VOLUME 100/ISSUE 7 OCTOBER 2009

ODA JOURNAL

The official publication of the Oklahoma Dental Association

CE Special Edition! Treating Special Needs Patients pg.16

Register to volunteer for the Oklahoma Mission of Mercy! More information on page 11.

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Message from the President
Dr. C. Rieger Wood

I am excited to report that things are rockin' at the ODA! At the last House of Delegates meeting we voted to do our first Mission of Mercy and there was also a resolution to address the rural dentist workforce issues. At the Dental Leadership Summit in July, we worked on both topics and I am excited to report the results.

First, let me bring everyone up to speed on the Oklahoma Mission of Mercy (OkMOM). The Web site, www.okmom.org, is now live and will be able to answer questions about the event. Volunteer registration opens on October 15th. **However, I suggest you make your hotel reservations now!** You can reserve a room through our Web site, make sure you put the code listed on the reservation form for our special rate. We have had a magnificent response from the Tulsa community in regards to corporate sponsors. The volunteer meals (which include breakfast, lunch and dinner) have all been secured, as well as the food for our patients.

The OSU and OU Medical Schools will be working in the triage area of the OkMOM. They also will be holding a mini health fair to conduct blood sugar screenings as well as other health screening tests at the event. This is the first time for the two schools to collaborate on an event in the Tulsa area. We are also going to be looking for OUCOD Alumni volunteers to help rally their classmates to come and treat patients. I need people from each class to contact other classmates and encourage them to attend. We will have the chairs arranged so that people will work alongside friends from their graduating class. We are also having a great response from the local churches. If you speak Spanish or have employees that speaks Spanish we need them! We will need between 50-60 Spanish-speaking people all day for both days. OUCOD students are also excited to work on the event and will be present. I understand that the Tulsa Community College Dental Hygiene School is going to cancel classes on Friday so their students can help. When it is all said and done we will have a combined volunteer need of 425 people all day each day! To say the least, things are firing up and we are moving fast. I hope you will develop the same enthusiasm as all the people working on the committee. The staff at the ODA is also working hard and they are very excited. Delta Dental Charitable Foundation in conjunction with their advertising agency is developing the patient advertising campaign, which will come out in January.

The 2009 Dental Leadership Summit was a huge success! Attendees represented all aspects of dentistry from education to general practice. When discussing education, an emphasis was placed on the decline of practicing dentists in our rural communities. As a group, we learned most dental students tend to have their location decisions (regarding practicing in a rural community vs. metropolitan area) made by the end of their third year! The group discussed developing a rural dentistry program that would target first, second and third-year dental students and their spouses. The program would help students meet rural dentists (and their spouses) to learn more about the lifestyle and advantages of living in a rural community. Also discussed was the idea of developing a program for students who have just completed their first or second year to be hired by rural dentists to work in their offices. Each rural dentist will help coordinate finding a place for the student to live while working in the community for a 4-6 week period. The job opportunity would not only afford the student an income, but also foster a relationship with rural dentistry and quite possibly develop a long-term relationship with the rural dentist. I have appointed Dr. Doug Auld to oversee the development of these concepts. It is our goal to have a pilot program in place for next summer! The officers of the ODA realize the importance of the rural dental practice and its complexities, so we want to help our rural members on the workforce issues. Look for more detailed findings from the Dental Leadership Summit in the November *Journal*.

I want you to know what an honor it is serving as your President. We are all working hard to make sure your ODA is making a difference in Oklahoma.

After all, our future is our destiny!

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MEMBER PUBLICATION
AMERICAN ASSOCIATION
OF DENTAL EDITORS

Calendar of Events

November 2009

3rd
– **TCDS Executive Committee Meeting**: Tiamo's Restaurant, 6:00 PM

6th
– **C.O.R.D. Meeting**: ODA, 11:00 AM
– **ODA Chili Cookoff**: ODA, 12:00 PM
– **ODA Board of Trustees Meeting**: ODA, 1:30 PM
– **TCDS All-Day Meeting**: Tulsa Renaissance Hotel

10th
– **TCDS Evening Meeting**: Tiamo's Restaurant, 5:30 PM

12th
– **OCDS General Assembly**

13th
– **OkMOM Planning Committee Meeting**: ODA, 9:00 AM
– **ODA Council on Dental Education & Public Information Meeting**: ODA, 1:00 PM
– **OCDS CE Meeting:** Castle Falls, Dr. Tom McGarry

16th
– **Retired Dentists Lunch**: ODA, 11:30 AM

26th
– **ODA Offices Closed**

27th
– **ODA Offices Closed**

December 2009

3rd
– **TCDS Holiday Party**: Meadowbrook, 6:00 PM

21st
– **Retired Dentists Lunch**: ODA, 11:30 AM

24th
– **ODA Offices Closed**

25th
– **ODA Offices Closed**

31st
– **ODA Offices Closed**

SPOTLIGHT

Featuring an ODA-endorsed company each issue

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ODA

presents the

New Dentist Seminar

Medical Emergencies in the Dental Office - What Situations Warrant the Status "Emergency"?

presented by Dr. J. Mel Hawkins

earn 6 hours of CE credit

Friday, October 23, 2009

8:30 AM - 4:30 PM

Lunch included

@

Oklahoma Dental Association

317 NE 13th Street

Oklahoma City, OK 73104

(405) 848-8873

(800) 876-8890

Register by October 15, 2009!

Registration:

ODA Member Dentist:	$89
Non-ODA Member Dentist:	$134
Student:	$12

To register, call / email Jerrell at the ODA: (800) 876-8890 / jwelch@okda.org.

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New Dentist Seminar

ODA PATIENT'S PAGE

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

Bulimia and Your Teeth

Given time, eating disorders like bulimia may lead to serious dental problems. Repeated vomiting can result in loss of tooth enamel, tooth decay, and gum disease. After frequent exposure to gastric acid, teeth become rounded and soft as enamel is eaten away, and fillings may stick out above the gum line. Loss of enamel and unconscious grinding of the teeth, usually during sleep, are the two most common causes of tooth loss.

The recurring vomiting of bulimia produces a distinctive erosion pattern that acts like a signature in a person's mouth. There is no other erosion pattern quite like it. Dentists can tell if the bulemia is a relatively new or chronic condition by the amount of damage done. There is no way to stop the hydrochloric acid from the stomach stripping the teeth of protective enamel and exposing the dentin underneath. The result is a long list of symptoms and conditions that can include:

- Cavities
- Enamel Erosion
- Gum soreness, pain, and inflammation
- Dry mouth
- Chronic sore throat
- Inflammation of the esophagus
- Hemorrhaging palates (caused by tiny blood vessels on the roof of the mouth bursting open during purging)
- Dramatically reduced saliva production
- Difficulty in swallowing
- Dislocations of the lower jaw and temporomandibular joint (where the lower jaw hinges with the rest or the skull)

The recurring vomiting of bulimia produces a distinctive erosion pattern that acts like a signature in a person's mouth.

To reduce the chances of enamel erosion and gum disease for those who have not yet been able to completely stop vomiting make sure to brush daily with fluoridated toothpaste after each meal, followed by flossing.

