

OKDA JOURNAL

VOLUME 99/ISSUE 11

OCTOBER 2008

The official publication of the Oklahoma Dental Association

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From the Executive Director

Dana A. Davis

DENTISTRY UNITED! *Legislative Journal Issue*

The Summer Olympics, football season, gas prices, foreclosures, to drill or not to drill, political party conventions, health care crisis, the future of SSI, war against terrorism, and the November elections. What will be the “new” face of Washington DC politics come January 2009?

These have been the major news stories lately (or seemingly forever). There are some things we can just sit back and enjoy reading about like football season, the Olympics, and maybe the two National Political Party Conventions.

We have all heard the saying “get out of your own little world”. If you are like me, there are days when I like my own little world and would rather not deal with the bigger issues. I read two newspapers a day and several dental journals. I honestly get tired of reading about violent crimes, the economic slowdown, foreclosures, the growing cost of health care, Obama versus McCain, suicide bombings, etc. I could go on but I am getting depressed just writing this.

The truth is, I realize I cannot just live in my own little world – most of which is the ODA (I know, get a life, Dana!). I also know that being depressed or angry and not taking action will not change the state of the world, Oklahoma, or the USA. Most importantly, I know I, as one individual, cannot have a major impact. It is true that there is strength in numbers.

In August, the ODA DENPAC Board approved contributions to some primary campaigns and will, in the near future, decide on contributions to the November election campaigns. Also, ADPAC has sent several contributions for ODA members to give to their Congressional Representatives.

The decisions in both cases were based on the voting records of the candidates as they relate directly to the safety and quality of dental care provided throughout the state and country. Both political party candidates received funds. These candidates are also individuals with whom dentistry has developed long-term relationships. In other words, we can approach them when we need a bill introduced, supported, amended, or defeated. These bills are not always specific to dentistry; rather, they include such issues as things that impact small business and tort reform. By virtue of my position, I am the person that members call when they are upset. I have had many calls about the teeth whitening kiosks in shopping malls this year (see page 18). I get calls when Sooner Care changes a reimbursement rate or procedure, or HealthChoice does something. Some members are concerned about the Advanced Dental Hygiene Practitioner proposal that is moving forward in a few states (see page 22).

During the current dues year only 430 of our members paid DENPAC dues (\$ 110 remains with DENPAC and \$40 is sent to ADPAC). Only 29% of ODA members have gotten out of their own little world and are helping the ODA fight on behalf of 100% of the membership. I applaud and thank those members listed on page 10 who know how important it is for dentistry to have a voice or clout in the political world.

I hope the 71% who are reading this and have not paid 2008 DENPAC dues will send a personal check for \$150. It is not too late.

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OCTOBER

- 3rd**
> Adopt-a-Dentist Orientation & Lunch - ODA - 10:30 AM
> ODF Board of Trustees Meeting - ODA - 1:30 PM
- 8th**
> Children's Oral Health Coalition Meeting - ODA - 10:00 AM
- 9th**
> DentFest - OUCOD - 5:00 PM
- 10th**
> Adopt-a-Dentist Orientation & Lunch - ODA - 10:30 AM
- 13th**
> ODF Mobile Dental Unit - Caring Hands/McAlester - 9:30 AM
- 14th**
> ODF Mobile Dental Unit - AK Verdigris Valley Community Center/ Porter - 9:30 AM
> OCDS Board Meeting - ODA - 6:00 PM
- 15th - 21st**
> ADA Annual Meeting - San Antonio
- 20th**
> Retired Dentists Lunch - ODA - 11:30 AM
- 23rd**
> OCDS Spouse Night - Crabtown/Bricktown - 6:00 PM
- 24th**
> Dental Leadership Summit Planning Meeting - ODA - 11:00 AM
> Annual Meeting Planning Committee Meeting - ODA - 1:00 PM

NOVEMBER

- 7th**
> C.O.R.D. Meeting - ODA - 10:00 AM
> ODA Board of Trustees Meeting - ODA - 1:30 PM
> TCDS CE Meeting - All Day
- 10th**
> ODF Mobile Dental Unit - Caring Hands/McAlester - 9:30 AM
- 11th**
> ODF Mobile Dental Unit - AK Verdigris Valley Community Center/ Porter - 9:30 AM
- 12th**
> Children's Oral Health Coalition Meeting - ODA - 10:00 AM
- 13th**
> OCDS General Assembly Business Meeting
- 14th**
> OCDS CE Meeting - All Day
- 17th**
> Retired Dentists Lunch - ODA - 11:30 AM
- 21st**
> ODA New Dentist Conference - ODA - 9:00 AM
- 27th - 28th**


In Memoriam

Dr. Leo Gene McAtee
1929 - 2008 ~ Laverne, Oklahoma

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ODA News You Can Use

This month's spotlight on an
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ODA PATIENT'S PAGE

This message brought to you by your dentist - a proud member of the Oklahoma Dental Association

Cracked Teeth

With more sophisticated procedures, dentists are helping people keep their teeth longer. Because people are living longer and more stressful lives, they are exposing their teeth to many more years of habits that can potentially cause cracks, such as clenching, grinding and chewing on hard objects.

Types of Cracks

There are many different types of cracked teeth. The treatment and outcome for your tooth depends on the type, location and severity of the crack.

Craze Lines: Craze lines are tiny cracks that affect only the outer enamel. These cracks are extremely common in adult teeth. Craze lines are very shallow, cause no pain, and are of no concern beyond appearances.

Fractured Cusp: When a cusp (the pointed part of the chewing surface) becomes weakened, a fracture sometimes results. The weakened cusp may break off by itself or may have to be removed by the dentist. When this happens, the pain will usually be relieved. A fractured cusp rarely damages the pulp, so root canal treatment is seldom needed. The tooth will usually be restored by your dentist with a full crown.

Cracked Tooth: This crack extends from the chewing surface of the tooth vertically towards the root. A cracked tooth is not completely separated into two distinct segments. Because of the position of the crack, damage to the pulp is common. Root canal treatment is frequently needed to treat the injured pulp. Your dentist will then restore your tooth with a full crown to bind and protect the cracked tooth. At times, the crack may extend below the gum line, requiring extraction.

