THE DENTAL TEAM:
IMPROVING ORAL HEALTH TOGETHER
pg. 16
In response to growing consumer demand, DDOK has developed DeltaPatient Direct™ - our new discount referral program that allows patients to access quality dental care and pay dentists directly - at the time of treatment.

Currently, there are an estimated 1.5 million Oklahomans without access to employee-sponsored dental benefits. Delta Dental of Oklahoma has developed DeltaPatient Direct™ to benefit these Oklahomans who might not otherwise be able to access quality dental treatment. Additionally, we want to help bring additional patients to our valued participating dentists.

Here’s how it works...

DeltaPatient Direct™ is not an insurance product. Individuals or families pay a low annual fee to DDOK. This fee provides access to a network of participating DeltaPatient Direct™ dentists, treatment financing options through Care Credit, vision care benefits from EyeMed, educational and treatment resources (including “Ask a Dentist”), and much more.

Dental services are offered at discounted rates that you, the provider, agree to. The patient visits your office and pays you at the time of treatment, according to the DeltaPatient Direct fee schedule.

It’s that easy!

- No claim forms!
- No administrative costs!
- No verification of maximums and deductibles!

If you are currently a DeltaPreferred Option (DPO) dentist, or if you wish to add additional patients to your practice with no additional paperwork – we invite you to consider DeltaPatient Direct™.

Access 1.5 million patients while incurring no administrative costs, no network enrollment fees and no verification of maximums or deductibles. DeltaPatient Direct™ from one of the most trusted names in dental benefits – Delta Dental of Oklahoma.

Be sure to visit www.PatientDirect.NET. Should you need an enrollment package, or if you have additional questions about our new DeltaPatient Direct™ network, please contact Kim Montgomery, with our Professional Relations Department at: 405-607-2142 (OKC metro) or 800-522-0188, ext. 142 (outside the OKC metro).
ON THE COVER: Dr. April Lai and her staff, Tulsa

ODA Today
Executive Director’s Message / pg. 4
Dental Organization News / pg. 4
ODA Student Fall Festival / pg. 5
Calendar of Events / pg. 6
$mart $tart / pg. 6
Online Radio Broadcast / pg. 10
Leadership Training Session / pg. 11
ODA New Members/ pg. 12
In Memoriam / pg. 12

Who & What
Profile: Dr. Darrell Daugherty / pg. 14

Features
Team Building / pg. 16
I Have Had Enough... / pg. 18
Update: Hurricane Katrina Relief / pg. 20

Clinical
Xerostomia: A clinical approach / pg. 22

Classifieds
General Listing / pg. 26
Limited Practice / pg. 28
There are many topics for this column as there is much going on at the ODA. The new building is a great asset to the ODA. To date we have raised $450,000 in pledges and cash to pay down the mortgage. “Thank you” to those of you who have stepped up to the plate. We currently owe $822,000 and have over 1,000 members who have not joined the Centennial Section. Remember our current annual payment in interest alone is $25,000. If every member purchased a brick for $1,000 the building would be ODA’s, free and clear.

The Strategic Planning Task Forces have met several times to develop specific mission statements and projects. The three Task Forces are: Access to Dental Care, chaired by Dr. Lisa Grimes; Technology, chaired by Dr. Raymond Cohlmia; and Volunteer Participation, chaired by Dr. Doug Auld. When these Task Forces have completed their charge the ODA will have a well-defined game plan to follow for the next three years. The Volunteer Participation Task Force developed an activity that we began implementing in September. If the ODA has your email address, you began receiving the ODA Update informing you about ongoing and new ODA projects. This e-newsletter will be sent two times per month.

The Oklahoma Dental Foundation is also conducting Strategic Planning activities and redefining its priorities and programs. It is addressing many of the same issues that the ODA is, such as Access to Care and Technology. Both organizations are working closely to pool their resources and prevent duplication of effort. We all look forward to the new ODF.

You all should have received the new Membership Directory. We hope the new binding, additional information, and new layout will better serve your needs.

We are all aware of the horrible destruction caused by Hurricane Katrina and the lasting impact it will have on the lives of Mississippi and Louisiana residents for years to come. I am proud to say that the ODA is doing its share in helping both the evacuees and the members of our dental family in those states. Through the ODA Relief Fund we have established a special fund to raise money for the Louisiana and Mississippi Dental Associations to use for both the needy and the dentists in their states. In September, the ODA sent $7,000 to each Association and the ODA purchased 7,000 toothbrushes and toothpaste to distribute to the evacuees. We began receiving telephone calls shortly after the hurricane for these items. Also, as I write this column we are assessing what needs to be done to provide dental care to the evacuees who are residing in Oklahoma. The ODA has many dentists who want to help but coordinating with the various camps, voluntary organizations, and governmental agencies is a slow process, certainly much slower than I anticipated.

Dr. Sid Nicholson, ODA President, has established a Committee to develop a disaster response plan for the ODA. We have learned through our experiences with Katrina that we need better ways to coordinate our efforts with the state and federal agencies responsible for the official disaster. Dr. Phil Abshere will chair the Committee. Dr. Abshere certainly has a wealth of knowledge in this area.

As always, the ODA wants to hear from you regarding your ideas, recommendations, and yes, even criticisms. We need your participation at all levels (councils, officers, component societies, task forces, etc.) and hope that you will volunteer your time and services. Take time to visit the ODA website (www.okda.org) and tell us what you want from us and what you are willing to do for us.

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Tulsa County Dental Society (TCDS)

By: Jeff Parker, DDS - Editor

Many thanks to the following who partnered with us and the Tulsa and Creek Counties Senior Nutrition Program for The Medication Management Health Promo/2005 for the seniors in our community at five site visits this summer: Bob Jones and Sarah Polley with POH Company who donated toothbrushes, floss, and toothpaste packets; Chera Hereford, RDH, who donated Biotene; Laura with the Neighbor for Neighbor Dental Clinic; Pam Beard and Margaret Lippert with Eastern Oklahoma Donated Dental Services; and Linda Bilby, CDA, with the Creek County Health Department.

Our second annual “Back to School on a Full Stomach” canned food drive to benefit the underprivileged in the Tulsa area is in full swing! Our TCDS Dental Care Standing Committee has worked very hard to make this year’s campaign as successful as last year’s! And our Activities Committee is fine-tuning plans on our second annual Dental Family Day Festival that will be held at the home of Dr. Kent and Jan Shacklett on November 6th.

Our Professional Development and Education Standing Committee is putting the finishing touches on our October 27th New Dentists Party that’s being held at the home of Dr. Todd and Kellye Johnson. Also this committee wants to encourage everyone to attend our excellent schedule of evening and all-day meetings that will be held at the Tulsa Renaissance Hotel:

- Tuesday, September 13th evening meeting will feature local radio host Michael Delgiorno
- Tuesday, October 18th evening meeting will feature Robert Dowd, JD, on “Improved Patient Care Through Malpractice Protection: Advanced Lawsuit Protection Strategies”

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contd. pg. 7
ODA HOSTS FALL FESTIVAL TO WELCOME DENTAL STUDENTS

For the seventh year in a row, the Oklahoma Dental Association hosted a Fall Festival for the Oklahoma College of Dentistry students and their families. The event took place at the ODA Building on Thursday, August 25. There were 228 dental students in attendance with an additional 60 family members and guests.

In addition to the students, several ODA representatives attended the function, including ODA President-Elect Pamela Low and her husband Dr. Karey Low, Dr. and Mrs. Lee Beasley, Dr. Jerry Miller, Dr. Raymond Cohlmia, Dr. Fred Lucas, Dr. Steve Young, Dr. Ken Coy, Dr. Larsson Keso, Dr. Tamara Berg, Mr. Kyle Shannon, Dr. Steve Powell, ODA Executive Director Dana Davis, and ODA staff Kay Mosley and Guillermo Gallegos.

The Student Fall Festival serves as a great opportunity for dental students to become familiar with the benefits and camaraderie available to them through organized dentistry and it also introduces the students to ODA members and leaders. The Council on Membership and Membership Services coordinated the event, which

contd. pg. 10

Students enjoy barbeque at the fall festival.