Some dentists recommend using a fluoride mouthwash or fluoride applications to help repair tooth damage. If tooth enamel has already eroded, another option is to have your teeth restored with resins or crowns because the inner portion of the tooth, also called the dentin, is especially vulnerable to acid erosion. Finally, if you are uncomfortable talking to the dentist about your concerns, it may be easier to speak privately with the dental hygienist first.

ODA Oklahoma Dental Association

OKLAHOMA DENTAL ASSOCIATION'S

LEGISLATIVE LOOP

October Legislative Update

A BIG THANK YOU to our DENPAC members!

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

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Ahrend, Melinda L
Allen, Harold E
Allison, Errol J
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Ariana, James M
Ariana, Jamie M
Ashmore, Glenn A
Ashmore, Glenn C
Augsburger, Robert A
Auld, Douglas
Barresi, Janet C
Battle, John B
Baumann, Robert E
Beasley, William L
Beaver, Brandon E
Beddoe, Ray A
Benson, Jerry K
Berg, Tamara
Black, Wesley N
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Bowman, Curtis J
Brackett, Ryan L
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Breece, Gary
Breland, Michael S
Brewer, Gary T
Bridges, George III
Bridges, George I
Bridges, C T
Brooks, Perry L
Brooks, Tim J
Brown, Nathan K
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Bryant, Roger L
Buchanan, Stephen
Burchard, William B
Burton, Bonnie L
Bussman, George C
Cannon, Patricia
Cara, Wuse H
Carbone, Keefe E
Carmen, Bobby J
Carper, Chasity A
Carruth, William L
Casey, Mary K
Casler Jr, Conrad C
Cha, Jerome Y
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Chang, Euna K
Chastain, Stephen A
Cheatham, Bobby D
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Clark, James L
Clayton, Mary N
Clement, Richard A
Cobb, Kristi E
Cobble, Jan L
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Cohlmia, Raymond A
Cohlmia, Ray Sr
Collins, Yvonne
Colombin, Jack B
Conkling, Leon A
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Corwin, James O
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Deem, Steven E
DeHart, Kathy L
Deprater, William
Dew, Robert M
Doan, Thai-An
Dorrough, Bryce
Dubberstein, Neill
Duffy, Kevin C
Duong, Nha T
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Gregg, Steve W
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Harman, Aaron S
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Heim, Vernon M
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Hendrick, Janet
Henry, Janice R
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Hetrick, Clinton
Hiatt, William G
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Hogg, Steven W
Holden, Lori C
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Hunter, Nicholas S
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James, Larry F
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Johnson, Donald T
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Jones, Mathew L
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Karami, Mohammad
Kasting, Dale
Keim, Matthew
Kendrick, Steven M
Keso, Larson R
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Klontz, Herbert A Jr
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Lamb, Robert M
Lander, Larry D
Lanman, Ashley N
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Layton, Kevin L
Ledbetter, Leslie
Lee, Jason M
Leemaster, Larry D
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Leseberg, Dennis A
Leverich, Ronnie G
Levinson, Marti L
Lim, Heng L
Litteken, Gene
Little, Brookes F
Littlefield, Cloyce W Jr
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Lockard, John T
Loper, Eric
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Lowe, James B
Lucas, Fred R Jr
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Lyle, R R Jr
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Maddox, David L
Marks, David O
Martin, Dana J
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Massaro, Mark E
Mauldin, Alan K
Mayer-Ward, Jandra
Mayer, Stephen
McAnear, Garrick O
McConnell, Kesa
McCormick, Eugene W
McDougall, Hugh
McIntire, Tracy E
McIntosh, Stanley P
McKamie, J A
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Mead, Glenn A
Meador, Joseph M
Melton, Robert H
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Montgomery, Ronald K
Moore, Kyle R
Moore, Timothy E
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Morgan, Michael L
Morrison, Jack T
Murtaugh, James N
Nelson, Jeffrey R
Nelson, Rodney
Norton, Fred E
NyQuist, Bill
Oister, Jana K
Owens, James F
Patel, Anand N
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Plant, Raymond
Pottorff, Adam L
Powell, Phillip
Powell, Steven E
Power, Philip J
Price, Dana B
Pruett, Geoffrey A
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Reeves, William G
Reid, Janet M
Reid, Chad M
Reiter, David
Reneau, J R
Revels, Stacy L
Richardson, Jimmy J
Rigdon, Terry F
Riggs, L D
Riggs, Celeste C
Riggs, Michael L
Ring, Philip N
Roane, James B
Roberts, Erin K
Robertson, J D
Rockwood, Douglas P
Rouse, Brant
Ruleford, Miranda
Schick, Robert D
Schoonmaker, Devin P
Schreiner, Terry J
Schuessler, Scott A
Segnar, Randall R
Sellers, Floyd T
Serfoss, Kyle
Sessom, Carrie D
Sessom, Wade
Shadid, Paul A
Shadid, Nanay L
Shadid, Scot R
Shanbour, Greg
Shannon, Kyle R
Sheets, John J
Sherwani, Palwasha N
Shivers, Rodney E
Simon, Floyd Jr
Sjulin, John L
Smart, Erin M
Smith, M K
Smith, Lindsay
Smith, Twana F
Smith, Curtis
Smith, Gary H
Sparks, Donna
Sparks, James A
Steffen, J M
Steyer, James G Jr
Storm, B D
Stover, Patrick P
Strand, James M
Sullivan, Jackson L
Susman, Marc L
Sutherland, Edwin E II
Switzer, Monica D
Taylor, Jim O
Taylor, John E
Templeton IV, Christopher
Thomas, Jonathon
Thomas, Dirk S
Thomas, Paul E
Thomas, John A
Thornbrough, Roy L
Todd, Dean O
Torchia, James S.
Trammell, Vic H
Tucker, Charles R
Utecht, Robert
Van Dyck, Larry
Vanbuskirk, Paula
Vandiver, Jonah R
Vaughn, Ronald D
Venk, Randall E
Villines, Nathan C
Wallis, Dennis L
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Warn, Brett
Waugh, W S
Webb, Robert P III
Weems, Mark W
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West, James L
White, Mori K
White, Steven V
White, Teri D
White, Robin E
Whiteneck, Susan
Wilcox, Christopher M
Wilguess, Daniel J
Willcox, V R
Williams, Thomas H
Winder, Ronald L
Wood, John C
Woods, Patrick A
Worthen, Tamara B
Wyatt, Kent H
Wyatt, Wayne N
Wynn, William B IV

SAVE THE DATE

Dentist Day at the Capitol

3.3.2010

More info to come.

bulletin board

Looking for fans...
Looking for followers...

Facebook: Oklahoma Dental Association
Twitter: OklaDentalAssoc

EMAIL! EMAIL!

In an effort to reduce operational costs, the ODA is making a concerted effort to communicate with the membership electronically. Because electronic communication is much more timely and cost-effective, please notify the ODA with your E-mail address.

November 6, 2009, at the ODA Building, 12:00 - 'til it's gone!

Five Alarm - White Bean - Vegetarian

You name it, we'll have it. For $20, enjoy a bottomless bowl of chili and fixin's.

All proceeds will benefit the Oklahoma Dental Foundation.

Board Members, come early for your meeting and chow down with us!