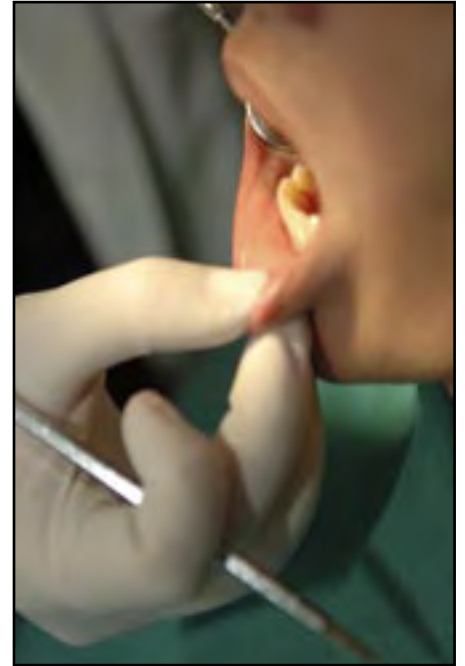
Split Tooth: A split tooth is often the result of the long-term progression of a cracked tooth. The split tooth is identified by a crack with distinct segments that can be separated. A split tooth can never be saved intact. The position and extent of the crack, however, will determine whether any portion of the tooth can be saved. In rare instances, endodontic treatment and a crown or other restoration by your dentist may be used to save a portion of the tooth.

Vertical Root Fracture: Vertical root fractures are cracks that begin in the root of the tooth and extend toward the chewing surface. They often show minimal signs and symptoms and may therefore go unnoticed for some time. Vertical root fractures are often discovered when the surrounding bone and gum become infected. Treatment usually involves extraction of the tooth. However, endodontic surgery is sometimes appropriate if a portion of the tooth can be saved by removal of the fractured root.

Will My Tooth Completely Heal?

Unlike a broken bone, the fracture in a cracked tooth will never heal. In spite of treatment, some cracks may continue to progress and separate, resulting in loss of the tooth. Placement of a crown on a cracked tooth provides maximum protection but does not guarantee success in all cases.

The treatment you receive for your cracked tooth is important because it will relieve pain and reduce the likelihood that the crack will worsen. Once treated, most cracked teeth continue to function and provide years of comfortable chewing. Talk to your dentist and/or endodontist about your particular diagnosis and treatment recommendations. They will advise you on how to keep your natural teeth and achieve optimum dental health.



Early diagnosis is extremely important. Like cracks in a windshield, cracks in teeth often start small and progress slowly. The sooner a crack is detected and treated, the better the chance of saving your tooth.



Drs. Tamara Berg and Lisa Grimes present U.S. Representative Frank D. Lucas with a campaign contribution from ADPAC. You can help contribute to candidates by joining ADPAC/DENPAC today!



The Oklahoma Dental Foundation welcomes Kristin Vineyard

Kristin is the new Volunteer Coordinator. Her experience includes recruiting, training, and motivating volunteers while she was Director of Ozone Ministries, and coordinating volunteer staff at a sports and adventure camp. She holds a Bachelor of Science degree from Texas Christian University, and is currently completing a second degree from Oklahoma City University in Organizational Communication.

Kristin recently married her camp sweetheart, KR Vineyard, and relocated to Oklahoma City from Dallas. Kristin loves dodge ball (thanks to camp and her middle school and high school students), indoor soccer, running, reading, and spending time with her husband and family.

The position is supported by a partnership with the United Way of Central Oklahoma with funds provided through a grant from the Inasmuch Foundation. Kristin can be reached at 405-241-1299, extension #114, or by email at kvineyard@okdf.org. Please join us in welcoming her.

ODA Back-to-School Picnic

The 10th annual ODA Back-to-School Picnic for the OUCOD dental students was held August 26, 2008. Everyone enjoyed great bar-b-q and beverages, music and a moonwalk for the kiddos. Dr. Tamara Berg, ODA Vice President and Chair of the ODA Council on Membership and Membership Services, presented door prizes donated by members of the Council. The event is a fun and entertaining way for the ODA officers and staff to get to know the future leaders of the Association, as well as an opportunity to introduce the students to organized dentistry. Others in attendance included Dr. Jandra Mayer-Ward, ODA President, Dr. Rieger Wood, ODA President-elect, Dr. Steve Young, Dean of the OUCOD, and Dr. John Taylor, ODA Council on Membership and Membership Services member. The ODA paid half of the 2008-2009 ASDA dues for all those students who joined that evening. The ODA would like to thank the Oklahoma Dental Foundation for the music, as well as ASDA president, Brenon Farmer, ASDA vice-president, Kevin Howarth, and our event sponsor, Stillwater National Bank. We hope to see you all next year!



DENTIST DAY AT THE CAPITOL - FEBRUARY 11th -

ODA Today

MARK YOUR CALENDARS!

1:00-2:30 p.m.

educational session and lunch at the ODA building to learn about legislative issues on the docket that may affect dentistry in Oklahoma. Lunch sponsored by DENPAC.

2:30 – 5:00 p.m.

Dentists meet with legislators. Schedule an appointment with your legislator to meet during this time. Park at the ODA building and ride a van to the Capitol.

5:30 – 7:30 p.m.

A Legislative Reception at the ODA Building - Hors d'oeuvres and drinks provided.

Your participation is imperative! Sixty legislators attended the 2008 Dentist Day at the Capitol reception and many districts were not represented by ODA members. The first question every Legislator asked was "Is there anyone here from my district?". **That answer needs to be YES!** A personal relationship with your State Representative and Senator is the most important step toward educating the legislature about our issues. **Don't sit back and assume others will be representing your district. YOU be the one!**

DENTIST DAY AT THE

Attend all day events

CAPITOL – COMMITMENT FORM

attend only what your schedule allows.

- Yes! I will attend all of the day's events
- Yes! I will attend only the educational session/lunch and meet with my legislators
- Yes! I will represent my legislative district during the Legislative Reception

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Return this form to the ODA by fax 405-848-8875

Contact your Legislator to make an appointment:

House of Representatives: 405-521-2711 or 800-522-8502

Senate: 405-521-5692

**Don't
Miss It!
February
11th**

2008 DENPAC Members

A BIG THANK YOU to our DENPAC members!

Your contributions help support legislators on the state and national level.

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A better-built lab coat can make all the difference.



Finding an exceptional lab coat at a great price is no easy process. Just ask Kim Ross, senior merchant at Lands' End Business Outfitters. When her quest to find a style that met customers' basic criteria failed, she enlisted the help of her design team. "My father was in the medical field so I had a pretty good idea where to start," she says. "But to make sure, I talked to customers."

Kim Ross succeeded in building lab coats practically made to order. She used a durable cotton/polyester fabric that releases stains in the wash. She added pockets inside and out for optimum discretion. Side slits on lab coats make for easy pants pocket entry. She even made sure the women's styles had princess seams. The result is added functionality. "When we add your monogram or logo, it really adds a custom look," says Ross.

"The detailing is really nicely done," says Debbie with Booth Orthodontics in Homer Glen, IL. She appreciates the hidden inside pockets and fit-for-her shape. "It's nice to have a jacket that feels made for me."

