9 AM - 12 PM	ODA	D	H			
Lumps and Bumps in the Gum	8148	3	Ng	9 AM - 12 PM	ODA	D	H	A		
Esthetic Realities for Today and Tomorrow	8150	3	Pizzi	9 AM - 12 PM	OADL	D	H	A	OM	LT
Minimum Dentistry Maximum Results: Is Less More?	8152	3	Sameni	9 AM - 12 PM	ODA	D	H	A		
Health History Hurdles	8154	1.5	Watts	10:30 AM - 12 PM	ODA			A		
A Dentist's Guide to Treating the Medically Compromised Senior Patients	8156	3	Wiseman	9 AM - 12 PM	ODA	D	H	A		
The More I Know, the Less I Understand: Contemporary Management of Periodontal Disease	8158	3	Wong	9 AM - 12 PM	ODA	D	H	A	OM	
Introduction to Medical Billing in the Dental Practice	8160	3	Zahrebelny	9 AM - 12 PM	ODA	D	H	A	OM	LT
Keys to Social Media Marketing Success*	8161	3	Zamora	9 AM - 12 PM	ODA	D	H	A	OM	
Friday - Afternoon Courses										
Chairside Excellence for the Dental Assistant (Workshop)*	F9006	3	Bujalski; et al	2 - 5 PM	ODA			A		
Medical Teams International: At Home and Abroad	8131	3	Canfield; et al	2 - 5 PM	ODA	D	H	A		
Hygiene Superstar*	8133	3	Czubiak; Sperry	2 - 5 PM	ODA	D	H			
Functional Esthetics: Predictably Creating Lasting Beauty	8135	3	DeWood	2 - 5 PM	ODA	D		A		LT
CPR for the Health Care Provider*	F9008	3.5	EMT Associates	1:30 - 5 PM	ODA	D	H	A	OM	LT
Anesthesia in the Dental Setting: How to Maximize Patient Safety and Satisfaction	8136	1.5	Geisler	2 - 3:30 PM	ODA	D	H	A	OM	
Diagnosing the Non-odontogenic Toothache	8139	3	Hargreaves	2 - 5 PM	OSAE	D				
Medical Emergencies	8140	4	Hopkin; Howerton	1 - 5 PM	ODA	D	H	A	OM	
Infection Control in Dentistry*	8142	3	Jorgensen	2 - 5 PM	ODA	D	H	A	OM	LT
Women's Health: A Woman's Guide to Wellness	8144	3	Low Dog	2 - 5 PM	ODA	D	H	A	OM	LT
To Use or Not to Use: When is the Question? Time management and Product Integration for the Dental Hygienist	8147	3	Miller	2 - 5 PM	ODA	D	H	A	OM	LT
Early Detection of Oral Cancer in the Dental Practice	8149	3	Ng	2 - 5 PM	ODA	D	H	A		
Face, White and Pink, Simplify Complex Restorative Cases	8151	3	Pizzi	2 - 5 PM	OADL	D	H	A	OM	LT
Minimally Invasive Adhesive and Esthetic Indirect Anterior Bonded Restorations	8153	3	Sameni	2 - 5 PM	ODA	D	H	A		
Geriatrics for the Dental Team: A 'How to Guide' to Make Your Practice Senior Friendly	8157	3	Wiseman	2 - 5 PM	ODA	D	H	A		
Life Beyond 5mm—Treatment Options for Severe Periodontitis	8159	3	Wong	2 - 5 PM	ODA	D	H	A	OM	
Correctly Completing the Medical CMS-1500 Claim Form (Workshop)	F9010	3	Zahrebelny	2 - 5 PM	ODA	D	H	A	OM	LT

* Courses marked with an asterisk are offered more than once. See course description for details. Course numbers beginning with "8" are included with registration. Course numbers beginning with "F" require an additional fee.

Oregon Dental Conference: Courses at a Glance

COURSE TITLE	COURSE NUMBER	CE CREDITS	PRESENTER(S)	TIME	GROUP	DENTIST	HYGIENIST	ASSISTANT	OFFICE MGR.	LAB TECH
Saturday - Full Day Courses										
Oral Systemics the Now, the Wow, and the How? Riding the New Wave	8172	6	Lodding	8 AM - 4 PM	ODA	D	H	A	OM	
CBCT Imaging: Principles, Clinical Applications, and Interpretation	8173	6	Mallya	8 AM - 4 PM	OSOMS	D				
Learn to Listen, Communicate with Purpose	8177	6	Spradley	8 AM - 4 PM	ODEA	D	H	A	OM	
Saturday - Morning Courses										
Contemporary Approaches for Periodontal Plastic and Implant Site Development Procedures	8162	3	Aalam	8 - 11 AM	OSP	D	H			
Medical Emergencies	8164	4	Auzins	8 AM - 12 PM	ODA	D	H	A	OM	
OSHA Compliance and Safety for the Dental Practice	8165	3	Barry	8 - 11 AM	ODA	D	H	A	OM	LT
Excellence in Dental Hygiene (Workshop)*	F9011	3	Carrier Denis; et al	8 - 11 AM	ODA		H			
Human Papilloma Virus, Warts and All: A Concise Review for the Dental Practitioner	8167	1.5	Cheng; Patel	9:30 - 11 AM	ODA	D	H	A		
CPR for the Health Care Provider*	F9013	3.5	EMT Associates	8 - 11:30 AM	ODA	D	H	A	OM	LT
Soft Landings: An Evidence-based Approach to Minimizing CAD/CAM Catastrophes*	8168	3	Gold	8 - 11 AM	ODA	D	H	A	OM	
Let's Stick It Together: Simplifying All Restorations with the Most Successful Aesthetic Materials Ever	8169	3	Griffin, Jr.	8 - 11 AM	ODA	D			A	
Online Reputation Management: Getting Good Reviews and Dealing with Bad Reviews	8174	2	McNickle	8 - 10 AM	ODA	D	H	A	OM	LT
Conversion Secrets: How to Turn Shoppers into Lifelong Patients	8175	2	Puhl	9 - 11 AM	ODA	D			OM	
Pediatric and Adolescent Oral Pathology	8178	3	Yepes	8 - 11 AM	ODA	D	H	A		
Saturday - Afternoon Courses										
Pearls for Success—50 Tips for Navigating Your Early Dental Career	8163	1.5	Alexander; et al	1 - 2:30 PM	ODA	D				
Review of CDC Guidelines for Infection Control in Dental Health-Care Settings	8166	3	Barry	1 - 4 PM	ODA	D	H	A	OM	LT
Excellence in Dental Hygiene (Workshop)*	F9012	3	Carrier Denis; et al	1 - 4 PM	ODA		H			
CPR for the Health Care Provider*	F9014	3.5	EMT Associates	12:30 - 4 PM	ODA	D	H	A	OM	LT
Planning to Preparation to Placement: Perfecting the Art of Cosmetic Porcelain Restorations	8170	3	Griffin, Jr.	1 - 4 PM	ODA	D			A	
Dental Management of Patients on Antithrombotic Medications	8171	2	Lasho	1 - 3 PM	OSP	D	H			
What's Working in 2017? Exact Strategies to Drive New Patient Growth	8176	2	Puhl	1 - 3 PM	ODA	D			OM	
Pediatric and Adolescent Oral Radiology	8179	3	Yepes	1 - 4 PM	ODA	D	H	A		