L-R: Drs. Raymond Cohlmia, Kenneth Coy, Jerry Miller and OUCOD Dean Stephen Young.

A dinosaur moonwalk beckons festival attendees.
**OCTOBER**

- OCT 6 – ADA Annual Meeting, Philadelphia, PA
- OCT 7 – ADA Annual Meeting, Philadelphia, PA
- OCT 8 – ADA Annual Meeting, Philadelphia, PA
- OCT 9 – ADA Annual Meeting, Philadelphia, PA
- OCT 10 – ADA Annual Meeting, Philadelphia, PA
- OCT 10 – ADA Success Program, OU College of Dentistry, 12:30 PM
- OCT 11 – ADA Annual Meeting, Philadelphia, PA
- OCT 12 – Oklahoma Children’s Oral Health Coalition, ODA Headquarters, 10:00 AM
- OCT 15 – South Central District Meeting featuring Dr. Robert White on “Bonding Systems, Overview of Composites, ClassII Posterior Direct Composite Restorations and Provisional Restorations”, Best Western Lawton Hotel and Convention Center, 8:00 AM
- OCT 17 – Retired Dentists Lunch, ODA Headquarters, 11:30 AM
- OCT 18 – Tulsa County Dental Society Dinner Meeting featuring Dr. Michael Dowd, JD, on “Improved Patient Care through Malpractice Protection: Advanced Lawsuit Protection Strategies”, Renaissance Hotel, Tulsa, 6:00 PM
- OCT 18 – Oklahoma County Dental Society Golf Tournament, Gaillardia Golf & Country Club
- OCT 25 – Oklahoma County Dental Society Board Meeting

**NOVEMBER**

- NOV 4 – Northwest District Meeting
- NOV 8 – Tulsa County Dental Society Dinner Meeting featuring Dr. Angelo Cuzalina on “Extreme Dental Makeovers”, Renaissance Hotel, Tulsa, 6:00 PM
- NOV 9 – Oklahoma Children’s Oral Health Coalition, ODA Headquarters, 10:00 AM
- NOV 17 – Oklahoma County Dental Society General Assembly, 8:00 AM
- NOV 18 – Tulsa County Dental Society All-Day CE: Dr. Charles Blair, Renaissance Hotel, Tulsa
- NOV 21 – Retired Dentists Lunch, ODA Headquarters, 11:30 AM
- NOV 24 – ODA Offices Closed
- NOV 25 – ODA Offices Closed

**GETTING OFF TO A SMART START**

Dr. Matt Krische, ADA 12th District New Dentist Committee Chair, and April Ellison-Cates, from the ADA, presented the Smart Start Program to the first-year dental students recently at the OU College of Dentistry. Dr. Tamara Berg, Chair of the Council on Membership, greeted the students and encouraged them to become active in organized dentistry. Ms. Kay Mosley, ODA Assistant Director of Membership, spoke with the students regarding the transition from dental student membership to active membership in their professional organization. The ADA offers a variety of free programs and seminars for dental students on-site at the dental school.

The $mart $tart program includes the basics of financial planning for dental students. The students learn about credit, compound interest, and the impact of student debt; develop realistic expectations for their income as new graduates; and discuss the financial resources available to them. First-year dental students can evaluate their own personal financial situation and hear real-life stories from new dentists who have made both good and bad financial decisions.
Tuesday, November 8th evening meeting will feature Dr. Angelo Cuzalina on “Extreme Dental Makeovers”.

Friday, November 18th all-day meeting will feature Dr. Charles Blair on “Positioning Your Practice For Profit”.

Thursday, December 8th Holiday Casino Party at the Renaissance Hotel.

Friday, January 13th all-day meeting will feature Dr. Michael Koczenski on “The Bread, Butter and Caviar of Contemporary Aesthetic Dentistry”.

Tuesday, January 24th evening meeting will feature Table Clinics & Election of Officers.

Friday, March 3rd all-day meeting will feature Dr. Gerard Chiche on “Recipes For Predictable Anterior Esthetics”.

Tuesday, March 14th evening meeting will be our Awards Banquet & Installation of Officers.

We want to say “Welcome” to our new TCDS members: Drs. Matthew Gray, Jason Hall, Lori Holden, Beena Lad, Casey Osterhout and Amy Stone.

University of Oklahoma College of Dentistry (OUCOD)

By: Frank J. Miranda, DDS, MEd, MBA
Senior Associate Dean

OUCOD HOSTS FIRST ANNUAL WHITE COAT CEREMONY

On Friday, August 19th, we conducted our very first White Coat Ceremony to formally introduce our new Class of 2009 to the dental profession. Long a staple of most medical schools and some dental schools, the White Coat Ceremony symbolizes the responsibilities and obligations that new students have to their profession during both their formal education in school and after graduation. Our keynote speaker Scott Waugh, District 12 Regent for the American College of Dentists and former president of the Oklahoma Dental Association, delivered a stirring and motivational address to the class and to their families and friends in attendance. Kenneth Coy, associate dean of students, then led the Class of 2009 in the recitation of the Dental Student Oath after which various faculty of the College of Dentistry formally cloaked each student with his/her white coat. The ceremony ended with some closing remarks by Dean Stephen Young.

We extend our thanks to all of the faculty who participated in this special occasion and especially to Ken Coy whose vision, hard work and dedication made this inaugural White Coat Ceremony a reality.

FACULTY NEWS

Patricia Nunn has retired from the University effective September 1st after ten years as chair of the Department of Dental Hygiene. “Retirement” pertains only to her position at OUCOD, however, since she has accepted a position as Academic Dean at the Utah College of Dental Hygiene, a new private school in Provo, Utah. We thank Trish for her decade of exemplary leadership here at the College and wish her great success in her new venture.

Replacing Nunn as new co-chairs of the dental hygiene department are Jane Bowers and Vicki Coury. Jane recently completed her PhD in Allied Health Sciences and has assumed directorship of the dental hygiene distance education program; Vicki has served previous stints as interim department chair and director of continuing education. Both are long-time faculty at OUCOD and are already hard at work revamping the administrative and academic missions of the department. Congratulations to our newest department chairs!

We have been somewhat remiss in announcing the arrival of new full-time faculty members to our dental family in recent years, so we’d like to extend warm OUCOD welcomes to Laurie Cunningham (Dental Hygiene), Jane Gray (Dental Hygiene), Van Henson (Oral & Maxillofacial Surgery), Johnny Siler (Fixed Prosthodontics), and Daniel Tylka (Removable Prosthodontics). In addition, Tammie Vargo, who had been teaching part-time, has joined the dental hygiene department full-time as of this fall. These new faculty members will be profiled in the Spring 2006 issue of OU Dentistry, our alumni magazine.

OU DENTISTRY

Speaking of OU Dentistry, we hope that all of you are receiving and enjoying our bimonthly alumni publication. Like the ODA Journal, the alumni magazine is sporting a new look and trying to include as many features about our alumni and affairs at the College as possible. All of our alumni, our J. Dean Robertson Society contributors, and other selected special friends of the College should be receiving OU Dentistry regularly. If you are not receiving the magazine, we probably do not have updated information about you in our database. Please let us know if you (or any others you know who should be on our mailing list) are not receiving it.

The next issue of OU Dentistry will be highlighting the 30th anniversary of the graduation of our very first dental class in 1976. If you were involved in the early days of the College and would like to contribute some reflections about the school and its history over the last three decades, we would love to hear from you. Please contact me at frankmiranda@ouhsc.edu with your comments and/or updated contact information.

STUDENT/ALUMNI NEWS

Congratulations to Beth Bohanon and her husband, Chad, on the arrival of their newborn daughter Sydney Marie who was born on August 17th. Beth is a 2005 graduate and is currently a resident in the school’s AEGD program.

Congratulations also to Bert Franklin (DS-4) who was awarded a scholarship from the Oklahoma Dental Group during a special luncheon at the Faculty House earlier this fall. This second annual scholarship award was presented to Bert by Sid Espinosa (ODG director of operations) and William Brewer (ODG president).

The Omicron Pi chapter of Omicron Kappa Upsilon (the national dental honor society) sponsored a special luncheon on September 7th to officially welcome our new freshman class (Class of 2009). After welcoming remarks from chapter president Susan Settle (Chair, Oral Diagnosis/Radiology), the class and OKU members in attendance enjoyed an informal lunch catered by Richey’s Restaurant.