Gordon Christensen:

On Friday, January 29, 2010, Tulsa County Dental Society will host Dr. Gordon Christensen for an all-day CE course. Don't miss it! Contact Rhonda at 918-451-1017 for more information.

DIRECTLY FROM THE ADA: RED FLAGS RULE SUSPENDED UNTIL NOVEMBER 1, 2009

The Federal Trade Commission announced another Red Flags enforcement delay to November 1st "to assist small businesses" in understanding the regulation.

In a posted announcement at www.ftc.gov , the commission said it will create a special Web link with materials offering "guidance and direction" for "small and low-risk entities", including dentists and physicians, who have questioned FTC's application of the Red Flags identity theft rules to their practices.

The ADA helped introduce legislation to exempt health care practices with 20 or fewer employees from the regulation.

TRACKING POLITICAL CONTRIBUTIONS

By Dr. Krista Jones, DENPAC Board Member

Many ODA members join DENPAC, but also make personal contributions to candidates' campaigns over and above their DENPAC contributions. Tracking this information gives us the clout we need to ask dentistry-friendly legislators to support pro-dentistry legislation, or to vote against legislation that is potentially harmful to our practices, our profession, and our patients.

Most political contributions are from my personal checkbook instead of my corporation. A way of tracking that works for me is, at the end of the year when I am going through my personal checkbook for my charitable contributions for tax purposes, I have another column that I have created for political contributions. This includes the name of the candidate and the amount contributed to that particular campaign for the past twelve months. These, of course, are not tax-deductible contributions. I then send the list to the ODA and they keep a detailed record of those campaigns to which I've contributed. We all know legislators are much more inclined to listen to you if you live in their district; but chances are they actually recognize your name if you've given them a check!

This is just an easy way for our Association to know to whom our members are giving in legislative, congressional, mayoral, governor, city council, and presidential races. Our Association members are active in government and that is a great thing, but it is also a great thing to know how much and to whom we are making political contributions. Our strength is in our numbers, and our numbers are bigger and stronger when armed with accurate information!

Contact lmeans@okda.org for more information.




2009 Student Fall Festival

The 11th annual ODA Fall Festival Back-to-School Picnic for the OUCOD dental students was held August 25, 2009. Everyone enjoyed great barbecue and beverages, music, and a moon walk for the kiddos. Dr. Lindsay Smith, 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. It is also a great opportunity to introduce the students to organized dentistry.

Others in attendance included Dr. Rieger Wood, ODA President, Dr. Tamara Berg, ODA President-elect, Dr. Steve Young, Dean of the OUCOD, and Dr. John Taylor, member of the ODA Council on Membership and Membership Services. The ODA paid half of the 2009-2010 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, Layla Chafi, and our event sponsor, Stillwater National Bank. We hope to see you all next year!

a perfect opportunity to pay it forward...what an amazing event...it was an experience you will never forget...my life story changed because of this mission...a perfect opportunity to pay it forward...what an amazing event...it was an experience you will never forget...my life story changed because of MOM...a perfect opportunity to pay it forward...what an amazing event...it was an experience you will never forget...my life story changed because of MOM...

The Oklahoma Dental Association and the Delta Dental of Oklahoma Charitable Foundation are proud to launch the first annual Oklahoma Mission of Mercy (OkMOM), scheduled for February 4-7, 2010, at the Tulsa Convention Center. Treatment is scheduled for February 5-6.

Two days of absolutely free dental care to the first 1,000 children and adults each day. OkMOM will be a 90-chair, fully functional dental facility which will require over 1,000 volunteers to be successful.

WE NEED YOUR HELP!
MARK YOUR CALENDAR!

How do I sign up?
Go to www.okmom.org to sign up.

Volunteer registration now open!!

Do I have to be a dental professional to volunteer?
No!! We need volunteers for many different roles.

When would you need me?
We'll need volunteers February 4th, 5th, and 6th. Several shifts are available each day. Please visit www.okmom.org for available shifts.

Oklahoma Mission of Mercy
MOM
Sponsored by:
Oklahoma Dental Association and
Delta Dental of Oklahoma Charitable Foundation

Oklahoma Dental Association
2010 AWARDS NOMINATION FORM
DEADLINE FOR NOMINATIONS IS DECEMBER 31, 2009.

NOMINEE INFORMATION (please print clearly or type)

Name: _____

Current Address: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____ ODA Member Since: _____

Date of Birth: _____ Email: _____

Award Nomination for:
_____ Dentist of the Year
_____ Young Dentist of the Year
_____ Thomas Jefferson (Citizenship)
_____ Robert K. Wynne (Public Info)
_____ Dan E. Brannin (Professionalism)
_____ Richard T. Oliver (Legislative)

NOMINATED BY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Fax: _____

NATIONAL, STATE &/or LOCAL POSITIONS HELD

Organization/offices held: (please use additional pages as necessary) Year

_____ _____

_____ _____

_____ _____

_____ _____

List all dental-related work experience in chronological order with dates: (please use additional pages as necessary)

_____

_____

_____

Please attach letters of recommendation, references and other documentation as necessary.

Submitted by: _____ Signature: _____

DEADLINE FOR NOMINATIONS IS DECEMBER 31, 2009.

Please use a separate form for each award nomination. Photo copies of this original form will be accepted. A letter of nomination must accompany each nomination describing the nominee's accomplishments and other contributions.

Submit to: Oklahoma Dental Association, Attention: Member Awards, 317 NE 13th Street, Oklahoma City, OK 73104

Volunteer Participation Survey

Are you interested in serving on an ODA Council or Committee? Do you want to become active in the Board of Trustees or House of Delegates? Let us know!

Print Name: _____

Component (District) Dental Society: _____

Email Address: _____

Phone Number: _____

Select the area(s) in which you are interested in serving:

- ☐ Budget and Finance
- ☐ Bylaws and Rules
- ☐ Dental Care
- ☐ OHCA and DHS
- ☐ Dental Education and Public Information
- ☐ Governmental Affairs
- ☐ Membership and Membership Services
- ☐ Insurance
- ☐ New Dentist Committee
- ☐ Technology and Electronic Communications
- ☐ Annual Meeting Planning Committee
- ☐ Oklahoma Mission of Mercy (OkMOM) Planning Committee
- ☐ Endorsed Products and Services Committee
- ☐ Board of Trustees
- ☐ House of Delegates
- ☐ DENPAC Board of Trustees
- ☐ Component (District) Office

Please return this form to:
Oklahoma Dental Association
317 NE 13th Street
Oklahoma City, OK 73104
800-876-8890
405-848-8875 (fax)
sfrantz@okda.org

2010 ODA Annual Meeting

CE Preview:

Steven Perlman, DDS, MScD

Dr. Steven Perlman is an Associate Clinical Professor of Pediatric Dentistry at The Boston University Goldman School of Dental Medicine. For the past 32 years, he has devoted much of his private practice as well as his teaching, to the treatment of children and adults with physical and intellectual disabilities. Dr. Perlman is a past president of the Academy of Dentistry for Persons with Disabilities, and a Diplomate of the American Board of Special Care Dentistry. He is the recipient of the Harold Berk Award from the Academy of Dentistry for Persons with Disabilities and the Manny Album Award from the American Academy of Pediatric Dentistry. Both awards are the highest honors of those organizations recognizing lifetime achievement in the care of people with disabilities. In 1993, Dr. Perlman founded Special Olympics Special Smiles, an oral health initiative for the athletes of Special Olympics International. It now has over 150 special events each year, taking place in every state in the United States and in over 40 countries. Dr. Perlman is a cofounder of the American Academy of Developmental Medicine and Dentistry and has served as an advisor to the President's Committee for Persons with Intellectual Disabilities. In 2008, in Shanghai, China, Special Olympics honored Dr. Perlman with a special Lifetime Global Leadership Award in promoting human dignity.