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Adopt-A-Dentist Update

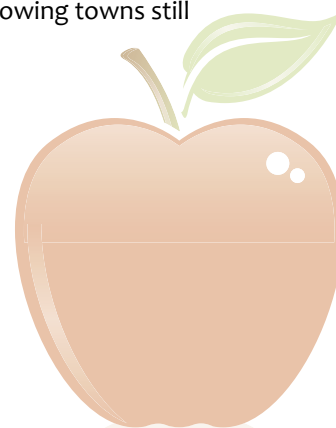
ODA's Adopt-A-Dentist program is off to a great start, but volunteer dentists are still needed to match with 18 Oklahoma elementary schools! The ODA, in partnership with Schools for Healthy Lifestyles (SHL), has launched the "Adopt-A-Dentist" program and we are asking you to consider serving as an adopted dentist to one of the SHL schools for the 2008-2009 school year. SHL's mission is to promote and maintain healthy lifestyles among students, families and educators. Elementary schools selected to enter the SHL program form a health advisory council to identify needs, establish goals, and implement plans to improve the well being of their entire school community. SHL currently has 50 schools throughout the state.

A big THANK YOU! to the following participating ODA members: Drs. Bun Baker, Jeannie Bath, Justin Beasley, Buddy Benson, Tamara Berg, William Bozalis, Ryan Brackett, Chasity Carper, Michael Chandler, Ken Coy, Jeffrey Danner, Thai-An Doan, Doug Durst, Melanie Emerson, Joe Fallin, Melissa Farrow, Sarah Fox, Martha Garzon, Steve Gregg, Jennifer Griffin, Joe Isaacson, Katherine Johnson, Krista Jones, Charles Keithline, Shannon Lewis, Pam Low, Alan Owen, Mark Revels, Stacy Revels, Don Roberts, Jerry Smith, Twana Smith, and Rieger Wood.

Volunteers are still needed for the ODA Adopt-A-Dentist Program!

Elementary schools in the following towns still need to be matched:

- Ardmore
- Blackwell
- Blanchard
- Choctaw
- Cushing
- Midwest City
- Muskogee
- Newcastle
- Oklahoma City (7 schools)
- Pauls Valley
- Shawnee (2 schools)



The success of this new program is 100% dependent upon ODA volunteers! Contact Lynn Means at (405) 848-8873 or (800) 876-8890; or lmeans@okda.org as soon as possible if you are interested in volunteering or have questions about the program.

Joy Rainey, SHL Coordinator at Western Village Elementary in Oklahoma City, recently had this to say about their adopted dentist, Dr. Buddy Benson:

"Our adopted dentist came out with his assistant this morning. Most of the kids were really engaged and had great questions which he did a good job answering! I think he's going to come out and be a part of the first grade career fair next month, too! He's great!"



Dentistry: A Team Effort

2009 ODA Annual Meeting CE Preview

George E. Bambara, MS, DMD

Dr. Bambara is a graduate and faculty member of the University of Medicine and Dentistry of New Jersey. He is past president of the Richmond County Dental Society and holds Fellowships in the American College of Dentists, the International College of Dentists and the International Academy of Facial Esthetics. He is an Adjunct Assistant Professor at the College of Staten Island and is on the attending staff at Methodist Hospital in Brooklyn and Seaview Hospital on Staten Island. He lectures nationally and internationally on attachment prosthetics and has been selected as one of the "Top Clinicians in Continuing Education" for 2006, 2007, and 2008 by *Dentistry Today* magazine. He is a general practitioner with a private practice on Staten Island.

Precision and Semi-Precision Attachments – Where, When, Why and How?

Six (6) Hours of CE Available

Friday, April 24, 2009

8:00 am – 11:00 am and 2:00 pm – 5:00 pm

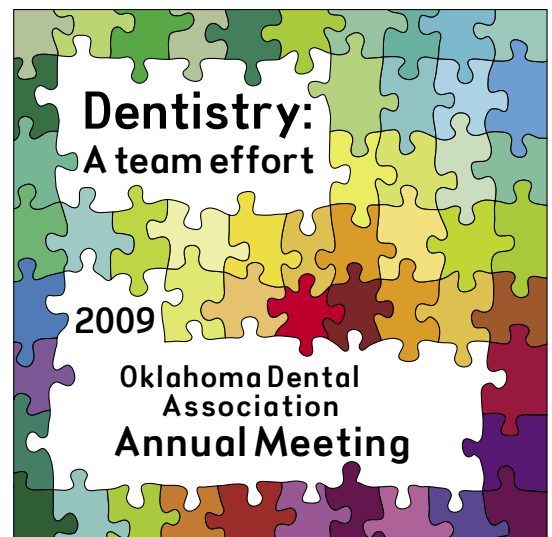
Lecture format

Recommended for dentists and lab technicians

Attachment dentistry provides superior cosmetic and functional alternatives to the traditional cast partial denture with clasps. Attachments are simply rigid or resilient connectors that redirect the forces of occlusion. They are stress attenuators and absorbers. Their function is to preserve soft tissue and bone as well as provide retention, correction of angular discrepancies and cosmetic alternatives. This program emphasizes the rationale for using precision and semi-precision attachments in the treatment planning of fixed and removable partial dentures, overdentures and implants. Each of these prosthetic options are discussed in detail providing a greater understanding leading to practice utilization. Various types of coronal and radicular resilient and non-resilient attachments are discussed including bar joints and bar units, studs and magnets. A logical approach to the treatment planning of attachment dentistry is presented which insures long-term success and patient satisfaction. Clinical cases are reviewed and participants will gather knowledge, excitement and confidence enabling them to utilize attachments in their

daily practice immediately. Participants are encouraged to bring questions which will be discussed throughout the presentation as well as any of their past experiences with attachments. Upon completion of the course, the participants will understand:

- What precision and semi-precision attachments are and how they are used in prosthetic dentistry.
- How to treatment plan attachment-retained removable partial dentures, overdentures, segmented fixed bridges using natural teeth, as well as implants as abutments.
- Various types of rigid and resilient intracoronal and extracoronal attachments including rod and tube, bar units and joints, studs, magnets, plungers, latches and screws.
- A logical approach to begin incorporating attachment dentistry into treatment planning.
- The redistribution of traumatic forces and how bone, soft tissue, teeth and implants are affected.
- How to control loading and rotational forces.
- Stabilization and support.
- Relining techniques.
- Conversion of a fixed attachment-retained partial denture to a removable attachment-retained partial denture.





give kids a smile!®

who: Many dentists across Oklahoma will take time from their practices to help underserved children who aren't getting the oral health care they need. **Will you join us?**

what: Give Kids a Smile!® is an annual one-day volunteer initiative to provide free educational, preventative and restorative services to children from low-income families.

when: February 6, 2009

why: To provide oral care to disadvantaged children and teach them how to take care of their teeth. It will also provide you an opportunity to educate the parents about the importance of regular visits to the dentist.

how: 1) Offer free educational, preventative and restorative services to children from low-income families in your practice.
2) Make a donation to Give Kids a Smile!® so other volunteer dentists will have help with the supplies they'll need.