THANK YOU, DELTA DENTAL!

Kevin Haney (co-chair, Pediatric Dentistry), state clinical director of the Special Olympics/Special Smiles program in Oklahoma, reports that the Delta Dental Plan of Oklahoma (DDPO) Foundation has approved a request for a grant of $3,200 to be used to support Special Smiles, an oral health initiative that provides education and screenings to the participating athletes of Oklahoma Special Olympics. Delta Dental assisted with the Special Smiles 2005 program last spring in Stillwater and has been one of the school’s most consistent and generous supporters of our activities and programs (including student scholarships) for many years. Thank you!!

STUDENT FALL FESTIVAL

On August 25th, the Oklahoma Dental Association and ODASCO, Inc. co-sponsored a special Friday evening event that featured a delicious dinner at Richey’s Restaurant.

- A toast to the Class of 2009
- A Request for Grant
- An announcement of upcoming events

ODG’s annual meeting on September 7th featured several special events:

- A pledge to the OMICRON PI chapter of OMEGA KAPPA UPI
- A presentation of awards to deserving members
- A special address by Dr. Kenneth Coy

OUCOD students sign up at the ODA Fall Festival

contd. from pg. 4

contd. on pg. 8
sored its 7th annual Student Fall Festival for OUCOD’s dental students. This event has been held each fall for many years and has proven to be an excellent way to introduce our students to organized dentistry and to encourage their participation in the affairs of the profession both during school and after graduation. Attendance was phenomenal, with 285 (including 228 students) enjoying a catered meal, door prizes, brief presentations by the ODA leadership, and of course good fellowship. Once again, the College of Dentistry extends its sincere appreciation to both the ODA and ODASCO for their continued work in welcoming our students to Oklahoma’s dental “family”, and thanks all of the dignitaries in attendance for taking time from their busy schedules to make our students aware of what a great profession they are entering. The annual Fall Function is just one of the many ways that the continuing positive relationship between the College and organized dentistry in Oklahoma is promoted. Since the particulars of the festival are reported in more detail elsewhere in this issue, we at the College just want to say THANK YOU!

IN MEMORIAM

It is with deep sadness that we report the passing of Karen Lynn Robinette Mallory on August 28th after a lengthy battle with cancer. A graduate of the OUCOD Class of 1986, Karen had operated a successful general dental practice in Del City for many years before she was forced to discontinue practice due to her illness. She is survived by her husband Jim, son Christopher, daughter Jennifer, and her parents Kenneth and Yvonne Blincoe. A native of Union, Tenn., Karen came to OUCOD from the University of Louisville and is remembered by her classmates and faculty as a diligent and hard-working student who always placed the welfare of her patients above all other pursuits – an attribute that was the major reason for her success in practice. We at the College extend our sincere condolences to her family and friends and wish to assure them that although she has been taken in body, she will always be with her OUCOD “family” in spirit. Karen’s family has requested that any donations in her memory be made to the Susan G. Komen Breast Cancer Foundation or to the charity of the donor’s choice. Rest in peace.

Eastern District Dental Society
Dr. Tyson Christy, President

The Eastern District rejuvenated their long lost Summer meeting on July 28-30 at Snake Creek Wilderness around Lake Tenkiller. The weekend consisted of great C.E., eating, boating, fun and fishing for the kids. A special thanks to Dr. Bernie Wynn and Dr. Jeff Cohlmia for providing us with excellent continuing education material.

The Eastern District members also elected new officers and voted to move the spring meeting from Hot Springs, Arkansas to Branson, Missouri. Details of this change will follow in a letter to members. I would like to personally encourage more participation by the Eastern District members, so that this event will be one that everyone can look forward to enjoying.
Be a part of the headquarters for organized dentistry in Oklahoma by making a pledge to the ODA Centennial Membership Section.

Your contribution to the new ODA Headquarters is tax deductible as a business expense. Paying for the new ODA Headquarters now instead of later helps build the financial strength of the ODA by eliminating an annual interest payment of $25,000, decreasing the annual operating budget by $65,000, and creating a one million dollar asset for the Association.

The financial support your pledge provides will be recognized in the new ODA Headquarters.

Contact the ODA today to make your contribution to the new building 405-848-8873 / 800-876-8890
featured door prize drawings and a moonwalk for children. In addition to providing the food, drink and entertainment during the Festival, the Oklahoma Dental Association pays one half of the ASDA dues for every student that attends the function. OUCOD has a very strong and active ASDA Chapter with almost 100% membership.

A special thank you to our event sponsors, Dr. Steve Powell of Norman Endodontics and ODASCO, Inc.

contd. from pg. 5

Dentist Unveils Online Radio Broadcast

When Dr. David Dodell, a general dentist with a private practice in Scottsdale, Arizona, introduced “DentalCast,” his weekly online talk show available via new and innovative technology known as “podcasting,” he expected a few friends to log on, and they did. What he didn’t anticipate was its instant popularity. In just six weeks, Dr. Dodell’s listeners exceeded 300 and the audience is growing.

Dentists may listen to DentalCast via personal computer, or synchronize with an iPod or MP3 player. The weekly program covers the most current dental technology and clinical techniques, from procedures to equipment. “When I first began developing DentalCast,” Dr. Dodell noted, “I called on dentist friends to do the show with me. Now, I’m getting the calls from dentists who want to be on the show.”

Dr. Dodell, a member of the American Dental Association’s Council on Communications and Treasurer of the Central Arizona Dental Society, is the founder of the Internet Dental Forum, the oldest online discussion group for dentists. He lectures nationwide on integrating the Internet into the dental practice and is a highly sought consultant to the dental community on matters relating to technology.

For more information, log onto www.dentalcast.net

L-R: Sherry Beasley, Dana Davis, Dr. Lee Beasley and OUCOD Dean Stephen Young.

OUCOD Students fellowship and dine at the ODA Fall Festival

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The Leadership Training and Development Session, facilitated by Dr. Krista Jones, was Friday, August 5, 2005 from 9:00 a.m. to 1:00 p.m. at the ODA office. The Session was attended by officers of the ODA, officers of component dental societies, and council members and chairs.

Attendees received tips on running a meeting, following agendas, making motions, and understanding bylaws and duties. Dana Davis, Executive Director, kicked off the session with an overview of the organization of the Association and working with ODA staff.

Special guest speaker Mildred Keso, Registered Parliamentarian, reviewed the eight steps to completing a motion, how to expedite a meeting efficiently, and responsibilities of the presiding officer. Dr. Larson Keso, discussed the importance of bylaws and what they mean to the members. Dr. Vann Greer reviewed the ODA council manual structure and duties.

Participants wrapped up the session in small groups by discussing roles and objectives specific to each position. The written evaluations were overwhelmingly positive.
Dr. Dean E. Harrington
Death: August 15, 2005
Broken Arrow, Okla.

Dr. Dean E. Harrington passed away on August 15, 2005. Survived by wife Franca, two stepdaughters Donna Potts and Tracy DiLoreto and three grandchildren. Donations can be made in memory of Dr. Harrington to: OUCOD, Development Office, 2901 N. Stonewall, Oklahoma City, OK 73104

Dr. Robert L. Wood
Birth: March, 1931
Death: August, 2005
Elk City, Okla.

Dr. Wood graduated from Georgia Military Academy and served his country during the Korean Conflict in Korea and Japan. He later went on to receive his Doctorate of Dental Surgery from the University of Tennessee. Dr. Wood practiced in Elk City until his retirement in 2002. He also served as an instructor at the University of Oklahoma College of Dentistry for a number of years.

Dr. Robert Hamilton
Birth: February, 1923
Death: August 19, 2005
Oklahoma City, Okla.