Dental Care for People with Special Needs

Three (3) Hours of CE Available

Saturday, April 24, 2010
9:00 am – 12:00 am
Lecture format
Recommended for the entire dental team!

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Mega Numbers, Lobbying and Providing Care for Individuals with Autism

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Abstract

Lobbying is a competitive effort directed to reaching legislators who are attempting to balance the demands of individuals, organized groups, political parties, and the complex economic realities of our times. Unfortunately, the use of all-inclusive "mega numbers" (whether it is the millions of individuals with disabilities or the billions of dollars for needed services) is difficult for any person to place in proper perspective. As a result, the estimated 1.5 million children and adults with autism spectrum disorders and their families in the United States become just "numbers" – not actual people. The need is to somehow personalize these numbers if we are to bring increased attention to these individuals with special needs. Centers for Disease Control and Prevention and private research foundation data are used to illustrate an approach to better personalize the information for individual politicians and health practitioners.

> *"Our minds can't cope with the large distances that astronomy deals in… Our minds can't imagine a time span as long as a million years, let alone the thousands of millions of years that geologists routinely compute"* [1]

> *"Autism is a national health crisis, costing the U.S. at least $35 billion annually."* [2]

Unfortunately, the use of all inclusive "mega numbers" (whether it is billions of dollars for needed services, the annual carnage of tens of thousands killed in automobile accidents, or the thousands of children brought to emergency rooms as a result of playground accidents) is difficult for any person to place in proper perspective. We tend to generalize and smother such numbers, unable to comprehend the impact of these costs, and the particular conditions and events on individuals and their families. And so the fact that there are an estimated 1.5 million children and adults with autism spectrum disabilities becomes just "numbers" – not actual people. [2] The need is to somehow "personalize" these numbers if we are to bring increased attention to these individuals with special needs.

What is autism?

Autism is one of a group of disorders known as autism spectrum disorders (ASDs). ASDs are developmental disabilities that cause substantial impairments in social interaction and communication, and the presence of unusual behaviors and interests. Many people with ASDs also have atypical ways of learning, paying attention, and reacting to different sensations. The thinking and learning abilities of people with ASDs may vary – from gifted to severely challenged. An autism spectrum disorder begins before the age of three and lasts throughout a person's life. [3] (See Autism Fact Sheet issued by the National Institute of Neurological Disorder and Stroke for additional details on ASDs. [4])

ASDs include autistic disorder, pervasive developmental disorder – not otherwise specified, and Asperger syndrome. These conditions all have some of the same symptoms, but they differ in terms of when the symptoms start, how severe they are, and the exact nature of the symptoms. [3]

Who is affected? ASDs occur in all racial, ethnic, and socioeconomic groups and are four times more likely to occur in boys than girls. "CDC…released data in 2007 that found about 1 in 150 eight-year-old children in multiple areas of the United States had an ASD." [3]

Is autism a new disorder? "Autism may seem like a modern disorder, but it's not. People have probably lived with what we know today as autism spectrum disorders throughout history." [3]

What causes autism? "…we still don't know a lot about the causes of ASDs. Scientists think that both genes and the environment play a role, and there might be many causes that lead to ASDs." [3] Studies have shown that among identical twins, if one child has autism then the other will be affected about 75% of the time. Parents who have a child with an ASD have a 2% - 8% chance of having a second child who is also affected. [3]

Is there a link between autism and vaccines? "There is no conclusive scientific evidence that any vaccine or combination of vaccines (i.e. measles-mumps-rubella [MMR]) causes autism…There is also no proof that any material used to make or preserve the vaccine plays a role in causing autism" [5] "The doctor behind (the) controversial study linking children's vaccines to autism went before a (British) investigative panel probing misconduct allegations…" [6] Nevertheless, the controversy regarding the combined MMR inoculation continues. [7]

Annual economic costs. The economic costs are primarily the additional cost of education, medical expenses, and caring for children and adults with autism. This economic cost is a huge burden to parents and society. For example, the annual cost of education for a typical child is around $10,000, while the annual cost of education of a child with autism is estimated at $40,000. Typically a child with autism requires specialized medical treatment, which is an additional expense. Some parents report spending $65,000 per year. [8]

How is autism treated? "There is no cure for autism." [4] Therapies and behavioral interventions are designed to remedy specific symptoms and bring about improvement. These include:

> Educational behavioral interventions: Structured intensive skill-oriented training sessions to help children develop social and language skills. Family counseling for parents and siblings often helps families to cope with the particular challenges of living with an autistic child.

> Antidepressant medication to handle symptoms of anxiety, depression, or obsessive-compulsive disorders. Anti-psychotic medications are used to treat severe behavioral problems.

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Anticonvulsants are used for seizures, and stimulant drugs (such as those used for children with attention deficit disorder) have been used to help decrease impulse and hyper activities. [4]

Personalizing Mega Numbers

If "all politics is local," as Tip O'Neill, former Speaker of the House of Representatives, frequently intoned, then somehow the stream of "mega numbers" must be presented in such a manner that would be most understood – in particular by politicians (and health care providers). Rather than discussing incomprehensible numbers of individuals with autism and their needed services that range in tens of billions of dollars, the members of Congress and the health professions need to be lobbied with particular information about the constituents in their states and, if possible, in their respective communities. (President Ulysses S. Grant escaped the pressure of the presidency with a brandy and a cigar at the Willard Hotel in Washington, where many would-be power brokers approached him in the hotel lobby. Grant called these people "Lobbyists.")
To this end, data from StateMaster, a statistical database which compiles information from various primary sources such as the US Census Bureau, the FBI, and the National Center for Educational Statistics, were used to present available information at the state level, which should be more meaningful for politicians and health providers [9]

State Level

Numbers: The total number of children (3-22 years of age) with autism spectrum disorders (ASDs) in a state is, to a great extent, a reflection of the variation in state populations. As of 2003, there were almost 25,000 youngsters with ASDs in California, almost 12,000 in Texas, and approximately 9,500 in New York. In addition there were between 5,000 and more than 7,000 children with ASDs in nine states, plus between 1,000 and more than 4,000 children with ASDs in 21 states. (Table 1)

Per capita: The marked differences in the proportion of youngsters with ASDs in the different states can be particularly important when attempting to 1) "lobby" individual politicians regarding their constituents, and 2) reaching health professionals concerning the needs of residents in their communities. For example, the proportion of children with ASDs in Oregon and Minnesota is about 4-5 times greater than the proportions in West Virginia, Montana, Oklahoma, Mississippi, New Mexico, and Colorado (as well as the Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and American Samoa). (Table 2).