The ODA will have a limited number of supplies available to help you as well as special GKAS! t-shirts to wear that day. Please return the form below to the ODA by **January 1, 2009** to have priority:

Oklahoma Dental Association/GKAS
317 NE 13th Street, Oklahoma City, OK 73104
or fax to: 405-848-8875

To learn more please call Lynn Means at 405-848-8873/800-876-8890 or email her at lmeans@okda.org.

Please tell us what you have planned for Give Kids a Smile!®

List full names of all participating dentists: _____

Name of your practice (for press release): _____

Address _____ City _____ Zip _____

Phone _____ Fax _____ Email _____

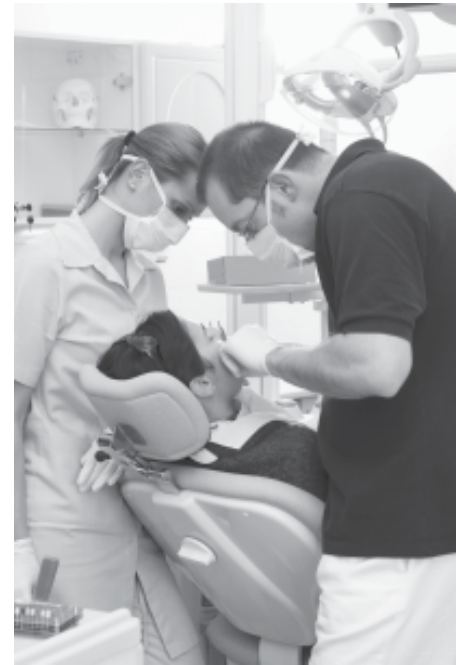
Please mark all that apply:

- YES!** I am planning to participate in GKAS! in my office. Here is what I have planned: _____
- Please send supplies. I realize the ODA's inventory is limited.
- No, I do not need supplies from the ODA.
- YES!** I would like to make a donation to assist in purchasing GKAS! supplies. My check is enclosed. *Make check payable to the ODA and send with this form.*

If you participate in GKAS! every year, and do not need supplies or t-shirts, the ODA still wants to hear from you! We will send a press release to the hometown newspaper of every participating dentist and will list the names of all participating members in a future issue of the ODA Journal. Please take digital photos of your activities and email them to Lynn Means at lmeans@okda.org.

thank you for volunteering for give kids a smile!®

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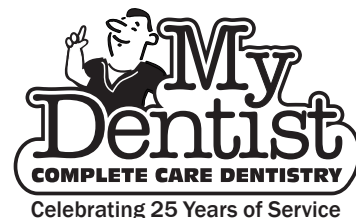
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President/CEO



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Meet the Staff

A series of articles designed to help members put a face with a name of the ODA staff.



LAURYN CARTER Membership Services Manager

Lauryn joined the ODA forces in 2008.

Interesting Fact: Her favorite dessert is her mother's Cherry Cheesecake.

I am a recent graduate of the University of Oklahoma, where I majored in journalism with an emphasis in public relations and a minor in psychology. I was a member of the Delta Delta Delta sorority and an active participant of campus activities including: Sooners and Seniors, OU Cousins, Relay for Life and Habitat for Humanity.

My mom (a.k.a. "Skinny") is the funniest person I've ever had the pleasure of knowing – there's never a dull moment with her. My dad is a very hardworking person and owns many businesses including Carter Backhoe, Oklahoma Underground and LAMP Properties. I have one brother, Matthew, who owns a lawn care business and attends UCO/OCCC. We usually spend our time together discussing how wonderful Moe's burrito's are, the hilarity of Christopher Walken, and our dogs.

In my free time I enjoy being a vegetarian, telling others about me being a vegetarian, highlighting the benefits of vegetarianism, cooking vegetarian meals (you can see a pattern developing...), volunteering at animal rescue organizations, playing tennis, reading medical books with my boyfriend, Mark, swimming, traveling, and spending time with my three spectacular dogs Zeke, Colbey and Gunnar.

What information/assistance does your position provide for the membership?

I'm here to answer ANY question, big or small. If members or potential members have a question or a need but doesn't know how to go about it, I'm their woman. I'm also here to coordinate all the events sponsored by the Council on Membership and Membership Services.

As the Membership Services Manager, what goals do you have for your area in the upcoming year?

1. To become a familiar face to dental students and dentists
2. To incorporate new ideas and themes into events
3. To be helpful and accommodating to any member
4. To convince the Board we need a mascot and it should be Gunnar the Chihuahua (he has really great teeth and his favorite color is green, the color of the ODA)

What has been the most interesting part of your job so far?

Interacting with dental students; they always seem to ask interesting questions that are difficult to answer. Example: "Do you think maxillofacial surgery is a good area of dentistry to get into?" Um, yes?

What is one dental-related thing you've learned since working at the ODA?

Everything I now know about dentistry is because of this job. I've learned the proper way to floss, what Periodontics is and how much a nice set of dentures cost (they're expensive!).



Contact Lauryn at
lcarter@okda.org

What is your favorite movie?

Supertroopers and Superbad. Both contain the word 'super' in them for a reason.

Favorite book?

Me Talk Pretty One Day by David Sedaris & Franny and Zoe by J.D. Salinger

Favorite sports team?

OU Sooners, NY Mets and NY Giants

Boomer Sooner or Orange Power?

I bleed crimson and cream

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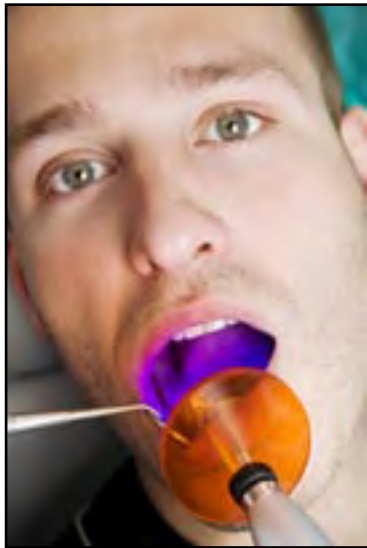
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Teeth Whitening by Non-Dentists: What you need to tell your patients!

