The New York State Dental Journal

Volume 89 | Number 1 Article 1

1-1-2023

N Y State Dent J January 2023

Is the Dental Profession in Need of Remediation?

THE NEW YORK STATE DENTAL JOURNAL

NYSDJ

Volume 89 **Number 1**
January **2023**

EMERGENCY ROOM

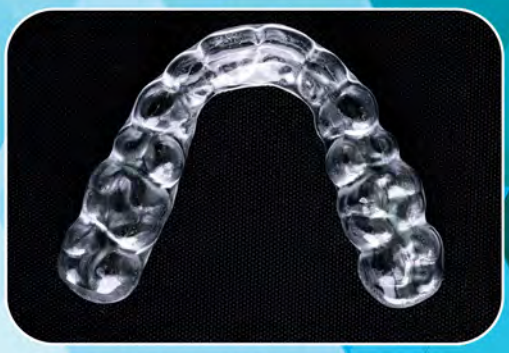
Understanding Repeat Urgent Dental Care Visits

Triggered by Third-Molar Pathologies

Inside: Year-end Legislative Roundup

UTICA
DENTAL LABORATORY
CONSISTENT·QUALITY·SERVICE

Zirconia Crowns



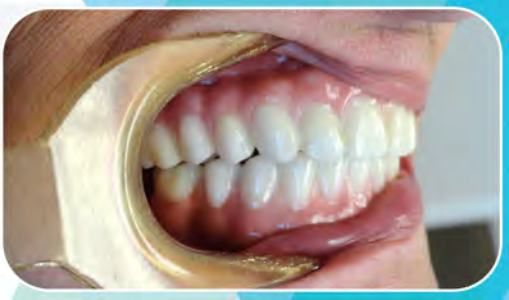
3D Printed Nightguards

Fixed

Removable

TCS 3D Flexible Partials

Implant Restorations



All on "X" Zirconia Arch

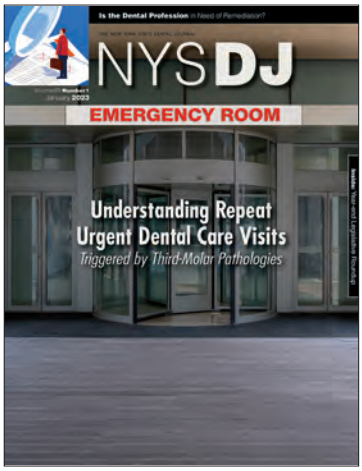
Fee Schedule Available Upon Request

302 Genesee St Utica, NY 13502 | 866-835-4968 | info@UticaDentalLab.com | www.UticaDentalLab.com

THE NEW YORK STATE DENTAL JOURNAL

NYSDJ

Volume 89 **Number 1** January **2023**



Cover: The emergency room is becoming a revolving door for patients with third-molar pathologies. What's behind this growing public health problem?

The New York State Dental Journal is a peer reviewed publication. Opinions expressed by the authors of material included in The New York State Dental Journal do not necessarily represent the policies of the New York State Dental Association or The New York State Dental Journal. EZ-Flip version of The NYSDJ is available at www.nysdental.org and can be downloaded to mobile devices.

Use your smartphone to scan this QR Code and access the current online version of The New York State Dental Journal.

Dentistry's Report Card

Organized dentistry's declining membership and limited effectiveness in collectively acting in society's best interests require remediation.

Society granted dentists the professional privileges we enjoy today. Like it or not, a license monopoly and the right of self-regulation come with reciprocal responsibilities.

Society continually assesses our performance in meeting our professional obligations to self-govern and place patients' and society's interests above dentists' individual and collective interests. Society remediates our unsatisfactory efforts to meet our country's oral healthcare needs through legislation and court decisions. As a final grade, society can and will reduce or rescind dentistry's professional privileges unless individual dentists maintain membership in organized dentistry and individually and collectively provide quality, affordable care to all.

Competencies Graded

We all recall the feeling of accomplishment when we completed our first procedure as a licensed dentist without supervision and grading. If we thought "no more grading," then our first taste of professional autonomy gave us the wrong impression. In fact, society continues to assess dentists' ongoing performance related to three core competencies and performance criteria as described in the report card below.