Growth in numbers: Whether because of 1) better diagnosis, 2) a broader definition of autism, 3) a marked enlargement in the population of a particular state (e.g. Nevada), and 4) an actual increase in the numbers of individuals with ASDs, nationally, between 1992 and 2003, there has been about a 2,560% increase in reported cases. These increases range from 23,300% in Ohio, 17,700% in Nevada, 16,200% in Wisconsin, 12,500% in Maryland, 11,600% in New Hampshire, to between 1,000% and 5,000% in 21 states and less than 500% in 8 states. (Table 3) One would anticipate (at least hope) that the knowledge of such increases of thousands of percent in the number of children (ages 6 to 22 years) with ASDs among a politician's constituents would ensure desired attention to the needs of these individuals.

New Accreditation Material

On July 30, 2004, the Commission on Dental Accreditation adopted new standards for dental and dental hygiene education programs to assure didactic and clinical opportunities to better prepare dental professionals for the care of persons with developmental disabilities, complex medical problems, significant physical limitations, and a vast array of other conditions which are considered under the rubric of "individuals with special needs." Implementation of this revised standard was required by January 1, 2006. Specifically, patients with special needs were defined as: "those patients whose medical, physical, psychological, or social situations that make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations." [11]

The recent modification in standards for dental education programs seeks to recognize and specifically prepare the next generations of practitioners who will be called upon to care for individuals (who live in our communities) and whose physical and intellectual limitations extend beyond the traditional definition of a "medically compromised patient." [12]

The Challenge

Lobbying is a competitive effort directed to reaching legislators who are attempting to balance the demands of individuals, organized groups, political parties, and the complex economic realities of our times. In such an environment, any effort that can personalize the needs of a large special group among the constituents of the home district and state of a member of the Congress enhances the potential for success.

Nevertheless, "mega numbers" do have their place and should be emphasized together with "personalized" information when making a presentation to legislative representatives and health practitioners. A statement of the sheer magnitude of a problem can have a desired effect. For example, in the early years of this decade, the approximately 13.5 million non-institutionalized individuals with cognitive disabilities included:

> Almost 2.3 million children 5-15 years, 7.5 million in the 16-64 age group, and 3.7 million in the older age population.
> 10 million white, 2.1 million black, and 1.4 million Hispanic men and women. [13,14]

It is not unimportant that there are more than 13 million individuals with cognitive disabilities. Nor should we fail to emphasize that there are about 1.5 million children and adults with autism spectrum disorders, and that in a little more than a decade, there has been a national cumulative growth of 2,560% in the number of children with ASDs. Rather, it is more meaningful to a member of the U.S. Senate, House of Representatives, and state legislatures, (even health practitioners) to describe the growth and magnitude in their jurisdictions and communities of individuals with special needs. For example, that there are 7,299 children with disabilities (primarily, intellectual disabilities) in the 2nd Congressional District in Georgia, 8,877 children with disabilities in the 5th Congressional District in Kentucky, 7,935 children with disabilities in the 28th Congressional District in Texas, 14,598 children with disabilities in the 16th Congressional District in New York, [14] and in your own district… well the numbers just speak for themselves.

Table 1. Number of children (ages 3-22) with autism by state: 2003 (10)

State	Number	State	Number
California	24,863	Kansas	1,130
Texas	11,940	Arkansas	1,114
New York	9,486	Maine	1,018
Michigan	7,259	Oklahoma	991
Pennsylvania	7,178	Colorado	978
Florida	7,151	Puerto Rico	894
Illinois	6,961	Hawaii	770
Minnesota	5,838	Mississippi	680
New Jersey	5,503	New Hampshire	667
Ohio	5,490	Rhode Island	655
Indiana	5,434	Nebraska	649
Massachusetts	5,087	Idaho	635
North Carolina	4,687	West Virginia	534
Oregon	4,389	New Mexico	413
Georgia	4,383	South Dakota	391
Maryland	4,084	Delaware	375
Virginia	3,951	Vermont	315
Wisconsin	3,669	Alaska	311
Washington	3,112	Montana	270
Missouri	2,863	North Dakota	240
Connecticut	2,357	Dist. of Columbia	215
Arizona	2,288	Wyoming	182
Tennessee	1,958	Guam	62
Louisiana	1,924	N. Mariana Islands	20
Kentucky	1,586	U. S. Virgin Is.	19
South Carolina	1,523	American Samoa	2
Alabama	1,479		
Iowa	1,331	**Total**	**163,647**
Utah	1,179		
Nevada	1,164		

Table 2. Number of children (ages 3-22) with autism per 10,000 population by state: 2003 (10)

State	Number	State	Number
Oregon	12.0	Delaware	4.4
Minnesota	11.3	Idaho	4.4
Indiana	8.6	Louisiana	4.2
Massachusetts	7.9	Kansas	4.1
Maine	7.7	Florida	4.0
Maryland	7.2	Arkansas	4.0
Michigan	7.1	Dist. of Columbia	3.9
California	6.8	Arizona	3.8
Connecticut	6.7	Kentucky	3.8
Wisconsin	6.6	North Dakota	3.7
New Jersey	6.3	Nebraska	3.6
Rhode Island	6.0	Guam	3.6
Hawaii	6.0	South Carolina	3.5
Pennsylvania	5.7	Wyoming	3.5
Illinois	5.4	Tennessee	3.2
North Carolina	5.3	Alabama	3.2
Texas	5.2	West Virginia	2.9
Virginia	5.2	Montana	2.8
New Hampshire	5.0	Oklahoma	2.7
Vermont	5.0	N. Mariana Islds	2.4
South Dakota	5.0	Mississippi	2.3
Washington	4.9	Puerto Rico	2.2
Missouri	4.9	New Mexico	2.1
New York	4.9	Colorado	2.0
Georgia	4.8	U.S. Virgin Islds	1.7
Nevada	4.8	American Samoa	.3
Ohio	4.7		
Utah	4.7	**Average 4.8**	
Alaska	4.6		
Iowa	4.4		

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Table 3. Cumulative growth of autism cases in children (ages 6 to 22 years) by state: 1992-2003. (10)

Percent increase	
Ohio	23,291%
Nevada	17,720
Wisconsin	16,195
Maryland	12,529
New Hampshire	11,600

Between 1,000% and 5,000% increase (In decreasing order)

(high)			(low)
Colorado	Arkansas	Minnesota	Illinois
Mississippi	Vermont	Nebraska	Montana
Kentucky	New Mexico	Idaho	Connecticut
Rhode Island	Alaska	Georgia	California
Oklahoma	Iowa	North Dakota	
Guam	Maine	Kansas	

Between 500% and 980% increase
(In decreasing order)

Wyoming	New Jersey	Utah	South Dakota
Arizona	Pennsylvania	Missouri	Texas
Alabama	South Carolina	Florida	Oregon
Hawaii	Dist. of Columbia	Massachusetts	Virgina
Indiana			

Between 40% and 472% increase
(In decreasing order)

Washington	Michigan	West Virginia	Amer. Samoa
N. Mariana Is.	North Carolina	Louisiana	Puerto Rico
Tennessee	New York	Delaware	U/S. Virgin Is.