* Courses marked with an asterisk are offered more than once. See course description for details. Course numbers beginning with "8" are included with registration. Course numbers beginning with "F" require an additional fee.

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Casino Night

After a day of learning, gather your team for an evening of fun! This event has something for everybody—dinner, drinks, music, dancing, casino games, and fantastic prizes. Join in the fun by adding a ticket to your conference registration. All are welcome and encouraged to attend!

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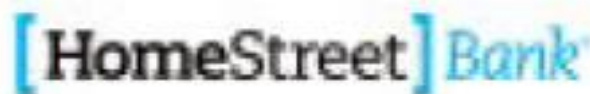
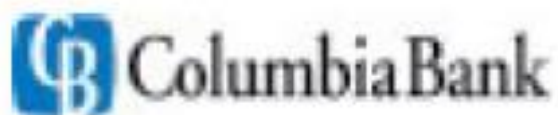


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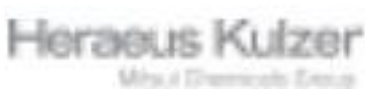
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- ▶ Classifieds Board in Attendee Lounge

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With the exhibitors

- ▶ New ideas, approaches and strategies for your patients and practice

With your Team

- ▶ Over 90 CE sessions, 200+ exhibitors and endless networking opportunities

Learn more about these offerings and everything the Oregon Dental Conference has to offer by downloading the conference Preview Program at www.OregonDentalConference.org.

NEW IN THE EXHIBIT HALL!

ODA Expert Express Lecture Series

Thursday, April 6 10:30 AM – 12 PM & 2 – 3:30 PM

Friday, April 7 10:30 AM – 12 PM & 2 – 3:30 PM

Saturday, April 8 9:30 – 11 AM


Learn from your colleagues! Don't miss the ODA Expert Express Lecture Series presented by Oregon Dental Association members. These 90-minute CE sessions will be offered in a special CE room built in the Exhibit Hall.

Attendee Lounge & Charging Station

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Need to update your website, LinkedIn, Facebook, or ADA member profile photo? We are here to help! Complimentary professional headshots will be offered to *ODA member dentists* in booth #815, located on the exhibit floor. (Designated hours included in registration packet.)

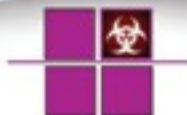
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Team Participation in Oregon Dental Conference Yields Personal, Professional Benefits

By Melody Finnemore

WITH MORE THAN 35 YEARS OF PRACTICE

EXPERIENCE, Portland's Martha E. Rich, DMD, has a wealth of knowledge about preventive dentistry, TMJ, neuromuscular dentistry and functional orthodontics. She also knows that dentistry is a rapidly evolving profession, which is why she has attended the Oregon Dental Conference for the last 20-plus years.

"I graduated in 1981 and so much has changed. In health care, it is dangerous to believe that if you learned something way back when, it is still true that many years later," she says. "It is also good to know about new products. This is the only state meeting with so many vendors."

Dr. Rich has invited her entire team to participate in the conference for many years as well. She views her practice as a learning organization, and she encourages her team

to choose the continuing education courses that are most interesting to them. Then, everyone shares what they learned during the next team meeting in the office.

"I think it is a perk to have the team go. It is a good teambuilding time. I even think it is good for the team to see the dentist interacting with colleagues. And the team gets a chance to build new relationships also," she says.

Ryan D. Sparks, DMD, FAGD, who practices family, cosmetic and implant dentistry in Corvallis, began attending the Oregon Dental Conference during dental school in the late 1990s and hasn't missed once since. As an individual, he appreciates the continuing education courses and the opportunity to catch up with colleagues from dental school and others he doesn't get to see often.

"...it is good for the team to see the dentist interacting with colleagues. And the team gets a chance to build new relationships also."

– Martha E. Rich, DMD



Martha E. Rich, DMD and Team



Ryan D. Sparks, DMD, FAGD and Team

“My staff looks forward to it every year, and I’m sure we’ve already got our hotel and dinner reservations set for April.”

– Ryan D. Sparks, DMD, FAGD



Jared M. Thompson, DMD and Team

Dr. Sparks has encouraged his team to participate since he established his practice and, like Dr. Rich, values the team building aspect. He notes that office staff and assistants often don't have as many opportunities for continuing education as dentists do, so he appreciates the chance to expose them to a variety of sessions. Before the conference, the team makes a list of products and equipment they need so they can shop in the Exhibit Hall and talk in person with representatives they usually only speak to on the phone.

“We go up and spend the weekend in Portland. Everyone participates in the conference during the day and we have dinner together in the evenings. It's fun to do some activities outside of the office,” he says. “My staff looks forward to it every year, and I'm sure we've already got our hotel and dinner reservations set for April.”