Dr. Hamilton served as a medic in WWII, including the Battle of the Bulge. He practiced in Henryetta after graduating from the Baylor University School of Dentistry. Dr. Hamilton then moved to Oklahoma City where he practiced until retirement in 1989.
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PROFILE: DARRELL DAUGHERTY, DDS

Do you remember your student mailbox in dental school? Darrell Daugherty does. Sorting through all of the flotsam and jetsam that would accumulate in that cramped space, he came across a flyer recruiting dental students to become a Big Brother/BIG SISTER through the local Oklahoma City program. Extra time to devote to volunteer activities are limited at best while in school, but he saw an opportunity to make a real difference in someone’s life, and made the call. As fate would have it, he was matched up with an eleven-year-old middle school student who turned out to be the son of Darrell’s first patient at OUCOD. The relationship continued even after Darrell finished up at OU and moved to Nebraska for a two-year endodontic residency. His “Little Brother” is now a student at OSU and, along with two younger brothers, are all in the pre-dental program. No biological parent could be prouder, and his involvement shows that one person truly can make that all-important difference.

Darrell was born in 1972 in Marietta, Okla. to Jack and Joyce Daugherty. A move to Muskogee saw him through the local school system and graduating from Muskogee High School in 1990. Stillwater beckoned, and he spent almost 4 years in the mechanical engineering department at OSU before switching to pre-dental, a move that resulted in his graduation from OUCOD in 1998. Acceptance in the endodontic residency program at the University of Nebraska College of Dentistry finally produced a board-certified endodontist in 2000 and a rapid move back to Stillwater, where he started Stillwater Endodontics. Practice growth has been rewarding, and a new office is currently under construction with a move-in date of November, 2005. Darrell and his wife Jill are the proud and busy parents of three daughters: Julia, 6, Camille, 3 and Kelly, 1. He is on the board of directors of the Big Brother/Big Sister program in Stillwater. In addition, he manages to find time to pursue his passion for all things outdoors, especially hunting and fishing. The opening of bow season the first week of each October has been designated an official holiday for some time.

In addition, he manages to find time to pursue his passion for all things outdoors, especially hunting and fishing. The opening of bow season the first week of each October has been designated an official holiday for some time. 

DAUGHERTY with his United Way Little Brother, Jimmey, after Jimmey shot his first deer.

DAUGHERTY with wife, Jill and daughters Julia, Camille and Kelly

ODA - Who or what was most influential in your decision to become a dentist and why?

DD - My high school history teacher, Larry Herd, told me about his friend who became a dentist so that he would always have plenty of time to hunt and fish, so I naturally became interested. The business aspect is also very similar to my father’s auto repair shop. He taught me to always be honest and do work that you’re proud of when you think about it right before you fall asleep at night.

ODA - During your dental education, what professor made the biggest contribution in forming your abilities to practice dentistry?

DD - I didn’t realize how great our Endo faculty at OU was until I visited other dental schools and spoke with other graduates. I was very lucky to have practicing endodontists as professors. Drs. Jim Roane, John Biggs and Fred Benenati were all instrumental in my applying for endodontic residency.

ODA - What do you like the most about dentistry? The least?

DD - I like the flexible schedule the most. I can take time off whenever I need to attend kindergarten graduations or Christmas parties. Practicing dentistry is so much better than fixing cars in the hot sun or trying to meet an engineering project deadline. I can’t think of anything to complain about.

ODA - What is the biggest change in how dentistry is practiced that has occurred since you began?

DD - I’ve only been in practice for five years, so not much has changed. There have been several technological advances in the practice of endodontics that have made some big changes. The use of the microscope is huge. Before, it was assumed that only a small percentage of maxillary first molars had four canals. Now we know that ninety percent have four canals, and we can see them with the scope. Rotary instrumentation has sped up treatment. I use the Tulsa Profile System, but all of them are about the same. You need to develop a feel for them. The use of MTA for rapid apexification in young teeth makes a big difference in successful treatment for kids.

ODA - What advice would you give to a newly graduated dentist?

DD - Even though starting a career is very stressful, try to enjoy the journey. The best advice I ever got was to take time now and then to turn over your shoulder and call an old friend. Then think about what you would have done differently with your time now. I usually conclude that I need to maximize time with the family.

Bow season is about to start, so expect some delays in appointment scheduling at Stillwater Endodontics in early fall. That’s Darrell and his little brother over there on the deer stand in that grove of blackjack oaks just outside of town.●
Linda Miles
Hal Crosley
Howard Farran
Harald Heymann

ADA Oral Cancer Seminar
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Modern dental practices are operated by teams of individuals working together to provide the best care and customer service to a practice’s patients, and every dentist knows that quality dental team members increase the efficiency and effectiveness of the treatment provided in a dental office. Each member of the dental team has distinct roles and makes important contributions to the entire dental practice.

Typical dental team members include office staff members who are often the first faces a patient sees when arriving at the dental office, and, as such, the team members placed in the front of an office serve the function of setting the tone for the visit. That is, a warm, friendly greeting can often set a patient’s mind at ease by helping to assure the patient that the appointment will be a positive one. Office staff are also often responsible for the bulk of the processing that occurs in an office: submitting insurance claims, reminding patients about appointments, creating the schedule for the day, ordering supplies, making sure the office is in order, etc. When these tasks are done well, dentists are able to focus most of their energy on treating patients. When these tasks are not done well, a practice can come grinding to a halt.

In addition to office staff, the dental auxiliary staff contributes to the effectiveness of a practice in a myriad of ways. Skilled dental assistants facilitate efficient treatment through the support they provide dentists during treatment, and they also help calm and assure patients that may be anxious about various procedures.

Excellent dental hygienists are also a tremendous asset to a dental practice. The hygiene members of a dental team can give a dental practice a warm, personal feeling. Dental hygienists are also excellent avenues for providing oral health education, demonstrations, and suggestions for patients.

It is good to take the time to remember how much a practice contributes to the overall practice, so that these contributions are not taken for granted. When patients visit your office, they don’t just see a dentist, they see all of the dental team members, and their impression of the practice and quality of care provided is shaped by each of these team members.

So if dental team members are so important to providing excellent care, their contribution to the practice should be recognized. If there’s one thing in life that everyone wants it’s to be appreciated, rewarded and recognized for their contributions. Studies indicate that employees find personal recognition more motivational than money.

Be sure to take the time to recognize the members of your dental team. Also, the more you communicate to employees how much you appreciate their attitude and contributions, the more motivated those employees will be to do a good job.
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I Have Had Enough!

WORLD-RENOOWNED DENTAL LECTURER AND EDUCATOR, GORDON CHRISTENSEN, DDS, MSD, PHD SOUNDS OFF ABOUT THE DENTAL PROFESSION’S ETHICS

By: Gordon J. Christensen, DDS, MSD, PhD

Where has the professionalism of my “profession” gone? I have seen a major degeneration in the ethics of the dental profession over the past several years.

Until recently, I have had the opinion that dental professionals and those companies involved with them were working for the good of the public; that service was a major purpose for a profession—not money; that advertising in professional publications was observed carefully by editors to weed out any hint of dishonesty; that the “peer reviewed” dental literature contained only scientifically acceptable, non-commercially oriented information; that the public trusted the dental profession; and that dentists treat their patients like they would like to be treated themselves. WOW, have I been misinformed!

On the positive side, as I start this written tirade, dentistry has made unbelievable progress during my career so far. As I look back at the profession when I became a dentist, the ability of dentists to serve patients was only partially developed when compared to today. The introduction of high-speed tooth cutting, implants, tooth-colored restorative materials, porcelain-fused-to-metal restorations, staff involvement in clinical procedures, advanced surgical procedures, and great strides in preventive dentistry have made dentistry fulfill my three favorite words for patient care—dentistry is now faster, easier, and better than it was when I became a dentist. However, in my opinion, the ethics of the dental profession have taken a real “dive” during the same time. At the beginning of my career, dentists and dentistry used to be ranked by pollsters at the top of the list of professions the public trusted. Now, in numerous surveys of public respect, we are reported to be far down on the trust scale.

This editorial discusses the relatively recent and obvious degeneration of ethics in the dental profession and calls for a change of direction by all parties involved. The following actual documented examples do not name specific individuals or companies to avoid confrontations. I present the following information as examples of the problems I see in the ethics of our profession. If the shoe fits—wear it! Let’s examine some of the negative situations that are contributing to this degeneration.

OVERTREATMENT

I was one of the original instigators of the recognition of esthetic dentistry, over 25 years ago. However, my pet subject has turned into a monster with unbelievable overtreatment of unsuspecting patients. This problem of overtreatment is not limited to esthetic dentistry. It is spread throughout the profession. I will list a few current examples.