The grading scale reflects the legal regulatory response society deems necessary to remediate dentists' failure to meet their professional obligations.

Grading Scale

S = No legal/regulatory action (Satisfactory)
S- = Legal/regulatory remedial action (Requires Remediation)
U = legal/regulatory action to rescind professional privileges (Unsatisfactory)

Competency 1: Self-Governance

The duty to self-regulate requires dentists to form and join a professional association that articulates and enforces dentists' professional obligations to patients and society. The American Dental Association's Principles of Ethics and Code of Professional Con-

	COMPETENCIES	INTERIM GRADE	FINAL GRADE
1	Dentists regulate themselves (Self-Governance) Maintain membership in a professional association with an effectively enforced ethical code.		
2	Individual dentists place patients' interests above their own interests (Best Interests of the Patient) Deliver quality oral healthcare.		
3	Dentists act collectively to place the public's interests above dentists' collective interests (Best Interests of Society) Provide access to affordable care for all.		

The decreasing number of dentists with ethical commitments puts future grading regarding dentists' delivery of quality care into question.

duct ("Code") represents the written expression of our obligation to self-regulate implied in dentistry's contract with society. Membership in the ADA and adherence to the Code stand as key elements of professional status. In joining the ADA, we ratify that the ADA House of Delegates drafted the Code pursuant to an ongoing dialogue with society, commit to be bound by the Code's principles and interpretations and subject ourselves to discipline for violations.

As the percentage of dentist membership in organized dentistry dwindles, fewer dentists formally agree to honor the Code and participate in the self-regulatory process. Consequently, discipline in the form of state board or administrative law action for professional misconduct remains society's only avenue of control over nonmember conduct. This process in most states involves a hybrid of dental self-regulatory and government action. For example, a state agency may receive complaints, investigate and prosecute offenders, and a panel of dentists may make final determinations on disciplinary penalties. However, these agencies currently suffer from a lack of comprehensive reporting laws that help identify dentists warranting investigation and inadequate resources to effectively manage credible cases. As a result, society views dentistry as less willing and able to self-govern and, thus, a more likely target of remedial government intervention. ***Interim Grade: S-***

Competency 2: Best Interests of the Patient

The law mandates that the quality of dentists' treatment rendered meets the standard of care. The standard reflects what an average dentist would do under similar circumstances. To act in the best interests of patients, we often must rise above this legal minimum and voluntarily undertake the affirmative duties set forth in the Code. These include to "do good"; act for the benefit of others; deal fairly with patients; and, generally, adhere to high ethical standards of conduct.

Nonmember dentists do not formally agree to perform beyond their minimal legal duties. Without the added ethical commitments, nonmembers, similar to occupations and trades with no ethical code, must merely refrain from criminal law violations, such as committing fraud and acting with undue influence and avoiding substandard care that causes patient injury. However, when dentists act like members of a trade, it violates our obligation to aspire to a higher standard in return for our professional privileges.

The decreasing number of dentists with ethical commitments puts future grading regarding dentists' delivery of quality care into question. Furthermore, current measurements of the overall quality of U.S. dental care lack reliability and, hence, have limited validity.

THE NEW YORK STATE DENTAL JOURNAL
NYSDJ

PRINTER
Fort Orange Press, Albany

NYSDJ (ISSN 0028-7571) appears three times a year in print: January, March and June/July. The April, August/September and November issues are available online only at www.nysdental.org. The Journal is a publication of the New York State Dental Association, 20 Corporate Woods Boulevard, Suite 602, Albany, NY 12211. In February, May, October and December, members have online access to the NYSDA News. Subscription rates $25 per year to the members of the New York State Dental Association; rates for nonmembers: $75 per year or $12 per issue, U.S. and Canada; $135 per year foreign or $22 per issue. Editorial and advertising offices are at Suite 602, 20 Corporate Woods Boulevard, Albany, NY 12211. Telephone (518) 465-0044. Fax (518) 465-3219. E-mail info@nysdental.org. Website www.nysdental.org. Microform and article copies are available through National Archive Publishing Co., 300 N. Zeebe Rd., Ann Arbor, MI 48106-1346.