Jared M. Thompson, DMD, owner of Pacific Oak Dental in Forest Grove, began attending the conference as a student and has attended every year since he returned home from his residency in 2006. He appreciates the variety and affordability of the CE courses and the chance to experiment with new products and equipment he has read about on blogs or in dental publications. He also likes being able to talk with vendors and representatives who have become friends in the 10 years he's owned his practice.

“Camaraderie is a huge part of why I attend the ODC. Social media today gives us the ability to stay 'up to date' with all of our dental colleagues when our personal lives make it difficult for us to physically reconnect,” he says. “The ODC is the perfect venue to see our old friends, reminisce about the old days and share our professional struggles. Though I value the content in the CE provided, much of what I have learned or taken home from

continues



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Team Participation, continued

the ODC has come from networking events with old friends.”

Dr. Thompson has invited his team to join him at the conference since he purchased his practice. In the early years just two or three people went, but last year all nine staff members attended. He says they all agreed it was a worthwhile experience.

“Yes, there is an opportunity cost in blocking time during the week to attend the course, and then after to review our notes as well as paying for all of them to go, but again I believe the benefits far outweigh the financial burden,” he says.

Among those benefits, staff members attend different CE courses and then share the information they gained during a review session back in the office. This helps Dr. Thompson absorb new information and gives the team a chance to discuss new techniques or ideas they hope to implement in their practice.

“It’s impressive and gratifying to see how energized they are after the ODC. I truly believe much of our success can be attributed to what we’ve learned as a team at the dental conference,” he says. “In addition, the teambuilding experiences from lunch outings or happy hours while attending the conference are invaluable.”

“It’s impressive and gratifying to see how energized they [the staff] are after the ODC.”

*– Jared M. Thompson,
DMD*

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PRESENTED BY **Theresa Johnson, RDH**

Establishing patient trust takes time and effort and in the mind of the patient confidence equates to competence. This is particularly important during the hygiene examination as this is where you build patient trust and practice revenue. Understanding the importance of the relationship and the steps involved to creating an environment of trust and confidence between patient and practitioner are essential to practice success. This course will review the basic concepts of effective communication and relationship building, discuss the importance of collaboration between the dentist, hygienist and dental team and provide tips for communicating treatment and patient care option with confidence.

At the conclusion of this breakout, attendees will be able to:

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- Discuss how to build trust and credibility through effective communication
- Explain the key information that needs to be shared during the hygiene exam

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Considerations in the Management of Traumatic Dental Injuries

By Leif K. Bakland, DDS

THE OUTCOMES OF TRAUMATIC DENTAL INJURIES (TDIS) depend on at least two factors: the treatment provided and the patient's healing response. The management of TDIs includes initial assessment and possible stabilization of the injured tissues, followed by evaluation of the response to the initial care, and development of both short- and long-term treatment options.

The patient's healing response is governed by the circumstances of the TDI and the patient's physical health and age. Extensive additional injuries often result in delays in treatment of the TDIs and may compromise treatment outcomes. The patient's physical health will also certainly affect outcomes. But one aspect that is often overlooked is the role the patient's age plays in both treatment recommendations and prognosis.

In this article, management of TDIs will be described from the standpoint of wound healing and how treatment selections can be connected to age specific benefits. Specifically, the description of TDI management will include stabilization of the injury, reducing the role of bacteria, how to allow potential healing particularly of pulp tissue, and preservation of the alveolar crest in children.

Stabilizing the initial injury

The purpose of stabilizing injured tissues after trauma is to promote initial wound healing. This can have a positive effect on the recovery of the gingival tissues, the supporting alveolar bone, the periodontal ligament (PDL), the root cementum and the dental pulp.¹ An example illustrating this point is that of tooth luxation injuries. The teeth may be displaced, there may be fracture of the alveolar bone, and gingival tissues may be lacerated. Repositioning of the teeth and bony fragments along

with re-adaptation of the gingival tissues will facilitate initial healing (FIG.1).

Repositioning of displaced teeth and bone needs to be accomplished in a most gentle manner. These tissues have already been traumatized by the initial injury and additional forced movements such as repositioning will add to the total injury. The repositioning must therefore be done with care to minimize additional but necessary trauma. Of particular concern is the possibility of root resorption following damage to the cementum. With that consideration in mind, there may be situations where it is preferable to only reposition displaced teeth into their approximate ideal position and follow up with orthodontic fine-tuning to more ideal positioning after initial healing has taken place. Of course, it is necessary to avoid leaving any teeth in hyper-occlusion in the initial repositioning.

Another type of TDI where injury stabilization is beneficial is that of horizontal root fractures.² Frequently the coronal segment is displaced and if the displacement is in a palatal direction it will interfere with occlusion. Relieving the occlusal interference by repositioning the coronal segment is of itself beneficial, but repositioning in all cases of coronal displacement favors desirable healing of the root fracture. The sooner such repositioning takes place after injury the better the odds are for good healing, often through revascularization of the coronal pulp tissue which may have lost all or part of its blood supply during the TDI (FIG. 2).

The replantation of an avulsed tooth is probably the most dramatic example of stabilizing a TDI. Timely replantation favors survival of the PDL and its cells, which allows re-attachment between the root and the bone.³ Further, in some cases of very immature teeth, if the pulp

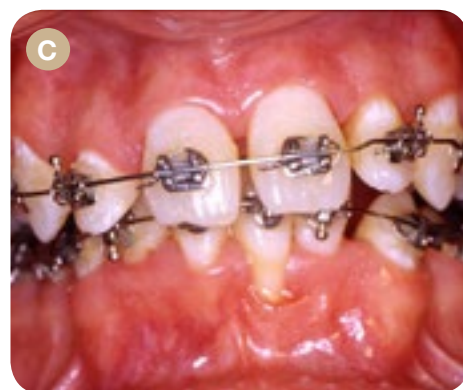


FIG. 1—A. Extensive luxation injury in a 12-yr old boy. **B.** The teeth were gently repositioned and the orthodontic appliance adjusted. Note the soft tissue repositioning. **C.** Follow-up 3 weeks later; note good soft tissue healing. Gingival recession labial to tooth #24 unrelated to the injury. (Courtesy, Dr. James M. Tinnin, Fayetteville, AR)

A significant concern about bacteria is their role in the healing process of replanted avulsed teeth.