Convincing patients that removal of amalgam restorations is mandatory for systemic health reasons is not a legitimate or logical practice in most situations. Yet, many patients go through that elective procedure with the hope that some miraculous cure of a systemic condition will be accomplished. Of course, there are a few situations in which amalgam removal may actually be indicated for reasons other than esthetics. Recently, a patient was examined by me and my staff for a second opinion on an “esthetic upgrade”. She had traveled several hundred miles to have the examination, and she did not inform me of her reasons for requiring a “second opinion” until later. We suggested a treatment plan that included scaling, polishing, at-home bleaching, minor esthetic tooth recontouring, a few anterior and posterior tooth-colored resin-based composite restorations, and two elective veneers. When the plan was presented, she sighed in disgust. Just a few hundred miles from Utah, she had received a treatment plan for twenty-eight veneers and a total occlusal rehabilitation, equal to the cost of a very good new automobile. If this were a singular occurrence from one less-than-reputable dentist, I could understand it, but this has happened to me several times in the past from various practitioners. Dentists are actually being taught by popular speakers on how to do the same overtreatment to their own patients. I have had the unfortunate challenge to redo several of these over-treated cases after the fracture failure of the ceramic restorations, debonding of veneers placed over grossly overprepared dentin surfaces, or degeneration of the occlusion that appeared to have little occlusal adjustment after seating the restorations. If treatment plans containing all of the treatment alternatives are presented to patients, including the advantages, disadvantages, risks, and costs of each alternative, and if the consenting patient accepts and demands a radical plan, the treatment becomes more understandable. It is well known that patients elect to have radical esthetic plastic surgery on various parts of their bodies, knowing that the
Overtreatment in the name of esthetic dentistry without total informed consent of patients, primarily for dentist financial gain, is nothing less than overt dishonesty in its worst form.”

Gordon J. Christensen, DDS, MSD, PhD

Solution: Dentists should evaluate their diagnosis and treatment planning procedures to ensure that all of the various treatment options are presented to patients. If patients choose a radical, elective treatment plan, primarily for appearance purposes, they should be told all of the negatives before they choose to initiate the treatment plan, including potential premature failure, occlusal problems, and need for re-treatment in just a few years. Informed consent should be thorough and complete. Treatment plans should be separated into mandatory treatment and elective treatment, and patients should have a complete understanding of the difference. Financial income to the practitioner should be related to the needs and decisions of the informed patient, not the needs of the practice.

ADVERTISMENTS IN DENTAL JOURNALS AND MAGAZINES

As I thumbed through a current “cosmetic” magazine, I noted the presence of ads for several light enhanced in-office bleaching devices, touting their superiority to other bleaching techniques. It must not matter to some manufacturers that it has been proven and published that the tested bleaching lights do not effect a greater tooth color change than the bleach solution alone. I find it amusing that one manufacturer actually advertised that his product could be used with or without the light. Dentists are not without guilt in this situation. Recently, I talked to a practitioner in a course who blatantly told me that he knew the lights did not improve the bleaching, but he thought that patients accepted bleaching fees better if bleaching lights were used. At some time in the future, bleach-light combinations may be found that will allow faster and better tooth lightening than the bleach alone. We are still waiting.

Solution: I suggest that editors of journals and magazines recruit thoroughly informed, honest consultants, who have had actual clinical experience with the concept being studied, to screen the advertisements, weeding out the misleading or overtly dishonest ads. Additionally, dentists need to be wary of advertising from companies known to exaggerate product characteristics or to misrepresent the advantages of their products in ads. Companies should realize that honest advertising is clearly evident to informed readers, and similarly dishonest ads are soon disproved by clinical results. When clinical research and experience do not confirm the claims in the ads, dentists lose confidence in believing any future ads from the company involved.

ARTICLES IN JOURNALS

A recent research paper published on the most commonly used esthetic dentistry procedure in a prestigious “peer-reviewed” journal, and showing positive characteristics for the product evaluated, was funded by the company selling the system. In some situations, this may be legitimate, but in this case, studies from other researchers published in the same issue with the commercially supported paper would certainly have made the results more credible. Most companies are doing their best to be honest and sincere, but the few who flagrantly try to promote their products by “bought research” soon become identified by practitioners.

A popular, well accepted technique was denounced in another research paper in a “peer reviewed” journal. Immediately, dentist participants in continuing education courses asked why the clinically successful technique, which most of them were using, didn’t do better in the research. After reviewing the paper, it was found that a third-party payment company, with obvious vested interests to reduce the use of the popular concept, had funded the research.

You have read many scientific projects that test a group of commercially available products, and find one product to be the best. It should not be a surprise to find that the product from the company funding the study had the most positive results. Unfortunately, dental education and dental educators have always been underfunded. Dental manufacturers provide much of the funding for university-based dental research. Although not impossible, it is difficult for a dental faculty member to remain totally unbiased when accomplishing a research project, if all or a major portion of his/her salary comes from the research grant. Additionally, when a company-funded project does not come out to favor a given product, it is well known that publication of the ill-fated project can be delayed or stopped by the funding company. The recent tobacco research fiasco is manifestation of this problem on a larger scale. Such information is lost to the public or practitioners until someone else happens to study the same question.

Peer review of research in dentistry, with a few exceptions, is not a guarantee that a published paper has legitimate conclusions. In my opinion, peer review in dentistry is in need of major revision, bringing in many more practicing clinicians along with their academic counterparts, and using more than a few persons as reviewers on controversial topics.

Solution: Dentists – wake up! How many companies can produce an unbiased research project? I know a few, but there are many that are questionable. Editors – publish more than one paper on the same subject when a company-funded project is published in your journals, recruit peer reviewers who have expertise in the specific subjects of the papers, and expand your review teams to include more “real world” practitioners who know clinical dentistry. Companies – just be honest. We practitioners soon discover dishonest research by simply observing our clinical results, and you and the patients will be the losers.

contd. on pg. 21
DENTISTS NEEDED TO PROVIDE DENTAL CARE TO HURRICANE EVACUEES AT CAMP GRUBER

The Operations Chief at Camp Gruber has asked ODA member dentists to help provide care to the hurricane evacuees. Currently there are 300 evacuees at Camp Gruber, though the camp is expecting a possible 1,000 more evacuees in the coming weeks.

The dental care requested will take place in the offices of member dentists within driving distance of Camp Gruber (Tahlequah, Muskogee, Tulsa metropolitan area, etc.). The Camp will facilitate transportation of those needing care to participating offices.

Care to be provided includes the management of PAIN and INFECTION only.

If you would like to help, please provide your contact information to the ODA (405.848.8873; bhouston@okda.org; 405.848.8875 – fax). The ODA will then pass a list of participating dentists to the medical clinic at Camp Gruber. Personnel at Camp Gruber’s medical clinic will contact your office as the need for care arises and determine how and when you can help.

Relief fund donations
At the 12th District Pre-Caucus meeting in Dallas, TX, in September, Dr. Sid Nicholson presented the Louisiana Dental Association with a check for $7,000 for the LDA hurricane relief fund. Another check for the same amount is on the way to the Mississippi Dental Association. These checks were the result of ODA member dentists’ contribution. The ODA relief fund will still match another $3,000 in contributions to help dentists and communities struck by the Hurricane Katrina disaster.

If you would like to make a contribution, the ODA has set up a program to handle donations through its Relief Fund. All funds contributed to this effort will be divided between the Louisiana Dental Association (LDA) and the Mississippi Dental Association (MDA) for their hurricane relief programs. The LDA and MDA relief funds are set up to aid member dentists of both Associations affected by this storm, as well as provide oral health supplies for the general population in the affected areas.

To contribute, please send a check payable to the ODA Relief Fund: Hurricane, 317 NE 13th Street, Oklahoma City, OK 73104 This is classified as a charitable donation.

Additionally, the Oklahoma Dental Association has ordered toothbrushes and toothpaste for the hurricane evacuees who will be housed at Camp Gruber and Falls Creek. If you know of other hurricane evacuees that are residing in Oklahoma at locations such as Red Cross facilities, local churches, private homes, etc., please contact Brian Houston at the ODA (405.848.8873; bhouston@okda.org) and we will get you supplies as needed.