Statistics indicate that quality varies with geographic location, dentist/population ratio, median household income, and patient education and employment status, but we need improved metrics to obtain sufficient evidence of the true level of quality.

Since the United States traditionally has stood as one of the better oral healthcare service providers worldwide, society, by default, would assign a minimal passing grade to dentists for acting in our patients' best interests. ***Interim Grade: S***

Competency 3: Best Interests of Society

Dentistry can't have it both ways. We cannot continue to enjoy the benefits of a license monopoly and professional autonomy and, at the same time, fail to collectively deliver affordable quality care to all Americans. Organized dentistry offers programs to educate the public and expand access to care with limited success; however, current delivery systems and available financing still leave many vulnerable groups with inadequate access to affordable oral healthcare.

Society historically has remediated dentistry's poor performance in providing affordable access to care through government actions and intentional inaction that include the following:

- The Supreme Court upheld the Federal Trade Commission's order to allow dentist and physician advertising, declaring the respective professional associations ethical prohibitions on advertising as antitrust conspiracies that suppressed competition and reduced access.
- Multiple states legalized midlevel providers that perform procedures previously limited to licensed dentists.
- Various courts and legislators failed to prohibit non-dentist teeth bleaching, non-dentist practice ownership and aspects of "do-it-yourself dentistry."

Dentistry can expect more remediations as long as society perceives that we, as dentists, use our current model of practice to leverage our license monopoly for profit, while we ignore our duty to collectively act in the best interests of the public. In response, organized dentistry must work with, not against, state legislators and dental educators to create expanded duty auxiliaries that meet Commission on Dental Accreditation standards commensurate with the duties they can legally perform and that function under licensed dentists.

Dentists must also embrace new models of delivery, including Dental Service Organizations (DSOs), primarily to integrate DSOs' business expertise into dental practices to increase efficiency and access, while still meeting our ethical obligations. Ultimately, our failure to provide access to oral healthcare for all will prompt the government to expand non-dentists' scope of practice and itself administer a greater portion of oral healthcare funding and payments. ***Interim Grade: S-***

Dentistry's Self-Regulatory Assignments

The dental profession must correct our deficiencies with reforms in dental education and the role of organized dentistry. Dental schools must operate less as trade schools and more as prep schools. Dental education too often overemphasizes techniques and job skills as ends in themselves, rather than in the context of society's expectations and needs. Conversely, curricula underemphasize that our license privilege to provide this care to individuals is predicated upon our collective success in ensuring access to affordable care for all.

As a remedial reform, programs should grade students more on their abilities to not only perform operative skills, but also to apply the Code to patient care, work together to deliver care to the underserved and self-regulate. This educational focus would prompt graduates to perceive membership in organized dentistry as a requirement to meet their professional obligations rather than merely an optional trade union to obtain personal benefits.

Organized dentistry must rediscover its core mission as the vehicle to meet our collective obligation to place the public's interests above our profession's interests. To maintain this focus and to protect against special interest bias, we should apply our individual code of ethics to our professional association's conduct to avoid conflicts of interest with insurers, corporate entities, the specialties and government agencies.

As a secondary function, organized dentistry can act as a trade union to offer benefits, services and advocacy on behalf of our members and our profession, but only as necessary to accomplish our core mission. The splintered special interest organizations that many dentists elect to join in lieu of the ADA act more as trade unions and dilute rather than strengthen our ability to act collectively in the best interest of the public.

Final Grades

We, as dentists, can only maintain our professional privileges through meeting our professional obligations. We can only meet our professional obligations through membership in a professional association that enables us, as individuals and collectively, to earn passing grades in our core competencies. Dentistry's interim grades indicate deficiencies in meeting these competencies. Dentists must decide either to meet our reciprocal responsibilities or accept final grade remediations that erode or eliminate our professional privileges.