National average = 2,560% increase

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Native American Health Conditions: The Setting for Children and Adults with Disabilities

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"Did you know at least 550,000 (American) Indians live with disabilities?" [1]

THE SETTING

According to the 2000 U.S. Census, nearly 2.5 million Americans identified themselves exclusively as "American Indian or Alaska Native." (AI/AN) There are 4.1 million people who identify themselves either as Indian only or Indian in combination with another race. Approximately 944,400 of these Native Americans live on federal reservations or on off-reservation trust lands. Of the 50 states, 35 have federal reservations within or over state borders. The Federal Government officially recognizes 569 tribes and Alaska Native villages. They are known as "Federally Recognized Tribes." Each tribe has it own culture, beliefs, and practices. AI/ANs have a unique relationship with the federal government due to a history of conflict and subsequent treaties. Tribes exist as sovereign entities, but federally recognized tribes are entitled to health and educational services provided by the federal government. Although the Indian Health Services (IHS) is charged with serving the health needs of these populations, more than half of the AI/AN population does not reside permanently on a reservation and therefore have limited or no access to IHS services.

Two types of services are provided by the IHS: 1) direct health care services, which are provided by an IHS facility, or 2) contract health services which are provided by a non-IHS facility or provider through contracts with IHS. These contract services are provided principally for members of federally recognized tribes that reside on or near the reservation established for the local tribe(s). A member of a recognized tribe may obtain care at any IHS hospital or clinic if the facility has the staff and capability of providing the care. Most people who move away from their home reservations are not eligible for care. Some programs are operated tribally and may restrict services to members of their own tribe. There are a few Indian health facilities located in cities throughout the United States.

In general, geographic isolation, economic factors, inadequate sewage disposal, cultural barriers, and suspicion associated with traditional spiritual beliefs are some of the reasons why health among AI/ANs is poorer than for other groups. [2]

HEALTH AND GENERAL FACTS

An extended series of reports have documented the seeming endless array of serious health and general conditions that face the AI/AN child and adult populations. For example:

> Approximately one-quarter of AI/AN children and 20% of adults has been diagnosed with asthma, compared to 14% of white children and adults.

> Injury and violence account for 75 percent of all deaths among AI/AN ages 1 to 19 years.

> Compared to female counterparts, AI/ANs adult males are 1) twice as likely to die from a motor vehicle crash, 2) four times more likely to drown, 3) four times more likely to commit suicide, 4) three times more likely to be murdered, and 5) twice as likely to die from fire and burn injuries.

> Among AI/ANs 19 years and younger, motor vehicle crashes were the leading causes of injury-related deaths, followed by suicide and homicide.

> Lung cancer is the leading cause of cancer death among AI/ANs, "… yet of the 217 native languages spoken today most, if not all, do not include a word for 'cancer.'" [3]

> AI/ANsinfants have Sudden Infant Death Syndrome rates three times higher than white infants.

> AI/ANs are more than twice as likely to have diabetes as non-Hispanic whites.

> AI/AN tuberculosis case rates are nearly six times greater than in non-Hispanic whites.

> Among AI/AN youths aged 12-17, the rates of past month cigarette use, binge drinking, and illicit drug use are higher than those of all other racial/ethnic groups. AI/AN youths are more likely to believe that all or most of the students in their school get drunk at least once a week. They are more likely to perceive moderate to no risk of illicit or under-age substance use; almost 60 percent smoke marijuana once or twice a week, and almost one half smoke one or more packs of cigarette per day. Forty-one percent of AI/AN adults smoke; more than any other ethnic group.

> AI/AN adults are more likely to be obese or never engage in leisure time physical activity.

> AI/ANs have higher rates of hearing loss.

> AI/AN adults are at least twice as likely as other adults to have experienced serious psychological distress in the past month.

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> At the time of admission to publicly funded substance abuse treatment facilities, AI/AN individuals are more likely to report alcohol as their primary substance of abuse than reported by all other racial/ethnic groups.
> The proportion of the AI/AN population with an AIDS diagnosis ranks third after blacks and Hispanics.
> AI/AN families have a poverty rate of approximately 22 percent.
> AI/ANs are at least twice as likely as non-Hispanic whites and Asians to have unmet medical care due to cost.
> AI/ANs are much more likely than non-Hispanic whites and Asians not to have seen a dentist within the past five years. [3-9]

NOW ADD DISABILITIES

A recent national survey found that more than 23 percent of the AI/AN population had one or more disabilities. **"This is the highest rate of disability when compared with all other races in the United States."** [1,9] More than 50,000 Native American children had a disability, including 39,000 with multiple disabilities. [10] The term "disability" is defined by The Americans with Disabilities Act as " (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individuals, (B) a record of such an impairment, or (C) being regarded as having such an impairment." [1] Every type of disability that is found in the general population also can be found in the AI/AN population, but often at greater rates of proportion. The types of disabilities most often reported in community surveys include spinal cord injury, diabetes complications, blindness, mobility disability, traumatic brain injury, and intellectual disabilities.

BARRIERS AND CHALLENGES

"There is a lack of understanding about the number of Indians with disabilities, the types of disabilities in Indian communities, and the various opportunities our tribal government and service programs have to better protect and assist people with disabilities in Indian country." [1]

Disability is an idea familiar to Western culture but with no direct parallel in Native American culture. The concept does not look at physical characteristics but views disability as disharmony of spirit. [11]

"The healing traditions of Native Americans have been practiced in North America since at least 12,000 years ago and possibly as early as 40,000 years ago." [12] It is based upon a spiritual view of life. A healthy person is someone who has a sense of purpose and follows the guidance of the Great Spirit. To be healthy, a person must be committed to a path of beauty, harmony, and balance. Gratitude, respect, and generosity also are considered to be essential for a healthy life.

Theories of disease causation and even the names of diseases vary from tribe to tribe. Disease may be thought to have internal or external causes or sometimes both. Negative thinking may be most important in the internal causes of disease. Germs also are spirits. A person is particularly susceptible to harmful germs if they live an imbalanced life, have a weak constitution, engage in negative thinking, or are under a lot of stress. Other people or spirits also may be responsible for illness.

There is no typical Native healing session. Methods of healing include prayer, chanting, music, burning of sage or aromatic woods, herbs, laying-on of hands, massage, counseling, imagery, fasting, dreaming, sweat lodges, taking hallucinogens, use of a medicine bundle (a bag made of leader or an animal pelt in which the healer carries an assortment of ritual objects, charms, herbs, and other healing paraphernalia), and/or going on a shamanic journey. Note: Native American medicine is not covered by insurance unless the practitioner is a licensed health care provider. Most Native healers do not charge a set fee for their services. Healing is considered to be "a gift of the Great Spirit." Gifts to the healer may include groceries, money, an expression of respect and appreciation, or a pouch of tobacco. [12]

The many aspects of Native American healing have been kept secret and are not written down. The traditions are passed down by word of mouth from elders, from spirits in visit quests, and through initiation. It is believed that sharing healing knowledge too readily or casually will weaken the spiritual power of the medicine.

There is an appreciation that "the diseases of civilization," or white man's diseases, often need white man's medicine. In those cases, Native American medicine can be an important component of an integrative approach to healing. For example, the most successful programs for treating alcohol addiction in Native communities have combined Western approaches to psychological counseling, social work, and traditional Native American healing practices.