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EVALUATION OF PRODUCTS

Most dental journals and magazines have product endorsements in them from companies or individuals that have been paid to evaluate the products they are endorsing. If independent companies want to evaluate dental products and report on them, honesty in the results would be increased if these evaluations were accomplished without fees paid to the evaluating company by the manufacturer that produced the product. The evaluating companies should obtain their income from publication of their data, or other means. The lay group, Consumer Reports, is a prototype for such evaluations. This company does not allow publication of their data for commercial purposes, but it is readily available from the company. Some dental companies use information from published papers in their product advertisements. With the permission of the author/researcher, and if the information is used in fairness to other similar products in the study, such inclusions in ads appear to be appropriate. Reference to the published paper should be included.

Solution: Again, dentists beware! Analyze the source of endorsements carefully. When the endorsement in an advertisement looks questionable, money has probably changed hands. Companies, be honest! Your good products sell by word of mouth about clinical success. Honest, conservative ads are appreciated, and you are respected when practitioners read them.

SPEAKERS ON THE LECTURE CIRCUIT

After spending roughly 40,000 hours on the circuit, I can probably comment on this one with some experience. Can you smell a paid-off speaker? If you can’t, you are pretty naive. Although for most of the larger meetings, speakers have to sign a statement that they are not being paid by companies producing products contained in their lectures, there are many devious ways to get around that challenge. How about paying spouses or other relatives, funding children in college, donating to favorite charities in the speaker’s name (this is okay if the money is donated in the company name and the speaker does not get a tax deduction), using company condos, cabins, or planes, paid vacations, and many other manufacturer perks? It is relatively easy to observe when a speaker favors one company or another in lectures. It is obvious when the speaker is selling his or her own dental product to the exclusion of other products in the course.

Solution: Do not attend lectures of speakers who appear to be on the “take”. These speakers soon expose their financial commitments by their overt favor of products, companies, or commercial techniques. I have seen hundreds of speakers come on the circuit and burn out within a couple of years. Suggest reliable speakers to your colleagues, especially younger dentists.

SUMMARY

I apologize for making some of you nervous, and perhaps even resentful, but I HAVE HAD ENOUGH! I do not like the new unethical face of my profession, where incessant seeking of more money has replaced service to the public, honesty, and self-respect. Numerous areas of major ethical concern in dentistry are identified in this article. The ongoing, if not accelerating, degeneration of professional ethics in dentistry is clearly evident to even casual observers. Improvements in professional ethics are necessary to regain our self-respect and the respect of the people we serve. All of us need to improve, including practitioners, speakers, dental schools accomplishing research, manufacturers, editors, and evaluating groups. It is time to return to honesty and to dealing with our fellow men and women in the way we would want to be treated ourselves. I do not think it is too late.

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Salivary glands are composed of three paired major glands, (parotid, submandibular and sublingual) and 800-1000 minor glands dispersed throughout the oral mucosa except for the attached gingiva and anterior hard palate. The glands have two epithelial cell types: the acinar cells that secrete the salivary fluids as well as most of the proteins; and the ductal cells that secrete some proteins and modify the ionic composition of the saliva as they convey it to the mouth. There are two independent mechanisms for control of salivary components. The fluid component, which includes ions, is controlled by parasympathetic stimulation and the protein component is controlled mainly by sympathetic stimulation. Salivary gland secretions are predominantly under autonomic nervous control; however, various hormones may modulate salivary composition. Parasympathetic stimulation produces copious saliva of low protein concentration while sympathetic stimulation produces little saliva but high protein concentration and may give a sensation of dryness.¹

Xerostomia is a major complaint in the elderly with up to 50-60% of the population over the age of 65 complaining of xerostomia.² Xerostomia is a subjective feeling and up to one-third of cases do not reflect a real reduction in salivary flow rate but rather the subjective feeling of dry mouth. Acinar atrophy has been associated with age and is more prominent in the labial glands than the major glands.³ It is now generally accepted that reduction in salivary function associated with age is modest and xerostomia in older adults is more likely to be the result of other factors, most commonly medication.³ Only a small portion of patients suffer from xerostomia with a known etiology, while in the majority of cases the etiology is assumed to be related to age, disease, medication or idiopathic causes.

Dry mouth has a variety of possible causes (Table 1).⁴ A wide range of drugs can give rise to oral dryness, some causing a subjective complaint of dry mouth and many include objective hypo-salivation. There appears to be multiple mechanisms whereby drugs produce xerostomia.⁴ Medications associated with xerostomia are presented in Table 2.⁴

Recently it was found that there are three oral sensorial complaints (OSC): xerostomia with no established etiology, burning mouth syndrome (BMS), and taste disorders are often related and equally unexplained, having similar characteristics reflected in both taste acuity and saliva compositional analysis.⁵ If OSC are the result of a reduced salivary flow rate or altered salivary composition, this is where the clinician should look for solutions. However, if the OSC are related to neurological disturbances (central or peripheral) a completely different therapy should be administered.²

Clinical manifestations
Clinical manifestations of xerostomia can be divided into four areas: mealtime, night dryness, extraoral, and oral problems. At meal time patients may have decreased taste sensations. Taste sensation requires aqueous solution to function. Swallowing can be impaired by lack of saliva impeding bolus formation, bolus translocation and initiation of the swallowing reflex. Oral dryness can also limit tongue motion during speech for sounds (s, z, sh, ch, j, th) that require moisture to get sibilance at places of oral structures.⁵ The patient may complain of halitosis, chronic burning sensation and intolerance of spicy foods. These changes can lead to compromise of nutritional status, choking, and increased susceptibility to aspiration pneumonia, with colonization of the lung with gram-negative anaerobes from the gingival sulcus.⁵

Xerostomia at night is common, since salivary output normally reaches it lowest circadian levels during sleep. Diminished oral motor tone and increased mouth breathing can exacerbate night dryness. The resultant sleep disruption can lead to fatigue and a lowering of the pain threshold.

Extraoral findings include dry cracked lips and possible angular cheilitis. Salivary gland enlargement can occur secondary to obstruction caused by decreased flow or lymphoid replacement of salivary parenchyma as with Sjögren’s syndrome.

Oral findings include soft tissue changes such as furrowed tongue and desiccated and sticky mucosal surfaces due to lack of lubrication. Oral mucositis (micro abrasion) with burning pain or ulceration is likely to develop. Denture and partial denture retention will be adversely affected. Infection with candidiasis is extremely common with occurrences in up to 80% of patients with Sjögren’s syndrome.⁶ Candida is manifested most commonly as angular cheilitis and acute erythematous candidiasis rather than pseudomembranous candidiasis. Often there are no clinical manifestations, only symptomatic burning mouth. A second frequent infection in patients with reduced salivary flow is new and recurrent dental caries. These result from the inability of the salivary system to restore oral pH and regulate bacterial populations.
Diagnosing xerostomia

Determining who has xerostomia can be confusing because the complaint of a dry mouth is subjective and will vary from patient to patient. Some patients with low salivary flow will not complain, whereas others will complain of dry mouth when there is no relationship to a decreased salivary flow rate. Subjective evaluation can be based on the presence of clinical findings consistent with xerostomia such as hoarseness, difficulty with speaking, chapped lips, angular cheilitis, and desiccated or sticky mucosal surfaces. A positive mirror test, (a mouth mirror must be premoistened before contacting and sliding on oral mucosa) is a good indication of significant dry mouth. The “cracker sign” describes the difficulty a patient may have trying to eat dry food (such as crackers) without sufficient lubrication. Affirmative answers to any of the following four questions correlate with salivary dysfunction.

1. How does your mouth feel when eating?
2. Do you have difficulty swallowing food?
3. Do you have to sip liquids in order to swallow dry foods?
4. Is the amount of saliva in your mouth too little most of the time?