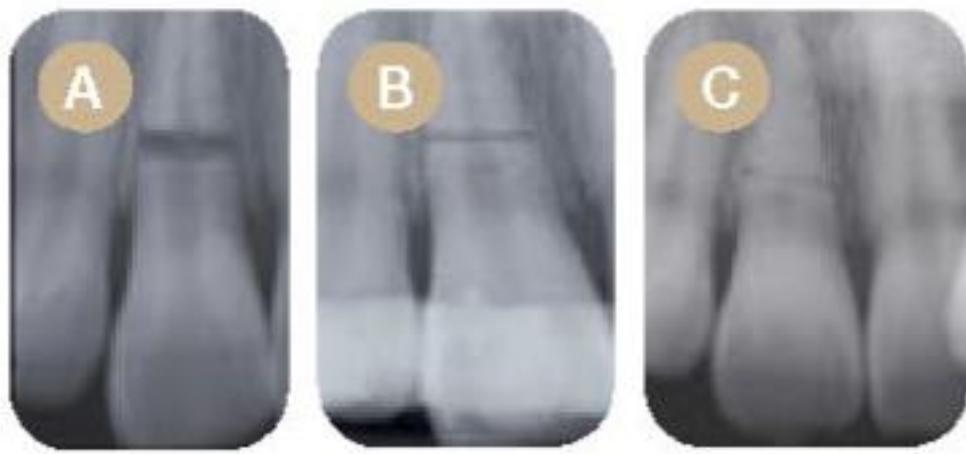


FIG. 2—A. Mid-root horizontal traumatic root fracture in a 25-year old male. The coronal segment was displaced coronally about 2mm. B. The coronal segment was repositioned with 30 minutes and a splint was placed and removed 6 weeks later. C. Radiograph taken 2 years later shows good healing; no other treatment was necessary.

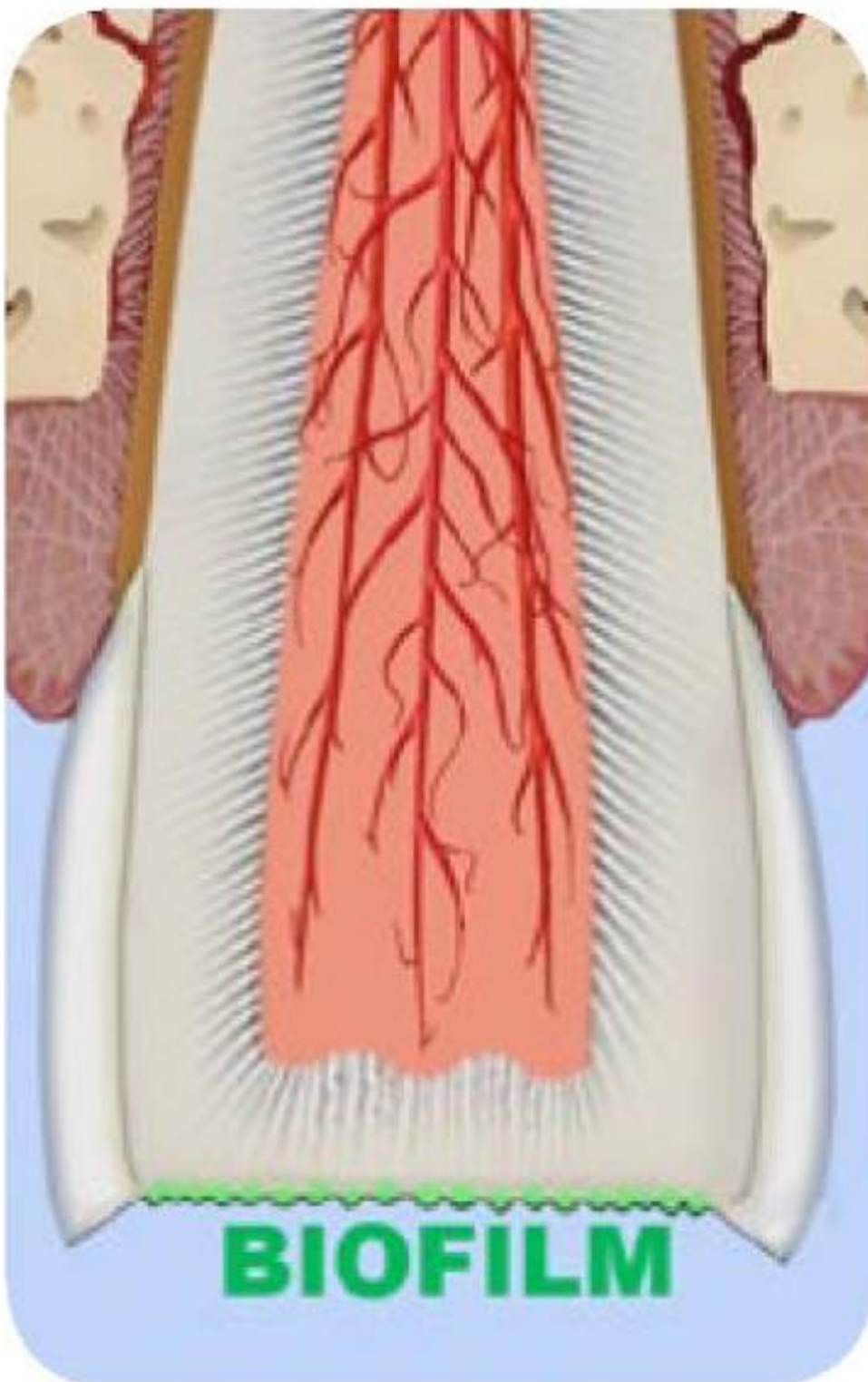


FIG. 3—In teeth suffering crown fractures, the exposed dentin surface is covered with bacterial biofilm very soon after the injury. The bacteria will gain rapid access to the pulp tissue if the blood supply to the pulp has been affected by a concomitant luxation injury of the tooth (6-8).