In addition, there are particular legal and environmental factors which serve to impede efforts to meet the needs of youngsters and the older populations with disabilities. These include:

Unclear legal enforcement: Federal laws designed to protect people with disabilities are not always enforced always against tribal governments because of their sovereign immunity and status. Many tribes have opted to adopt their own ordinances and codes to protect their people with disabilities within the tribal system.

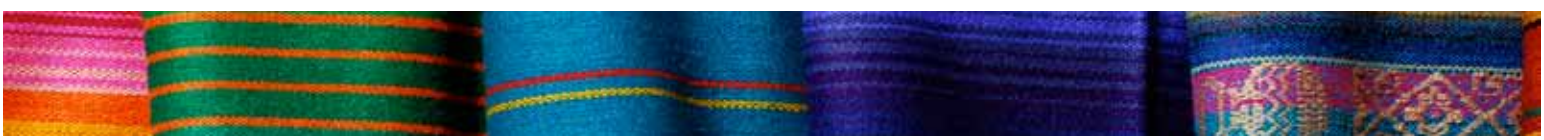
Rural transportation: Most tribal lands are located in rural and remote areas, and lack public transportation systems which could provide increased independence and access to added services for people with disabilities.

Rural infrastructure: Tribal communities may not have basic physical facilities such as sidewalks and sidewalk ramps for wheelchair access for individuals with disabilities.

Public access: Tribal buildings that serve the community are not always accessible for people with disabilities. Some of these tribes may lack the resources to retrofit buildings to accommodate people with disabilities.

Complex government programs: There are a variety of federal and state programs that can be important resources for individuals with disabilities who live on tribal lands. These programs may have overlapping or conflicting responsibilities and are difficult to navigate.

Education systems: The majority of AI/AN children are educated through the public school systems in each state. The balance of Indian children are educated in schools operated by local tribes or



federal schools run by the Bureau of Indian Affairs. Parents of Indian children with disabilities may not be aware of the services and support to which children are entitled and may not know how to advocate for the children effectively.

Employment: Federally recognized tribes specifically are exempt as employers under Title 1 of the Americans with Disability Act (ADA), which prohibits discrimination against qualified individuals with disabilities in employment and requires that employers make reasonable accommodations for employees with disabilities. This exemption is a barrier for AI/ANs with disabilities in Indian country, particularly in rural areas where tribal governments are the largest employers. Some tribal governments have complied voluntarily with ADA or adopted their own codes to protect people with disabilities from employment discrimination.

Housing: Homes generally are not designed to meet the needs of individuals with disabilities. There are limited funds at the tribal level to cover the cost of retrofitting tribal or private housing.

Service coordination and advocacy: IA/AN people with disabilities do not always have a central location where services are coordinated within the tribal settings.

Personal care assistance: Much more is needed in Indian communities to provide home and community based services. [1]

DIRECTIONS

Is there any answer to the seemingly complex dilemma of caring for youngsters and the not-so-young AI/AN with disabilities in general living settings and environments wrought with seemingly endless health and social problems? Maybe the answer lies in the process that we as authors followed. In preparation for this presentation, we dutifully researched the literature about the health of Native Americans, especially those with disabilities. The more we read, the more we recognized how little we knew. (It could well be that the financial success of those few tribes with successful casino operations have masked an appreciation of the intensive needs of the majority of other tribal members.) The needed direction may well be an increasing effort to tell the story of Native Americans with disabilities. Just as we learned, so too the necessary direction may well be to reach the general public and health practitioners with the situation and needs of this population.

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Health Care from a Family Perspective

By Sally Selvidge, Chair of the Children's Oral Health Coalition

Today's families struggle as never before if a family member needs full-time care. Gone are the days of having the extended family living in one neighborhood or generations under one roof. Families are faced with the mixed blessing of medical, pharmaceutical and assistive technologies that save and prolong lives, while the insurance industry continues to limit in-patient stays and units of service. Oklahoma like many other states in the last decade has undergone a period of rapid development of community based services to support de-institutionalization. However, trained care providers are still not widely accessible in rural areas; and for families whose income exceeds the poverty levels, the cost of substitute care may be a luxury ill-afforded when co-payments for therapies, expensive drugs and durable medical equipment are at stake.[1]

Families who are suddenly faced with caring for a new baby with special health care needs are thrust down a road they didn't choose or plan on. Their child is all of a sudden in need of a broad range of services, from primary and specialty care to prescription medications, medical equipment and therapies. As they grieve their dream they find themselves navigating a system that seems to be designed to confuse and intimidate all but the savvy. Families are on the phone to doctors and hospitals and fighting with insurance companies, while they wade through red tape and company phone menus to get answers to their many questions.

The impact of having a child with a special health care need can affect a family's finances, employment status, and mental health. There are an estimated 14.4 million employed caregivers who are balancing care giving and job responsibilities. 18% of the employed caregivers have had to quit their job to care for a family member and another 42% had to reduce their work hours. 20-40% of these caregivers have other children under the age of 18 to care for in addition to the child/family member with the disability. About one half of all primary caregivers have no outside assistance and 58 % of them showed symptoms of clinical depression.[2] Family Caregiver Alliance - www.caregiver.org

No one until they are faced with adversity knows how they will react. In the case of having a child with a special health care need professionals need to realize that families are trying to work full time, juggle day care that is not often available, waiting in emergency rooms for tests that could put their child's very survival at risk, sleeping 2-4 hours a night with one eye or ear open making sure they hear a breathing or

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heart monitor alarm, while caring for other children in the home and in some cases an elderly parent.

Coping with these challenges associated with their children's conditions can cause the caregiver's health to start to fail and the nucleus of the family to fall apart. The divorce rate for families who have a child with a disability is 80% and this stress puts them at a high risk for abuse and neglect. [3] Family Caregiver Alliance - www.caregiver.org

Families struggle each day just to survive in the tangled web of bureaucracy that is still enveloped in a "separate but equal model." The concept of having a system of coordinated, ongoing, comprehensive dental and medical care within a medical home in Oklahoma is slow in coming. Many Dental and Medical professionals still haven't perceived the benefits of working together to address the health of the "whole" child.

For the parents, the child with special needs is a deeply personal and more global experience; it is not something they can get away from at the end of the day. They may feel at a disadvantage as they find themselves in a situation where they must rely on the expertise and assistance of others. It is critically important to set a positive tone early on to help these parents feel valued, supported, and confident. They need to know that the professionals with whom they will be working not only care for them and their children but can be trusted to "be there" to assist them with the help they will need. [4] http:/mchb.hrsa.gov

One of the major complaints from medical and dental providers is the no show appointments from families who have a child with a special health care need. This frustration is felt on both sides, parents and professionals, and often not honored nor respected by either party. Both need to start learning to see the world through each others "eyes." One is trying to run a business, while the other is just trying to survive through the day.

1—Paragraph taken from Unsoliciated/unfundedCenter for Medicaid and Medicare Grant Proposal written by Sally Selvidge and RoseAnn Percival 2003.