- A thorough oral examination, performed by a licensed dentist, is essential to determine if bleaching is an appropriate course of treatment.
- Tooth sensitivity and gingival irritation may be side effects of bleaching and this is more likely to occur with higher bleach concentrations and more frequent bleach applications.
- Bleaching agents have the potential to cause injury to oral health by causing damage to tooth structure. It can penetrate into dentin with unknown effects on the dental pulp particularly for patients with cervical abrasion or leaking restorations.
- Bleaching agents have also been shown to affect bond strength, which can negatively affect dental restorations and orthodontic appliances.

BY: BRUCE HORN, DDS
President, Oklahoma Board of Dentistry

As many of you know, several kiosks have been appearing in malls across the state offering tooth whitening treatment. Complaints were received from dentists and dental hygienists concerned about these locations offering teeth whitening treatments to the public. It is now known that only one location still exists in a Tulsa mall that offers tooth whitening treatment. At the August 1, 2008, meeting, the Board voted to authorize the Assistant Attorney General to seek appropriate action against the individual offering teeth whitening procedures to the public in Tulsa.

Effective November 1, 2008, the **STATE DENTAL ACT [59O.S. Section 328.49]** was amended to change the illegal practice of dentistry from a misdemeanor to a felony. This new law will also increase the fine and imprisonment in the county jail. Each day a person is in violation of the law due to the illegal practice of dentistry, constitutes a separate criminal offense and, in addition, the district attorney may file a separate charge of medical battery for each person who is injured as a result of treatment performed in violation of this law. This amendment, and the amendment enacted several years ago to authorize the Board's investigator to be a certified peace officer, will strengthen the Board's ability to seek future action against the illegal practice of dentistry. As dentists, we should all be proud of these accomplishments.

The Oklahoma Board of Dentistry secured an "Agreed Order Permanently Enjoining Glamour White" from the unlawful practice of dentistry on August 21, 2008. Glamour White, respective agents, servants, and all persons acting by and under their authority or in concert with them are enjoined from:

- performing or engaging in the practice of dentistry
- providing teeth whitening products
- providing services or treatment at shopping malls or any other location in the State of Oklahoma

- providing any type of promotional material for teeth whitening
- employing any persons to provide teeth whitening products, services or treatment
- providing any professional instructions for teeth whitening or offering or undertaking, by any means or methods, to remove stains or discolorations from the teeth.

This Order is a victory for the public and the Oklahoma Board of Dentistry. We would like to thank Ms. Gretchen Harris, Esq., Assistant Attorney General, who works with the Board of Dentistry on these legal issues. Legal action is a collaborative effort taken by all concerned starting with complaints to District Courts. Everyone involved in the process has been concerned about protection of the health and safety of the public.

Over the last twelve months, five individuals have been identified as practicing dentistry illegally and action has been taken against each of them. A general mailing has been sent to alert all persons who attempt to practice dentistry illegally about the criminal action now authorized by statutes.

Some of you continue to submit complaints regarding an individual performing the illegal practice of dentistry on Indian land. Please understand that the State Board does not have jurisdiction on Indian land controlled by a tribal government.

Anyone may contact the office of the Oklahoma Board of Dentistry for more information. The new law appears on our web site at www.dentist.state.ok.us Just click on statutes, and review Section 49.

Doctor, would you like:

- A sound annual financial plan for your practice based on 'real' numbers?
- Your staff meetings and huddles to be more productive?
- Your staff members to learn great verbal skills?
- How to present treatment plans that get patients to say "Yes!"?
- A full appointment book?
- A rock-solid payment arrangement system?
- A recare system that really works?
- Leadership training, or one-on-one coaching for you or your staff?

If the answer to any of these questions is yes, please call me today. The solutions are easier than you think!

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UNIVERSAL health care

By Jeffery W. Johnston, DDS, MS
Editor in Chief, *Journal of the Michigan
Dental Association*

Early media reports of Hillary Care II sent the expected chills down where my spine used to be. No real surprises, just more of the usual proposals that are always associated with universal health. Hidden tax increases, redistribution of wealth, and expansion of entitlements to lure future voters were all included, except this time the plan was advertised as “better,” so I suppose we need not worry.

The 2007 ADA House of Delegates discussed and passed Resolution 58RCS-1 to promote organized dentistry’s concerns with the future of universal health care. There is little argument that our medical health care system is in trouble. Health care inflation is just over 10 percent annually. Insurance-driven (or limited) treatment is becoming the standard of care in medicine. Drug and device manufacturers are direct-marketing to patients. The Internet is a repository of both useful and nonsensical information to further confuse patients. All the while, the attorneys are waiting in the wings posing as the real “experts,” ready to second-guess the entire system. Sometimes it seems the person least involved in all the decision-making is the doctor.

What is the answer to the above problems? After many years of analysis, study, discussion and argument, I have no idea. However, as with all other problems in life, I am certain the federal government is the last place to look for an answer. Increases in bureaucracy, layers of oversight, governmental waste, inefficiencies, and control are not good answers. As evidenced by Medicaid and SCHIP, federal programs tend to lead to over-utilization, abuse, and increased costs for everyone.

What affect does this have on dentistry? Well, it seems that our message that oral health care

is primary health care finally has hit home with legislators.

Dentistry is in an enviable position. Aside from our recently publicized access-to-free-care problems, dentistry is health care that works. We have a record of supplying affordable, high-quality health care without the need for governmental oversight. In fact, governmental oversight is actually detrimental, as evidenced by the lack of widespread participation with Medicaid.

Of course we have problems, but organized dentistry is actively working to solve these problems with innovative programs on our own terms. Still, it is imperative that organized dentistry be present if any changes to the overall health system are discussed. Sticking our heads in the sand hoping to avoid being selected for action is not an option. It is better to act, rather than to react -- or worse yet, to get acted upon. We need to be involved in the education of our leaders and involved in the decisions that will affect our patients and our profession.

Governmental control would bring with it the compassion of the IRS with the efficiency of the post office, while providing the type of dentistry other nations suffering from national health insurance must tolerate. Yes, sticking our head in the sand always leaves our other end exposed.

I urge you to stay informed and stay active both in the organized dental world and in the political world. Educate your patients and legislators about the impact universal health will have on the quality and availability of care. Our message should be clear and unapologetic. If we lose our agenda, we will surely suffer theirs.

Reprinted, with permission, from the *Journal of the Michigan Dental Association*, January 2008 issue.