is not invaded by bacteria, the ischemic pulp tissue can undergo subsequent revascularization.⁴

In cases of tooth displacement (luxation injuries, root fractures, and avulsions) part of the injury stabilization often includes splinting the involved teeth. The major benefit in splinting is to allow the PDL to organize and re-attach. Healing appears to benefit from using non-rigid splints.⁵

Crown fractures may directly expose the dental pulp (complicated fractures) or indirectly through exposed dentinal tubules (uncomplicated fractures). Since crown fractures are often combined with luxation injuries of the teeth, the blood supply to the dental pulp may be compromised resulting in reduced ability of the pulp tissue to resist bacterial invasion, either through the exposed pulp or through the dentinal tubules. In ideal circumstances, crown fractures can be definitively treated soon after the injury. This is not always possible. Stabilization of such TDIs is directed towards protecting the dental pulp from bacteria until the definitive treatment can be accomplished (FIG. 3).^{6,7,8}

Temporary pulp protection can be accomplished quite conveniently by disinfecting exposed dentin and pulp using a cotton pellet soaked in sodium hypochlorite or chlorhexidine followed by covering the area with glass ionomer cement. Definitive treatment can then be scheduled at a convenient time, preferably as soon as feasible.

Recognizing the role of bacteria

Bacteria are present everywhere including the oral cavity. Under normal circumstances their presence is tolerated and may in some cases, such as in the digestive tract, play a positive role for

the host. They can become a problem, however, when a TDI has occurred.

A significant concern about bacteria is their role in the healing process of replanted avulsed teeth. Their presence on the root surface of the avulsed teeth can be reduced by vigorous rinsing with water before replantation. And once the tooth is back in the alveolar socket, the presence of an abundant surrounding blood supply containing defense cells can eliminate any remaining surface bacteria. The problem of concern is that bacteria can gain access to the un-infected necrotic pulp tissue before replantation. Once bacteria gain access to this ischemic pulp tissue they will multiply rapidly in the 'sanctuary' of the root canal space where, due to lack of existing blood supply, the body has no ability to attack the bacteria.⁴

The presence of bacteria in necrotic pulp tissue leads to infection-related root and bone resorption.⁹ Current guidelines¹⁰ strongly recommend that root canal treatment be initiated soon after replantation—ideally within 10 days to two weeks. Such timely initiation of root canal therapy can prevent resorption, and even

continues

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Traumatic Dental Injuries, continued

when resorption has started, endodontic intervention can arrest the resorption.

The use of antibiotics for TDIs does not have much clinical data supporting it. It is however, recommended in cases of avulsions and alveolar fractures. In addition, use of an antiseptic agent such as chlorhexidine is also recommended during the healing time period to prevent bacterial down growth periodontally.¹⁰

Bacteria also cause problems in many other post-trauma situations, but one problem that is of idiopathic origin is that of unhygienic dental splints. In particular, large resin splints become traps for food and debris and provide ideal environments for bacterial growth (FIG. 4). Splints must be hygienic and not impinge on gingival tissues; patients need to be able to maintain good oral hygiene to promote desirable healing outcomes (FIG. 5).¹⁰

Allowing for potential healing

Traumatic dental injuries tend to occur most often in children and adolescents. The teeth are usually caries free and the dental pulps are healthy at the time of injury, in contrast to pulps in carious teeth. Such healthy pulps in teeth subjected to TDIs can be expected to survive various traumatic situations if subsequently protected as described above. Such surviving dental pulps have the potential for generating continued root formation and hard tissue repair in cases of crown fractures.¹¹

Potential healing following TDIs is one reason for paying particular attention to the age of trauma patients. All the possible traumatized tissues—pulp, PDL, and alveolar bone—have potential for healing to a greater extent in

children than adults. For that reason, the management of TDIs in children can be aimed at allowing natural healing to take place.¹² For instance, ischemic pulps that have undergone coagulation necrosis can revascularize if bacteria can be prevented from invading the pulpal tissues. While such revascularized pulps will not generate normal new dentin, hard tissue—similar to reparative dentin—can form, thus thickening and strengthening the root walls. Because such revascularized tissues are not the same as normal dental pulp tissues, often there is a lack of response to pulp testing procedures.

Protecting pulps in immature crown fractured teeth in children is another opportunity to allow healing to take place. Biofilm will form rapidly on exposed dentin surfaces allowing bacterial invasion through the dentinal tubules into the pulp tissue, particularly if the pulpal blood supply has become compromised due to concomitant tooth luxation.⁶⁻⁸ Without active blood supply the pulp becomes an ideal growth medium for bacteria. If bacteria can be kept away, such pulps can readily undergo revascularization, particularly since the apical openings are for the most part wide and very receptive to allow ingrowth of vasculature.

Preserving the alveolar ridge

Loss of one or more maxillary incisors in a child or adolescent has serious consequences for the growth and development of the alveolar ridge. After loss of a tooth, the alveolar ridge collapses within a short period of time (FIG. 6)¹³ Rebuilding it later for insertion of a dental implant is complicated and not predictably successful. Other options are orthodontic closure of the space, autotransplantation, or replacement with a fixed or removable

appliance. The first two options when feasible provide good long term outcomes. Fixed and removable appliances are usually not ideal.

Preserving the developing alveolar ridge in cases of difficult TDIs may in some cases mean retaining the root of a tooth even if the crown is lost. Two examples will illustrate this concept.

In the case of a crown-root fracture where the crown cannot be saved, it may be possible to leave the root in the bone and allow the soft tissue to heal over the remaining root. This will prevent collapse of the ridge and the root can be removed surgically when the child is old enough for



FIG. 4—A dental splint with both wires and excessive amount of resin. Such splints are detrimental to healing. They induce inflammation in the gingival tissues and trap bacteria that further cause inflammation and infection.



FIG. 5—An example of a splint incorporating a braided wire and attached with composite to small areas on the teeth. Such types of splints allow for good hygiene which promotes healing of both soft tissues and the periodontal ligament.