ORAL PATHOLOGY
PROVIDED BY GLEN D. HOUSTON, DDS, MSD
CHAIR, DEPARTMENT OF ORAL AND
MAXILLOFACIAL PATHOLOGY
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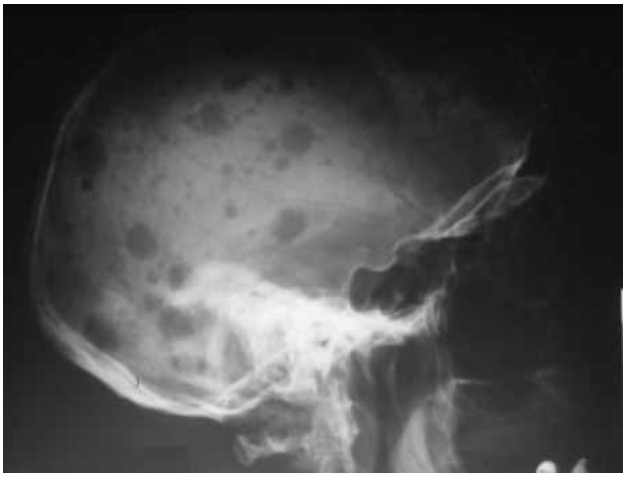

CASE HISTORY:
A 63-year-old male was initially examined by a neurologist with a complaint of "pain in my teeth, jaws, chin, head, and neck". The patient is referred to rule out an odontogenic origin of this condition. A thorough clinical history, oral examination, and complete radiographic survey (to include a skull series) are accomplished.

QUESTION 1: The radiographic appearance of this case is most accurately described as:

a. Multiple, "punched-out", radiolucent areas
b. An overall "cotton-wool" presentation
c. Multiple, ill-defined, radiopaque masses
d. A generalized "ground-glass" appearance
e. Multiple, "moth-eaten", ill-defined, radiolucencies

ANSWER: The radiographic appearance of this case is most accurately described as multiple, "punched-out," radiolucent areas (a). Because of these observed radiographic features, the other possibilities under consideration (b,c,d,e) are excluded in this radiographic assessment.

QUESTION 2: Your clinical and radiographic impression should include the following in your differential diagnosis (multiple answers):

a. Langerhans cell histiocytosis (eosinophilic granuloma)
b. Multiple myeloma
c. Hyperparathyroidism
d. Metastatic disease (carcinoma)
e. Paget's disease of bone

ANSWER: Your clinical and radiographic impression should include the following conditions in your differential diagnosis:

(a) Langerhans cell histiocytosis (eosinophilic granuloma)
(b) Multiple myeloma
(c) Hyperparathyroidism
(d) Metastatic disease (carcinoma)

Langerhans cell histiocytosis (a) is usually encountered in patients over a wide age range; however, the majority of the cases are seen in patients under the age of ten years. There is a male predilection and osseous lesions may be either solitary or multiple. Radiographically these areas often appear as sharply punched-out radiolucencies or other examples reveal ill-defined radiolucency. Extensive alveolar bone involvement causes the teeth to appear as if they are "floating in air." The skull, ribs, vertebrae, and mandible are among the most frequent osseous sites of involvement.

Multiple myeloma (b) is typically a disease of adult males and "bone pain" is the most characteristic presenting symptom. Radiographically, multiple, punched-out, well-defined or ill-defined radiolucent lesions may be observed. These may be especially evident on a skull film, although any bone may be affected.

Hyperparathyroidism (c) results in excess production of parathyroid hormone. A variety of osseous changes may occur with this disease and one of these is the appearance of well-demarcated unilocular or multilocular radiolucent areas. These lesions commonly affect the mandible, clavicle, ribs, and pelvis. They may be solitary or multiple.

Metastatic disease (d), particularly carcinoma, is one of the most common forms of cancer that involves osseous structures. Autopsy studies have demonstrated that breast, prostate, lung, colon, and kidney carcinomas typically will disseminate to one or more bones before a patient dies. Although metastatic lesions may be observed in any bone, the vertebrae, ribs, pelvis, and skull are the most frequent sites for metastasis. Most patients with metastatic disease are elderly and the radiographic appearance of these metastatic deposits usually appears as radiolucent defects. These areas may be well-circumscribed or exhibit an ill-defined, moth-eaten appearance.

Paget's disease of bone (e) would not be considered in the differential diagnosis because this process usually presents radiographically with patchy, sclerotic areas described as exhibiting a "cotton-wool" appearance. Additionally, the teeth often exhibit extensive areas of hypercementosis.

QUESTION 3: After discussing the differential diagnosis with the patient's attending physician, the serum parathormone and calcium levels were evaluated on the patient and were found to be within normal limits. A subsequent biopsy of one of the radiolucent areas in the mandible was performed, yielding the following microscopic features: sheets of closely packed cells resembling plasma cells, cellular nuclei exhibiting chromatin clumping in a "clock-face" pattern, and localized amyloid deposition. The correct diagnosis, based upon the radiographic and microscopic features, would be:

a. Multiple myeloma
b. Hyperparathyroidism
c. Eosinophilic granuloma
d. Metastatic disease (carcinoma)

ANSWER: The lesion is correctly diagnosed as multiple myeloma (a). See "Discussion" section.

The other possibilities are not considered here because: The osseous lesions of hyperparathyroidism (b) are characterized by a proliferation of vascular granulation tissue which contains numerous foci of multinucleated giant cells. Eosinophilic granuloma (Langerhans cell histiocytosis) (c) demonstrates a diffuse infiltrate of large, pale-staining mononuclear cells (Langerhans cells). Varying numbers of eosinophils may also be observed. Additionally, metastatic disease (carcinoma) (d) in most instances is well differentiated and closely resembles, histologically, a carcinoma of a specific organ or site (i.e., breast, kidney, lung, thyroid, prostate, colon).

DISCUSSION: Multiple myeloma was first reported in the literature by Schridde in 1905. It is a malignancy composed of plasma cells, the cells primarily responsible for the humoral antibody response. This disease is the most common malignant bone neoplasm and probably represents a multicentric malignancy, as multiple osseous foci of disease may be detected simultaneously involving a number of bones in the same patient.

Clinically, multiple myeloma occurs most frequently between the ages of 40 and 70 years, although it may occur in much younger patients. Men are affected more frequently than women. Patients usually present with pain as an early feature of the disease and, because of the destruction of bone, pathologic fracture is quite common. The disease demonstrates a predilection for bones with hematopoietic marrow, including the vertebrae, ribs, and jaws. The mandible is involved in about one-fourth of all reported cases. When the jaws are involved, pain and paresthesia are common complaints. The tumor cells may perforate the osseous cortex, causing a soft tissue swelling. Loosening of the teeth may also be observed.

Radiographically, multiple myeloma presents as multiple, "punched-out", radiolucent areas. This same pattern is also observed with hyperparathyroidism, metastatic carcinoma, and Langerhans cell histiocytosis.

Microscopically, monotonous sheets of malignant plasma cells are observed in various stages of differentiation. Amyloid deposition is also frequently present.

Multiple myeloma is a rapidly fatal disease. About one-half of the patients die within two years of the onset of symptoms. The 5-year survival rate is approximately 10%. The disease is usually treated by systemic administration of cytoxic drugs, as well as with systemic steroids and radiation therapy. Because the immune system is seriously impaired, the patient is very susceptible to infection; therefore, any surgical procedure that cannot be postponed should be accompanied by antibiotic therapy against both gram positive and negative microorganisms.

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