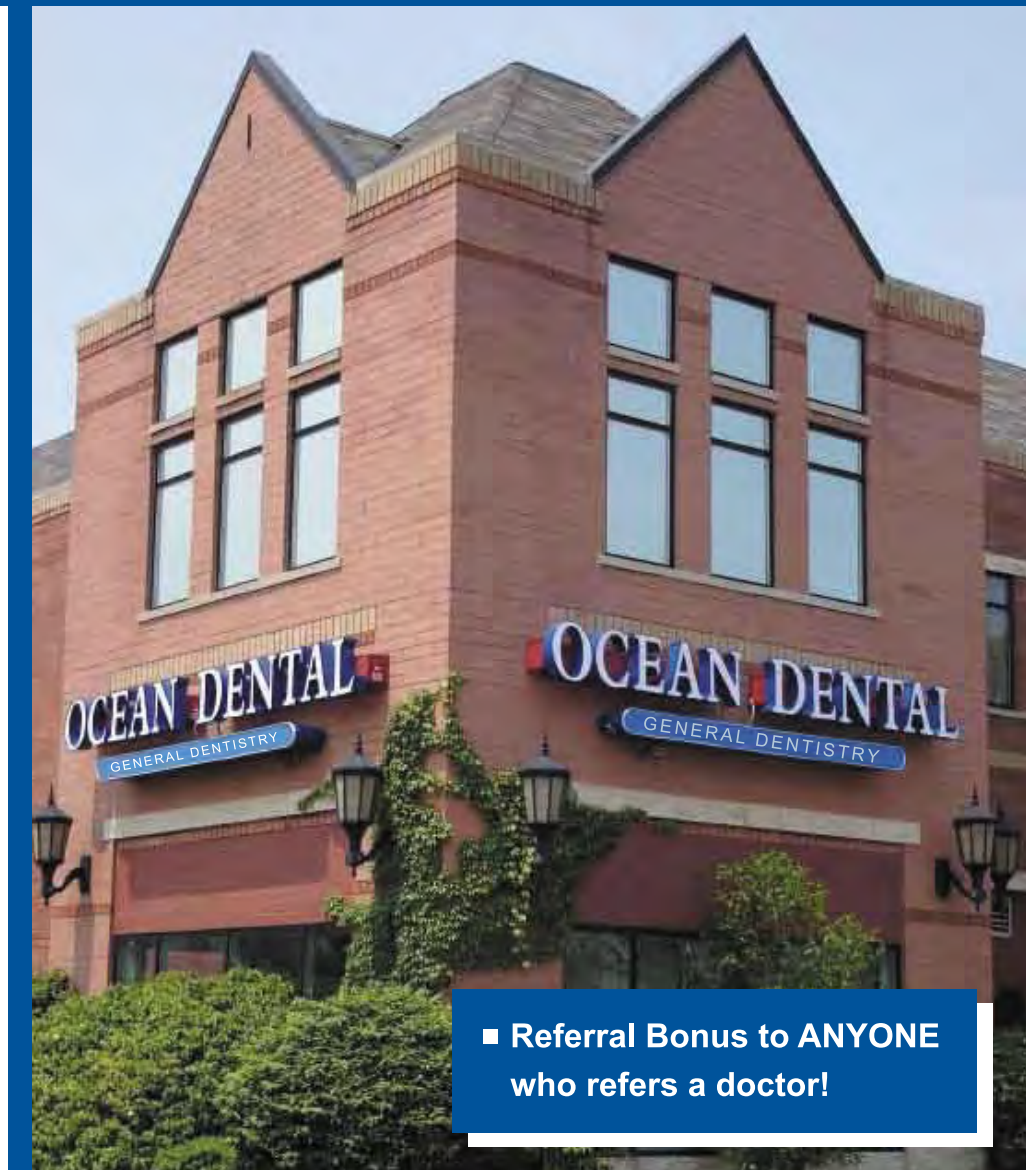


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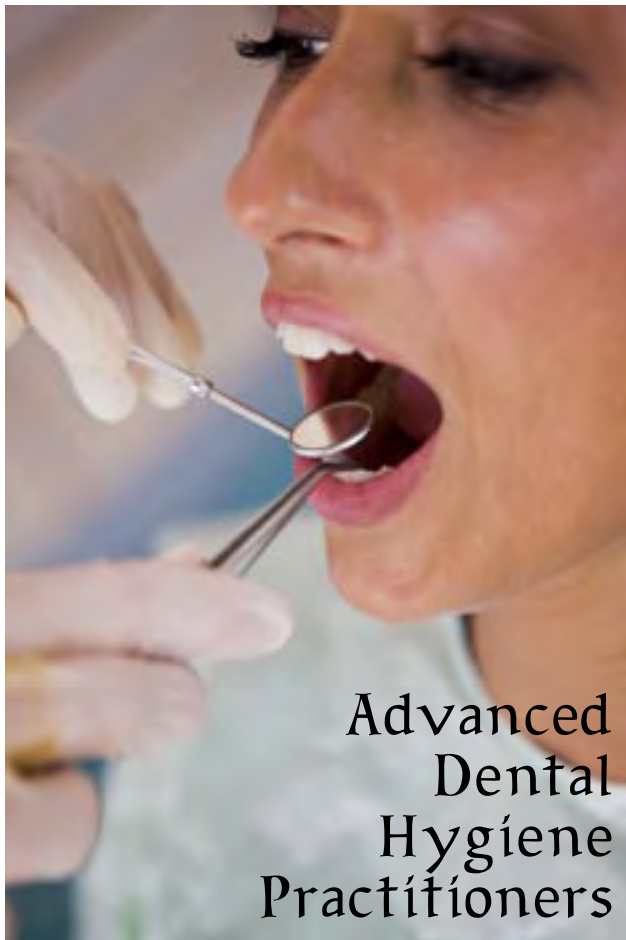
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Minnesota Oral Health Practitioner (OHP) Update

The broad stakeholder workgroup charged with creating recommendations for the scope, supervision and education requirements of the new position (OHP) has convened and developed an aggressive timeline under the auspices of the Minnesota Department of Health. The work group has established a series of nine meetings to review an array of topics and is tasked with submitting recommendations and legislation to the Minnesota legislature by mid-January.

The 13 member workgroup is comprised of a number of dentists (two appointed by the Minnesota Dental Association - MDA) as well as educators, a hygiene representative and a representative of the safety net coalition. The MDA is continually working to ensure the outcome and recommendations brought forth will actually work to deliver care to those in need.

The University of Minnesota Dental School has also announced it intends to begin a training program for a "mid-level" dental practitioner and has begun exploring models used across the world. The research has included fact-finding trips to Canada and New Zealand with a trip to the UK planned soon.

Both the U of M program and the OHP program anticipate beginning in the fall semester of 2009.

The OHP workgroup has posted a comprehensive website describing its charge, schedule and structure: <http://www.health.state.mn.us/healthreform/oralhealth/index.html>

We will keep you posted on developments as this breaking issue unfolds.