Loss of one or more maxillary incisors in a child or adolescent has serious consequences for the growth and development of the alveolar ridge.

a dental implant. The procedure is often referred to as coronectomy and is usually performed on impacted 3rd molars.¹⁴

Another situation where the alveolar ridge may be preserved is when a replanted avulsed tooth shows signs of ankylosis-related resorption. A procedure called decoronation can be done by which the crown is removed to a level just below the crest of the bone and the resorbing root is allowed to integrate with the bone. This procedure allows new bone to develop on the crest of the alveolus as the alveolus grows and the adjacent teeth continue to erupt normally. Such a dimensionally preserved ridge will provide an excellent site for placement of an implant at the proper age (FIG. 7).¹⁵

Conclusion

Application of sound biological principles can enhance the healing outcomes following traumatic dental injuries. 🗨️



FIG. 6—Example of ridge collapse following loss of maxillary incisor in a young child.



FIG. 7—Alveolar ridge following decoronation. Note the normal horizontal and vertical dimensions that will allow implant placement.

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Steak Behind the Sizzle

An Evidence-based Overview of Single Tooth CAD/CAM Restorations

By Steven A. Gold, DDS

Abstract

The purpose of this overview is to provide a summary of the clinical performance of single tooth CAD/CAM restorations including two of the materials commonly used in their fabrication. A clinical case report demonstrating the outcome that can be expected utilizing CAD/CAM technology is presented. With proper case selection and adherence to established clinical technique, dentists can achieve clinically acceptable to excellent results utilizing CAD/CAM for single tooth restorations.

Introduction

Computer Aided Design/Computer Aided Manufacturing (CAD/CAM) technology was first introduced to the dental profession in the 1970s. As the technology has undergone improvements, it has been adopted by an ever increasing number of dentists worldwide. Today's CAD/CAM systems allow dentists to provide esthetic restorations of high quality to their patients, often in one visit.¹

The evolution of this technology has paralleled, and is intimately entwined with the evolution of indirect esthetic restorative materials. Today, practitioners have a wide variety of tooth-colored materials from which to choose when restoring a patient's dentition, including highly sintered glass, polycrystalline alumina and zirconia based ceramic materials, and resin composite based materials.² Like CAD/CAM technology, these materials have become an increasingly popular choice for today's dentists.

In spite of this increase in the utilization and popularity of CAD/CAM technology, questions remain in the minds of many practitioners about the clinical success of CAD/CAM fabricated restorations. Although quality scientific

evidence investigating the long term clinical success of CAD/CAM restorations has historically been scant, the literature today is starting to yield evidence that may be useful to practitioners who use, or are considering using, CAD/CAM technology to fabricate restorations for their patients.

Evidence

Systematic reviews provide the clinician with the highest level of evidence quality relating to the success of CAD/CAM restorations. In the most current systematic review of the clinical performance of CAD/CAM single-tooth restorations, Wittneben, et al. determined CAD/CAM fabricated restorations had a 91.6% survival rate after five years.³

This compares to a 95.7% survival rate for metal-ceramic crowns after the same exposure period.⁴ An earlier systematic review by Fasbinder found the survival rate of CAD/CAM restorations to be 97% after five years and 90% after 10 years.⁵

As for materials available for use with chairside CAD/CAM systems, lithium disilicate (e.max, Ivoclar Vivadent) is the material of choice for many dentists owing to its excellent esthetics and favorable properties, including flexural strength. A recent systematic review of clinical outcomes of lithium disilicate single crowns shows survival rates to be 97.8% over five years and 96.7% over 10 years.⁶

A number of manufacturers have introduced composite resin based



Figure 1



Figure 2



Figure 3



Figure 4

materials for use in chairside CAD/CAM milling units. The performance of these materials has been less favorable than for all ceramic materials. Vanoorbeek et al. looked at the cumulative survival and success rates of CAD/CAM fabricated all ceramic versus composite restorations. They found that after three years of function, the composite restorations had success and survival rates of 55.6% and 87.9% respectively compared with 81.2% and 97.2% for the all ceramic restorations.⁷

Clinical Case Report

A healthy 54 year old male patient of record presented with a fractured buccal cusp of the maxillary right first premolar (Figures 1 and 2). A clinical and radiographic exam yielded no additional significant findings. Following presentation of all restorative treatment options and obtaining informed consent, the tooth was treatment planned for a CAD/CAM fabricated all ceramic restoration. The existing occlusal amalgam restoration was removed and, due to the amount of healthy tooth structure remaining, a conservative onlay preparation was completed (Figures 3 and 4). Among other advantages, this allowed for cavo-surface margins to terminate in enamel, which in turn provides for an optimal bond between tooth and restoration.

Digital scans required for restoration fabrication were acquired with a CEREC Omnicam (Sirona). A lithium disilicate (e.max, Ivoclar Vivadent) restoration was designed and milled using CEREC design software and a CEREC MC XL milling unit. The milled restoration was tried in and proximal contacts, margins and occlusion were checked and adjusted as needed (Figure 5). The restoration was crystallized according to manufacturer's directions