Objective measurement of salivary flow is possible and techniques for measuring salivary flow from individual major and minor glands are available. Stimulated and unstimulated flow can be measured for whole saliva (combined flow from all glands) either stimulated or unstimulated. Measurement of unstimulated flow of whole saliva is relatively simple and probably best reflects basal salivary flow. Unfortunately, collection of unstimulated whole saliva is not very accurate and no universal standard for what levels of flow constitute xerostomia, increased risks for caries or periodontal disease have been established. Normal salivary flow rates of 0.3 ml/min unstimulated and 1.7 ml/min for stimulated have been established. Arbitrarily <0.2 ml/min unstimulated flow rate is considered below normal for evaluation of caries incidence rates. Unstimulated flow rates of < 0.1 ml/min are considered xerostomic for Sjögren’s patients. Stimulated salivary flow rates of < 0.2 ml/min are considered severe xerostomia and < 0.6 moderate xerostomia. While flow studies are essential for epidemiological studies their clinical value is limited. The diagnosis of xerostomia can usually be made on clinical signs and symptoms alone. A technique for measurement of unstimulated whole saliva flow is given in Table 3.

Treatment of xerostomia

There is no good substitute for natural saliva and current therapies are only minimally satisfactory. The first step is patient education and life style changes to increase and preserve natural salivary production. Patients should be informed of the debilitating effects of xerostomia such as mealtime problems, night dryness, candidiasis and dental caries. Relationships to systemic disease and review of medical history for drugs that can potentially cause xerostomia should be done. Patients should be advised to avoid or decrease alcohol consumption, alcohol containing mouth rinses, and caffeine. Both cause dehydration. The patient should be encouraged to increase water intake to improve hydration. Swallowing at mealtime can be improved by drinking milk with meals. Milk has moisturizing properties that help some people swallow their food. Use a cool air humidifier in the bedroom at bedtime and run it through the night. An alternative to humidifiers is to sleep with a cone-shaped surgical mask at night to prevent loss of humidity in expired air and rehydrate inspired air. If possible have patients sleep on their side to minimize mouth breathing.

For dry lips, A&D Ointment® is useful at night and Vaseline Petroleum Jelly® during the day. A&D Ointment® contains 15% lanolin, which is good for dry skin but has a bitter taste and is not used in commercial lip preparations. Vaseline Petroleum Jelly® or other ointments are useful during the day. Avoid waxy stick products, as they tend to tear damaged lip tissue and delay healing.

Mechanical and gustatory salivary stimulation

If the patient has residual salivary gland function, stimulation of the glands can lead to hypertrophy and increased salivary flow. However, if there is minimal residual salivary gland present, as in radiation patients or in late stage Sjögren’s syndrome, salivary stimulants may be less effective. The act of chewing will stimulate salivary flow and chewing gums specifically marketed for xerostomic patients are available, Biotene Dry Mouth Gum® (Laclede Professional Products) and Thera Gum® (Omnii Products). Any of the sugar free gums can be used. Chewing raw vegetables (carrots) has also been recommended. Hard sugar-free candies with citrus flavor work well for gustatory stimulation. Products specially marketed as salivary stimulants include Saliva Sure® (Scandinavian Natural Products) and Thera Mints® (Omnii Products).

Electrical stimulation of salivary glands has been tried. The Salitron System® was available and FDA-approved in 1988 but it was cumbersome, not widely accepted in the market, and is no longer available. The Saliwell Development Project® is developing a miniature, remote-controlled electronic saliva stimulator, about the size of a tooth crown, using principles of the Salitron® device, as a dental implant. The prototype is currently in non-surgical trials in Europe. Hand-held transcutaneous nerve stimulator (TENS) units have been shown to improve salivary flow in some patients. Acupuncture has also shown some variable success and “significant improvement” in salivary flow.

Saliva substitutes

Water has long been used as a supplement for lack of saliva and proper hydration is important. Constant sipping of water to relieve xerostomia gives short-term relief and may be counter productive since the water washes away or dilutes the lubricant and protective properties of what little natural saliva is produced. Artificial salivas are available and are based on plant mucins, (carboximethycellulose), animal mucins, and synthetic polymers. Animal mucins and synthetic polymers were introduced to better mimic the rheological properties of natural
saliva. The optimal properties of a saliva substitute appear not to be the same for all patients. Still the best way to determine the best saliva substitute for a patient is to have the patient try a number of substitutes of different viscoelastic properties such as Salivart (carboxymethylcellulose) for low viscoelastic properties or Thera Spray or Oral Balance (synthetic polymers) for high viscoelastic properties. Some substitutes have excessively low pH and may cause demineralization of tooth structure or restorative materials (Mouth Kote pH 4.0 and Optimoist pH 3.5). Since tooth structure will demineralize at pH <5.5 these products are not recommended in dentulous patients. (Table 4)

Systemic salivary stimulants

Pilocarpine hydrochloride is derived from the Pilocarpus jaborandi plant. Observation of field workers in Brazil who chew the plant while working to increase salivary flow, prompted Coutinho, a Brazilian physician, to suggest the plant as a treatment for dry mouth. Pilocarpine is a parasympathomimetic agent with a broad spectrum of effects on muscarinic receptors. It increases secretions from all exocrine glands including sweat, lacrimal, gastric, pancreatic, intestinal, and the respiratory tract. Common side effects include gastrointestinal upset, sweating, tachycardia, bradycardia, increased pulmonary secretions, increased smooth muscle tone, and blurred vision. Contraindications include uncontrolled asthma, narrow angle glaucoma, acute iritis, and allergy to pilocarpine. The drug can be used with caution in patients with cardiovascular disease, retinal disease, pulmonary disease, biliary tract disease, and psychiatric disturbances. It is also contraindicated in patients on beta-blockers. Pilocarpine is supplied in 5 mg tablets (Salagen®) and can be used at 5-10 mg TID up to a maximum dose of 30 mg per day. It is best to titrate the dose up to reach the desired effect and minimize side effects.

Cevimeline hydrochloride (Evoxac®) is another cholinergic agonist but has selectivity for only two of the five known muscarinic receptors and is more selective for salivation. It has a slower onset and a longer half-life than pilocarpine. The same precautions apply to the use of cevimeline and pilocarpine. It is supplied in 30 mg capsules and is recommended TID. If side effects are encountered the drug should be taken with meals rather than before meals. Typical use has been suggested to give greater stimulation to minor salivary glands and reduce systemic side effects. The 30-mg capsule is dissolved in 100 ml of water, then used as an oral rinse TID for 2 minutes without swallowing. Sublingual absorption will give some systemic effects. These regimens should be tried for 2-4 weeks and discontinued if there is no improvement or too many side effects develop.

Other drugs that have been suggested are Bethanechol 25 mg TID, another cholinergic agonist, and Yohimbine, an alpha-2 adrenergic antagonist. Yohimbine is promoted as an aphrodisiac, to stimulate sexual desire and performance, impotence, and weight loss. It also increases salivary flow rates.

Another drug of interest is anethole trithione (Sialor), which is not approved for sale in the United States. It is an anticancer drug that increases salivary flow rates and in conjunction with pilocarpine has a synergistic effect on salivary flow rates by increasing availability of muscarinic receptor sites.

Caries control

Topical fluorides should be used in patients with salivary hypofunction as a preventive measure or when increased caries incidence is present. They can be applied with a brush or tray system. The tray systems are more efficient but patient compliance may be a problem. Stannous fluoride products are not recommended due to low pH and taste. Sodium fluoride 1.1 percent gel with a tray system or brush-on technique is recommended. Toothpastes containing 1.1 percent sodium fluoride are also recommended and may improve patient compliance over tray and gel procedures. (Table 5)

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October 2005 24 ODA JOURNAL
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Table 1. Causes of xerostomia

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<thead>
<tr>
<th>Iatrogenic</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Irradiation</td>
</tr>
<tr>
<td></td>
<td>Graft vs host disease</td>
</tr>
<tr>
<td>Diseases</td>
<td>Salivary gland disease</td>
</tr>
<tr>
<td></td>
<td>Salivary aplasia (agenesis)</td>
</tr>
<tr>
<td></td>
<td>Sjögren’s syndrome</td>
</tr>
<tr>
<td></td>
<td>Sarcoidosis</td>
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<tr>
<td></td>
<td>Cystic fibrosis</td>
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<tr>
<td></td>
<td>Primary biliary cirrhosis</td>
</tr>
<tr>
<td>Infections</td>
<td>HIV</td>
</tr>
<tr>
<td></td>
<td>Hepatitis C</td>
</tr>
<tr>
<td></td>
<td>Human T Lymphotropic virus (HTLV-1)</td>
</tr>
<tr>
<td>Dehydration</td>
<td></td>
</tr>
<tr>
<td>Psychogenic</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Drugs associated with xerostomia