Legislative News from Other States

(reprinted with permission from the ADA State Legislative Update)

Advanced Dental Hygiene Practitioners (ADHPs). During 2007-2008 state legislative sessions, the American Dental Hygienists' Association-backed Advanced Dental Hygiene Practitioner (ADHP) has been proposed in Minnesota and Maine. The Minnesota bill was introduced in 2008 and gained significant traction within the legislature. As originally configured, the measures would have allowed the unsupervised practice of ADHPs with a broad scope of duties, including surgical extractions, restorations, orthodontic procedures and even prosthetic adjustments. Because of the unique political climate and culture in Minnesota, it was highly probable that some version of this legislation would be enacted in to law this year. Through the intensive efforts of the Minnesota Dental Association (MDA) and the ADA's SPA program, considerable resources were brought to bear on this issue. In addition to contracting a public relations agency for the MDA to enhance the profession's positioning and reputation, the SPA program also hired additional lobbying capacity for the MDA to work against the measure in St. Paul. The end result, while far from a perfect outcome, was considerably better than the initial prospects. A law was passed creating the new dental position of an "Oral Health Practitioner" that will

go into effect in 2011. What was not included in the legislation was the scope, supervision requirements or education requirements for this position. A workgroup, a majority of who are dentists, was created to develop recommendations on those issues for the legislature to act on in 2009. Along with other stakeholders, the MDA will have two positions on the workgroup. Also in 2008, a bill was introduced in New Hampshire calling for the creation of a commission to study the creation of an ADHP to increase access to oral health care, which was amended to a study of all types of allied dental professionals.

In 2007, legislation was introduced in Maine to create a mid-level dental position similar to the ADHP model. That proposal was placed into a study measure for 2008. This year, the Maine Commissioner of Professional and Financial Regulation charged with studying the issue recommended against the creation of a mid-level dental provider. However, the Commissioner did recommend the independent practice of dental hygienists. The legislation moved quickly through the legislative process in Maine and was enacted into law. While this is a disappointing outcome it is important to recall that other aspects that may have been included within the dental practice act sunset bill such as an ADHP or separate governing boards for "denturists" and dental hygienists were successfully kept out of the final bill. When implemented, dental hygienists will be able to place temporary restorations, take impressions for athletic mouth guards and custom fluoride trays, and apply topical medications without the supervision of a dentist.

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Figure 1. Poorly defined radiolucency in left mandible.

Tumor metastases to the oral cavity are rare, representing approximately 1% of all oral malignancies. They can occur in soft tissue or bone. Because they are uncommon they are often not included in the diagnostic differential; however, they often present with clinical signs and symptoms of common benign/reactive oral lesions and are often the first manifestation of an undiagnosed primary lesion or the first manifestation of metastatic spread from a known primary lesion. The mechanism by which tumors can metastasize is still poorly understood but recent evidence suggests it is a genetically controlled process and not a random act.¹ In the United States 40,000 of the 950,000 new cancers diagnosed each year are cancers of unknown primary.² The most common locations are cervical lymph nodes, auxiliary nodes, inguinal nodes, bone, lung, brain, and liver.³

CASE REPORTS

Case 1. Is a 51-year-old male with a two-month history of neurosensory change to the left mental nerve and a poorly circumscribed radiolucency around the left mental foramen (Fig. 1). Loose stromal tissue that was difficult to curettage was encountered at biopsy. The pathologic diagnosis was adenocarcinoma with clear cell component. The tissue was negative for mucin and positive for immunoperoxidase stains Vimentin and CD10, and focally positive for CK7 and CD20. These findings were suggestive of renal cell carcinoma as a primary site, but other primary sites could not be ruled out. On further work up the patient was found to have renal cell carcinoma.

Case 2. Is a 59-year-old male with a 2.0 cm raised lesion on the alveolus of the right posterior mandible with a “grape-like consistency”. The patient has a history of renal cell carcinoma and a recently diagnosed renal cell metastasis to the right femur. The pathologic diagnosis was malignant clear cell proliferation consistent with renal cell carcinoma. The tumor was positive for immunoperoxidase stains Vimentin, Pancytokeratin, and CD10 which support the established diagnosis of renal cell carcinoma.

DISCUSSION

The differential diagnosis should be developed depending on the presenting signs and symptoms. In Case 1 with bony metastasis a differential for a poorly defined radiolucency should be developed (Table 1). Metastatic lesions to bone in the oral cavity are more common than soft tissue by a ratio of 2.5:1.4 In bone lesions the gender ratio is almost equal; however, in females there is a peak in age from 31 to 40 while in men the peak incidence is age 71-80.5 This is most likely a reflection of the fact that primary breast carcinoma occurs at an earlier age in women, whereas prostate and lung cancers occur later in life in men.⁵ Eighty percent of metastases in jawbones are to the mandible,

with most in the posterior molar/premolar area. Approximately 17% will show osteoblastic activity or be mixed.⁴ Classically, prostate will be osteoblastic while breast and renal may be mixed.⁵ In approximately 5% of patients the radiographs do not reveal any pathology.⁴

Table 1. Poorly defined radiolucencies

Periapical granuloma or cyst
Focal osteoporotic bone marrow defect
Osteomyelitis
Simple bone cyst
Metastatic disease
Osteosarcoma or chondrosarcoma
Ewing's sarcoma

The most common chief complaint for metastatic lesions of bone is pain, swelling, and paresthesia. A second differential for paresthesia should also be considered (Table 2). The symptom of mental nerve neuropathy or numb chin syndrome should be given special attention.⁶ Numb chin syndrome indicates a loss of function of the terminal sensory division of the mandibular branch of the trigeminal nerve. Any pathological process involving the mental nerve, the mandibular nerve, and even the mandibular trunk of the fifth nerve may produce this loss of function. The appearance of a mental neuropathy should always raise the possibility of metastatic disease in the mandible.⁴

Table 2. Paresthesia

Trauma
Infection
Malignancy

Pain of unexplained origin should include metastasis in the differential. Other areas of concern are: unexplained tooth mobility, lack of resolution of swelling and pain with endodontic treatment, and nonhealing extraction sites. In many cases a metastatic lesion will cause pain, swelling, and mobility prior to extraction. In some cases metastasis develops after extraction, with extraction serving as a promoting factor for the metastatic process.⁴

In Case 2 with metastasis to oral soft tissue, most patients complain of a lump. The most common location is the gingiva followed by the tongue and rarely in other oral sites. In dentulous patients about 80% have metastasis in the attached gingiva. In edentulous patients metastatic lesions are distributed equally between the tongue and alveolar mucosa.⁴ Most gingival metastasis will manifest as a gingival mass resembling a pyogenic granuloma, peripheral giant cell granuloma, peripheral ossifying fibroma, fibroma, or fibrous epulis. In other oral soft tissues, especially the tongue, the lesions manifest as a submucosal mass.⁴