Figure 5

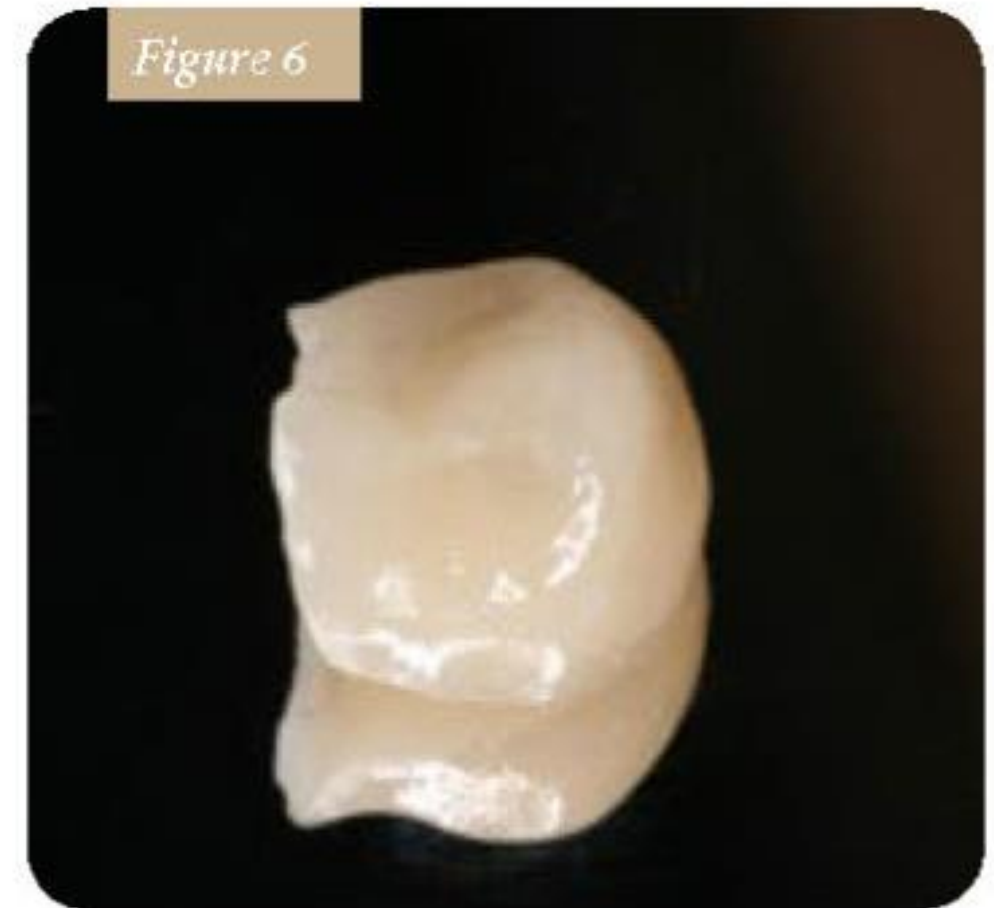


Figure 6



Figure 7



Figure 8

utilizing a Programat crystallization furnace (Ivoclar Vivadent) (Figure 6). An on-site laboratory technician aided the clinician in customized staining of the restoration at this stage. The final restoration was cemented using Scotchbond Multi Purpose adhesive system (3M) and Multilink Automix resin cement (Ivoclar Vivadent) (Figures 7 and 8). This procedure was accomplished in one appointment. The patient was satisfied with the result and the ability to complete the procedure in one visit.

Conclusion

It is safe to assume that most dentists and patients who have witnessed or experienced CAD/CAM dentistry first hand, find the technology exciting and impressive. The purely digital flow of data from prepared tooth to final restoration in one visit can be considered "high tech sizzle." But is there sound scientific evidence that the technology produces restorations that will lead to long-term clinical success? In other words, is there steak behind the sizzle? It appears that

the evidence in the dental literature is mounting to show high rates of clinical success in the short to medium-term for single tooth CAD/CAM fabricated restorations. Evidence supporting long-term clinical success remains limited. As with all dental procedures, proper treatment planning, selection of

continues


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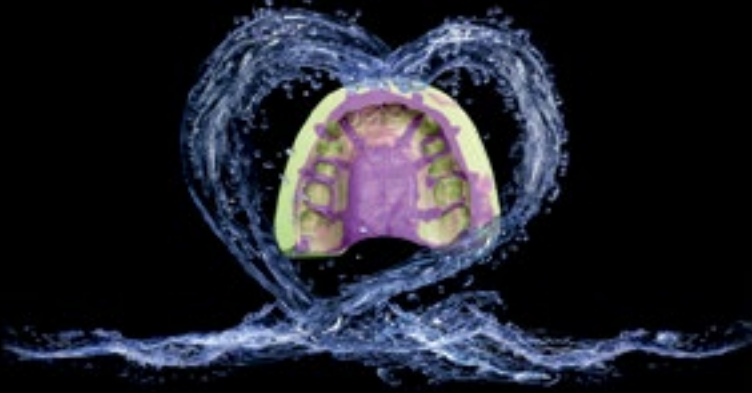
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Restorations, continued

materials, and execution of clinical steps will provide the best opportunity for such success. 📍

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Antimicrobial Mouthrinses for Plaque and Gingivitis Control

By Rebecca S. Wilder, RDH, MS

CONSISTENT “AT HOME” ORAL HYGIENE PROCEDURES performed by patients are essential to improved oral health and the control of plaque and gingivitis. Oral hygiene, even for the patients with very good skills, may result in areas where the biofilm remains untouched and, therefore, making the individual vulnerable to developing caries and/or periodontal diseases. Nearly half of the United States (US) population has some form of periodontal disease and 70% of adults 65 years and older have the disease.¹ Controlling plaque and gingivitis can help to prevent periodontal diseases. Fortunately, clinicians have several formulations of dentifrices, gels, and mouthrinses that are important adjuncts to mechanical methods of biofilm removal. This review will focus on the evidence for using antimicrobial mouthrinses that are available in the US market for plaque and gingivitis control.

Antimicrobial mouthrinses have been investigated as a therapy to reduce plaque and gingivitis. They are formulated to negatively impact the formation, growth and maturation of oral biofilms.² Mouthrinses are popular with patients as they are easy to use and have minimal side effects. In addition, about 20% of the oral environment is made up of tooth surfaces but plaque biofilm can occupy areas in the remaining 80% of the oral environment, including the oral mucosa and tongue.³ It is possible that a mouthrinse could provide an antimicrobial effect to the entire mouth.

The most widely investigated antimicrobial mouthrinses are those containing chlorhexidine gluconate (CHX), essential oils (EO) and cetylpyridinium chloride (CPC). Systematic reviews on these rinses

have reported impressive plaque and gingivitis reduction, in some cases.⁴⁻⁵ Following is a discussion regarding the evidence about current mouthrinses for plaque and gingivitis control.