<table>
<thead>
<tr>
<th>Anticholinergic drugs</th>
<th>Tricyclic antidepressants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Muscarinic receptor antagonists for treatment of overactive bladder</td>
</tr>
<tr>
<td></td>
<td>Alpha-receptor antagonists for treatment of urinary retention</td>
</tr>
<tr>
<td></td>
<td>Antipsychotics such as phenothiazines</td>
</tr>
<tr>
<td></td>
<td>Diuretics</td>
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<tr>
<td></td>
<td>Antihistamines</td>
</tr>
<tr>
<td>Sympathomimetic drugs</td>
<td>Antihypertensive agents</td>
</tr>
<tr>
<td></td>
<td>Antidepressants (Serotonin agonists, or noradrenaline and/or serotonin re-uptake blockers)</td>
</tr>
<tr>
<td></td>
<td>Appetite suppressants</td>
</tr>
<tr>
<td></td>
<td>Decongestants and cold remedies</td>
</tr>
<tr>
<td></td>
<td>Bronchodilators</td>
</tr>
<tr>
<td>Skeletal muscle relaxants</td>
<td></td>
</tr>
<tr>
<td>Antimigraine agents</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines, hypnotics, opioids and drugs of abuse</td>
<td></td>
</tr>
<tr>
<td>H2 antagonists and proton pump inhibitors</td>
<td></td>
</tr>
<tr>
<td>Cytotoxic drugs</td>
<td></td>
</tr>
<tr>
<td>Retinoids</td>
<td>Anti HIV drugs such as dideoxynosine (DDI) and protease inhibitors</td>
</tr>
<tr>
<td>Cytokines</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Unstimulated whole salivary flow determination

1. No salivary stimulus during preceding 2 hours.
2. Sit quietly without any conversation or oral activity for 6 minutes.
3. Spit into a funnel leading to a small milliliter graduated cylinder every 2 minutes.
4. After 6 minutes, measure the fluid, (not the foam on top) and record the volume.
5. Divide the volume by six to determine the ml/min of flow.

Table 4. Products for xerostomia

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>Telephone or web site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Saliva substitutes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oralbalance®</td>
<td>Laclede Research Laboratories</td>
<td>(800) 922-5856</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.laclede.com">www.laclede.com</a></td>
</tr>
<tr>
<td>TheraSpray®</td>
<td>Dunhall Pharmaceuticals</td>
<td><a href="http://www.omnipharma.com">www.omnipharma.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.4oralcare.com">www.4oralcare.com</a></td>
</tr>
<tr>
<td>Moi-Stir Mouth Moistener® pH 7.1</td>
<td>Kingswood Laboratories</td>
<td>(800) 968-7772</td>
</tr>
<tr>
<td></td>
<td></td>
<td>web site not available</td>
</tr>
<tr>
<td>Saliva Substitute® pH 6.5</td>
<td>Roxane Laboratories</td>
<td>(800) 520-1631</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.roxane.com">www.roxane.com</a></td>
</tr>
<tr>
<td>Salivart® pH 6.2-7.2</td>
<td>Gebauer Company</td>
<td>(800) 321-9348</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.gebauerco.com">www.gebauerco.com</a></td>
</tr>
<tr>
<td>Entainer’s Secret®</td>
<td>KLI corp.</td>
<td>317 846-7452</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.entainers-secreat.com">www.entainers-secreat.com</a></td>
</tr>
<tr>
<td>MouthKot® pH 4.0</td>
<td>Parnell Pharmaceuticals</td>
<td>(800) 457-4276</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.parnellpharm.com">www.parnellpharm.com</a></td>
</tr>
<tr>
<td><strong>Fluoride products and tooth paste</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride gel®</td>
<td>Omnii Oral Products</td>
<td><a href="http://www.omnipharma.com">www.omnipharma.com</a></td>
</tr>
<tr>
<td>Control Rx®</td>
<td>Oral-B Laboratories</td>
<td><a href="http://www.oralbprofessional.com">www.oralbprofessional.com</a></td>
</tr>
<tr>
<td>NeutraCare gel®(1.1% NaF)</td>
<td>Colgate Oral Pharmaceuticals</td>
<td><a href="http://www.colgate.com">www.colgate.com</a></td>
</tr>
<tr>
<td>Prevident Brush on gel®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevident 5000plus® Dentifrice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biotene® dry mouth tooth paste</td>
<td>Laclede Research Laboratories</td>
<td><a href="http://www.laclede.com">www.laclede.com</a></td>
</tr>
</tbody>
</table>
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THE BUCCAL PIT STUDY CLUB #3

The Ranger bass boat representative said he had never seen one so completely destroyed. Small chunks of once-shiny fiberglass had washed up on the south shore of Gator Crossing Lake, and the only identifiable piece large enough to take back for evidence contained part of the flame-shaped lettering “Viagracaine” barely visible to the unaided eye. It was not going to be easy to make identification from what little remained, but the boat rep was absolutely sure what had happened. It was not unusual for novice boat owners with more money than sense to overpower their rigs with more motor that it was designed for. The inevitable urge to “see what she’ll do” would finally kick in with predetermined results. Becoming airborne around 75, the boat would swap ends in mid-air resulting in a Jerry Bruckheimer-style crash that quickly dispatched anyone unlucky enough to be inside. It didn’t look good.

Not too far down shore a rough-looking character sat watching all the police activity. Several weeks of aimless wandering looking for something recognizable to jog his trauma-erased memory had transformed the once dapper LL Bean-clad dentist into a neo-mountain man with unshaven face and wild expression. What passed for camp was a sad collection of improvised gear complete with tent made from remnants of boat seat cushion material. A small fire from the previous night still smoldered, but the leftover possum barbeque no longer appealed. He was sure he could remember what had happened and who he was if he could stumble across something that looked the least bit familiar. There had been lots of clues around that he was not sure what to make of, like small glass vials with “2% Viagracaine” printed on the side scattered everywhere along the shoreline along with various boat parts. The inside pocket of his once-intact fishing vest held several identical scraps of water-soaked business cards that were unreadable except for “Unusual and Surprising Dentistry” and “Gator Crossing, Oklahoma”. None of this was helpful, and it didn’t improve his mood any hearing the distant snarling of some wild beast headed in his direction. K-Flex, on the other hand, was delighted to be in a major brawl. It was now close and Dr. Ed braced for the coming battle. K-Flex, on the other hand, was delighted to see his old friend and owner offering him lunch as he popped his head out from behind the brush. A few good licks on the face brought the bright light of recognition, and the reunion and memory restoration began. It was about then that the advanced units of the search party reached the campsite. Appropriate toasts were offered from the club ice chest and the case of the fresh pop was opened. No matches were found. The Sheriff, having had it up to here with the whole affair, told club members at their last meeting at the Long Branch that if they wanted to find Dr. Ed they could jolly-well do it themselves. By mid-afternoon a search party was recruited from available club members and they headed off in the direction of least resistance.

By now Dr. Ed had grabbed the nearest thing at hand to defend himself from the advancing snarl, although he wasn’t sure how effective the half-eaten possum carcass would be in a major brawl. It was now close and Dr. Ed braced for the coming battle. K-Flex, on the other hand, was delighted to see his old friend and owner offering him lunch as he popped his head out from behind the brush. A few good licks on the face brought the bright light of recognition, and the reunion and memory restoration began. It was about then that the advanced units of the search party reached the campsite. Appropriate toasts were offered from the club ice chest and the case of the missing dentist was closed. On the way back to town Dr. Ed was heard to say he had learned a valuable lesson: he would never again use free new stuff from drug reps, no matter how fast they claimed their bass rigs could go!

To have a story, anecdote, or tale considered for publication here, simply submit it to rootips@okda.org or contact Stephanie Trougakos at 405.848.8873. ODA staff will provide any assistance needed in getting your story down on paper, just the way you want it.
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