PATHOPHYSIOLOGY OF METASTASIS

Metastasis formation is an essential aspect of cancer, for which the molecular underpinning has long been subject to debate. Although the organ preference for dissemination is governed by tumor-host interactions on the epigenetic level there is a genetic basis to the ability of cancer cells to disseminate.⁷ The process is complex and not random, involving sequential steps. The tumor cells must detach from the primary tumor, spread in the tissue, invade blood vessels, and survive their travel through the circulation. The metastatic cells then settle in the microvasculature of the target organ, extravasate through the vessel wall, and proliferate within the recipient tissue. Different properties are required for the metastasis of a primary tumor to secondary sites than for the primary tumor's originicity. The most basic feature of the metastatic process is cell movement away from the primary tumor through the extracellular matrix.⁴

Cell motility involves remodeling of the cytoskeleton. During the process of epithelial-mesenchymal transition, cells progressively redistribute their apical and basolateral epithelial-specific proteins, and re-express mesenchymal molecules. These changes lead to the loss of cell-to-cell contacts and the gain of cell motility. The

motility of cancer cell is aided by extrinsic factors in the tumor microenvironment. Stromal cells have a role in modulating cancer cell motility by producing growth factors and proteases that support the survival and proliferation of carcinoma cells in a paracrine fashion.^{4,7}

Angiogenesis plays an important role in expanding the tumor mass, and increasing neovascularization is correlated with an increased rate of metastasis.⁷ Because small tumors of less than two mm in diameter already receive a vascular blood supply, it is likely that cancer cells have spread throughout the body years before they are first detected. However, only a small proportion of metastatic cancer cells survive in the circulation, probably due to intrinsic inhibiting of apoptosis.⁴

Evidence indicates that metastasis of various cancers to distant organs is not a random event, but a regulated site-specific process.⁸ Gene expression profiling studies indicate that distinct molecular pathways are involved in lymphatic and hematogenous dissemination of several cancers. The oral region is not a preferred site for metastatic colonization; cancers here are usually the result of secondary spread from other metastatic lesions especially those from the lungs.⁴ Approximately 30% of oral metastases are the first sign of the metastatic disease. Tumor cells bypass the filtration of the lungs, probably through Batson's plexus. Increased intrathoracic pressure directs the blood flow into this system from the caval and azygous venous system and accounts for the increased distribution of axial skeletal and head and neck metastasis.

The pathogenesis of the metastatic process in the jawbones is not clear. Skeletal bones with red marrow are the preferred site for metastatic deposition, especially cancers from breast, prostate, lungs, and kidneys. Jawbones have little active marrow, especially in elderly persons. Remnants of hematopoietic active marrow can be detected in the posterior mandibular area and extraction sites. These hematopoietically active sites may attract metastatic tumor cells.⁴

In the oral soft tissue, the rich capillary network of chronically inflamed gingiva can entrap malignant cells. The proliferating capillaries have a fragmented basement membrane through which tumor cells can more easily penetrate. The presence of teeth has a significant effect on site preference of metastases. In dentulous patients 80% have metastasis to the attached gingiva. In edentulous patients lesions are distributed equally between the tongue and alveolar mucosa.⁴

Table 3. Origin and site of metastatic tumors to the oral region in men.⁴

Soft tissue	Jawbones
Lung - 31%	Lung - 25%
Kidney - 14%	Kidney - 10%
Skin - 12%	Liver - 8.6%
Liver - 7.5%	Prostate - 7.5%
Colorectum - 5.2%	Bone - 7.5%
Bone - 5.2%	Adrenal gland - 5.3%
Testis - 4.5%	Colorectum - 4.7%
Esophagus - 4.5%	Testis - 4.4%
Stomach - 3.7%	Esophagus - 3.6%
Rare tumors - 12.4%	Stomach - 2.5%
	Bladder - 2.5%
	Rare tumors - 17.6%

Table 4. Origin and site of metastatic tumors to the oral region in women.⁴

Soft tissue	Jawbones
Breast - 24%	Breast - 36.6%
Genital organs* - 14%	Genital organs* - 9.5%
Kidney - 12%	Kidney - 8.5%
Lung - 9.4%	Colorectum - 7.1%
Bone - 9.4%	Bone - 6.7%
Skin - 6.8%	Adrenal gland - 5.8%
Colorectum - 6.8%	Thyroid - 5.4%
Rare tumors - 16.8%	Rare tumors - 20.4%
*Uterus, ovaries, cervix, and fallopian tubes.	

PRIMARY SITE DISTRIBUTION

In male patients the most common primary cancers that metastasize to the oral region are those of lungs, kidneys, prostate, bone, and skin (Table 3).⁴ About two-thirds of patients with bony metastasis have an unknown primary.⁵ Ninety percent of soft tissue metastasis have a known primary site at the time of presentation. In female patients, the most common primary cancers that metastasize to the oral region are those in the breast, female genital organs, colorectum, bone, and kidneys (Table 4).⁴

HISTOPATHOLOGIC EVALUATION

In some cases the appearance of the metastatic tumor will closely resemble the tumor at the primary site. More often the metastatic neoplasm will be less well differentiated than the primary and give little clue as to the primary site. Immunohistochemical reactions are usually necessary in such cases to establish a diagnosis.⁹ Because none of the individual immunohistochemical markers used for tissue identification are site-specific and site-sensitive, multiple markers are needed to improve the prediction of the primary site.¹⁰

CLINICAL EVALUTION

A complete history and physical examination should be performed, with special attention to the breast, rectal, and pelvic examination. A standard battery of laboratory tests to include a complete blood count, liver function tests, calcium, urinalysis, and serum creatinine should be ordered. A chest radiograph with supplemental CT in suspected areas is indicated. Gender-specific tests such as prostate-specific antigen and transurethral ultrasound for males, mammography and cervical pap smears for females are indicated. If these tests fail to find the primary tumor, CT scan of the abdomen and pelvis can be used to identify primary tumors in the pancreas, liver, adrenals, kidney, gall bladder, ovaries, and stomach. Positron electron transmission (PET) scanning with fluorodeoxyglucose (FDG) is rapidly gaining favor in the evaluation of unknown primary cancers, particularly in instances where other imaging modalities have failed to identify a source.³

PROGNOSIS

The average time between diagnosis of the primary tumor and the development of oral metastasis is about 40 months. In most cases the prognosis is grave with an average survival time of seven months. Where the oral tumor was the only metastatic lesion resection might improve the prognosis.⁴

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