Chlorhexidine Gluconate

Chlorhexidine is the most effective anti-plaque/antigingivitis rinse available today. In the US it is sold by prescription at a 0.12% concentration and a pH of 5.5–6.0. While most of the products contain 11.6% alcohol, there are formulations available without alcohol. The rinse works by altering the bacterial adsorption, reducing the pellicle formation and altering the bacterial cell wall causing lysis of the contents. The substantivity of CHX is excellent with 30% retention in the oral cavity after rinsing and it remains effective for 8–12 hours.⁶

CHX is approved for the reduction of plaque and gingivitis but not periodontitis. However, the reduction of gingivitis may impact the prevention of chronic periodontitis in some patients. A recent systematic review by Van Strydonck et al. reported a 33% reduction in plaque and 26% for gingivitis in studies ≥ 4 weeks.⁷ Studies in the review confirmed CHX to be effective in the reduction of plaque, bleeding and gingivitis when used as an adjunctive product. CHX should be used by patients twice per day for at least 20 seconds as a 15-ml rinse. Adverse effects include staining of enamel, alteration of taste and increased calcified deposits.

Essential Oils

Essential oil rinses consist of a combination of thymol, menthol and eucalyptol combined with methyl salicylate. Alcohol content varies from 21.0–26.9%. Depending on the concentration, EO rinses can either

disrupt the cell wall and precipitate cell proteins (higher concentration) or inactivate some essential enzymes (lower concentration). They have also been proposed to have antioxidant activity.⁸ Gunsolley concluded that EOs are among the most efficacious over-the-counter mouthrinses available in the US market.⁹ The author reported data on mean plaque reduction of 27% and 18.2% in gingival inflammation reduction in mouthrinses studies, with a minimum duration of six months, combined with mechanical plaque control.⁹ A recent meta-analysis was conducted by Araujo et al. with the purpose of evaluating the site specific effectiveness of EO mouthrinses with mechanical plaque control versus mechanical plaque control used alone.¹⁰ The analysis consisted of 29 industry sponsored clinical trials that investigated the anti-plaque, anti-gingivitis effects of EO mouthrinses conducted over a 32-year period. All studies were designed to meet criteria and regulations outlined by the American Dental Association and the US Food and Drug Administration. The results

continues

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Mouthrinses, continued

reported that after six months of use, clinicians could expect approximately 45% of patients to have at least 50% of sites without gingivitis and approximately 37% of the patients would have at least 50% of the sites without plaque, when using mechanical plaque control and EO twice daily for at least six months.

Questions frequently arise about the alcohol content of EO mouthrinses. Boyle et al recently reported that use of an EO mouthrinse containing alcohol does not pose an increased risk of oral cancer when used as directed.² Clinicians should not recommend antimicrobial mouthrinses to patients who are recovering or current alcoholics or to children. Also, patients who have xerostomia should avoid mouthrinses containing alcohol. Patients should be instructed to rinse with 20 ml for 30 seconds. Contraindications include a burning sensation during use with certain formulations.

Cetylpyridinium Chloride

Cetylpyridinium Chloride is a widely used cationic quaternary ammonium compound with broad antimicrobial spectrum. Part of its molecule interacts with the bacterial cell membrane, which can cause cell growth inhibition and eventually cell death. It is mostly effective against gram-positive bacteria and yeast. When evaluating the 6-month clinical trials focused on the relevance of the evidence of mouthrinses to control plaque and gingivitis, Gunsolley concluded that CPC was weaker than CHX and EOs. This was mostly because of the data with few clinical trials testing the same formulations of CPC.⁹ Another review on CPC and plaque accumulation and gingival inflammation comes from Haps et al. The authors concluded that, when used as an adjunct to mechanical oral hygiene, CPC rinse provides a small but significant additional benefit on reducing both biofilm accumulation and gingival inflammation.¹¹ CPC should

be used as a 20 ml rinse twice a day. Reported side effects include increased calculus formation, staining and occasional burning sensation.

Clinicians should recommend antimicrobial mouthrinses to patients who would potentially benefit from their use. Mouthrinses should be used as an adjunct to mechanical plaque control (i.e. brushing and interdental cleaning). The choice of mouthrinse should be based on the evidence available in the literature and both provider and patient preferences. 📌

This paper is reprinted with permission from Dimensions of Dental Hygiene. It represents a partial portion of the publication: Wilder R, Moretti A. Antimicrobial mouthrinses for plaque and gingivitis control. Dimensions of Dental Hygiene. 2016; 14(11):32-34.

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The Tooth Taxi

By Dr. Amanda Rice

The Dental Foundation of Oregon is the charitable arm of the Oregon Dental Association.

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THE BUSY TIME OF WINTER has been adventurous and rewarding for the Tooth Taxi team after completing our site visits down south in Woodburn and Cottage Grove. As we transitioned to treating middle and high school students during the month of December, our team adapted and found new ways to reach out to an older patient population.

Our site visit to Cottage Grove Alternative High school in particular made an everlasting impression on us for its heartwarming welcome from both students and staff. Our team was presented with the opportunity to provide life changing treatment to a site with substantial need. The services provided during our short visit also included conducting after school oral health presentations to young mothers and family members. Educating early and often is an impactful method towards changing a communities' projected outlook on dental health. The AAPD (American Academy of Pediatric Dentistry) advises counseling pregnant patients

as early as their first trimester in order to start establishing a dental home for their child. Topics emphasized and discussed in our presentations to teen mothers include relationship of maternal oral health and infant, preventive plans and dietary considerations.

To have class participants enthusiastic and curious to learn about how to reduce transmission of cariogenic bacteria, when to throw away the bottle and what baby foods to avoid illustrates the impact and necessity for these informative outreach opportunities. Education on early childhood dental care and disease prevention is key to helping undeserved communities tackle the cyclical nature of dental neglect.

We are truly grateful on the Tooth taxi to have the resources and opportunity to provide services to our local communities. A huge word of thanks to everyone who has generously supported our mission. 📅



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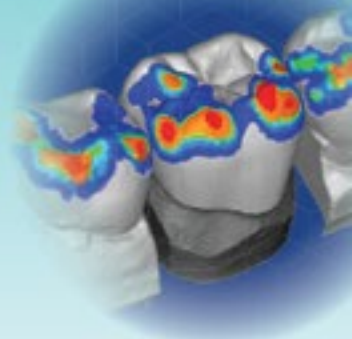
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