Final Grades: ***Pending Dentistry's Response***


D.D.S., J.D.

As the Legislative Year Comes to a Close

Latest legal developments provide good news/bad news scenario.

Lance Plunkett, J.D., LL.M.

Starting in November, several major legal developments occurred in New York State, thanks to the delay of legislative bills being sent to Gov. Hochul for action pending the outcome of the midterm elections.

The first development, on Nov. 21, was good news, as the governor signed into law, as Chapter 613 of the Laws of 2022, the bill that eliminated the "clinically-based" language in Section 6604(3) of the New York State Education Law defining required dental residencies for licensure. The elimination of this language now allows residency programs in dental public health, oral medicine and orofacial pain to qualify for licensure purposes. The New York State Education Department had taken the position that the previous language precluded such residencies from qualifying as a path to licensure. That language is now gone and the law takes effect immediately so that all the residents in the formerly disqualified residency programs will be able to use them for licensure once they successfully complete the residency.

The law also now allows the Education Department to amend its regulations to eliminate superfluous clinical requirements for all residency programs, particularly the laundry list of clinical duties for general residency programs. However, the earliest the Education Department could begin that process is January 2023. The bill that was signed into law—A.9967 (Glick)/S.8808 (Stavisky)—was sponsored by the two respective chairs of the higher education committees in the Assembly and Senate.

Curbing Collections

Proving the old adage that you have to take the good with the bad, on Nov. 23, Gov. Hochul signed into law, as Chapter 648 of the Laws of 2022, a bill—A.7363-A (Gottfried)/S.6522-A (Rivera)—that NYSDA had opposed. The law takes effect immediately and prevents hospitals and healthcare professionals from using liens against a patient's primary residence or using income attachments against a patient's wages as a means of satisfying a judgment against a patient for any medical/dental debts.

NYSDA had opposed the bill because it eliminates two of the most convenient and effective remedies against deadbeat patients. However, the bill was very popular with consumer groups as a protection against the burdens of medical debt, thereby swaying the governor to sign it into law and claim that it was part of her agenda to help protect patients from medical debts.

While the legislation was premised largely on hospital billing being out of control, healthcare professionals were swept up in the tide too. The bill does not eliminate all debt collection remedies, just the two items of liens on a patient's primary residence and attachment of a patient's wages. It does not have any effect on other collection activities and it does not prevent

pursuing a patient's bank accounts, automobiles or other personal property, or a second home. Nevertheless, the new law also illustrates the old adage of the cure being worse than the disease.

Taking Leave

On the employment law front, on Nov. 21, Gov. Hochul signed into law a bill—A.8092-B (Reyes)/S.1958-A (Krueger)—as Chapter 604 of the Laws of 2022, which protects employees when they take legitimate leave time from work. The law amends Section 215(1)(a) of the New York State Labor Law to prevent employers from assessing any type of penalty for an employee being absent due to using leave time granted by any federal, state or local law. For example, an employer is prohibited from "assessing any demerit, occurrence, any other point, or deductions from an allotted bank of time, which subjects or could subject an employee to disciplinary action, which may include but not be limited to failure to receive a promotion or loss of pay."

The law takes effect Feb. 19, 2023. While it may seem like apple pie, Section 215 of the Labor Law has a unique feature that allows employees to bring a private lawsuit against the employer within two years of any alleged violation. In such a lawsuit, the employer can be enjoined from any improper conduct and the employee can recover liquidated damages up to $20,000, costs and reasonable attorneys' fees, rehiring or reinstatement of the employee to his or her former position, with restoration of seniority or an award of front pay in lieu of reinstatement, and an award of lost compensation and other damages. This can become expensive, so it behooves an employer not to violate this new law.

While it was primarily designed to stop employer "no-fault" absence policies that penalized employees for any absences from work, the reality is that use of legitimate leave time never should have been part of such "no-fault" policies anyway.

Plan Disclosures

On the regulatory front, the New York State Department of Financial Services (DFS) adopted final regulations on Dec. 7 dealing with required disclosures by stand-alone dental insurance plans and with insurers putting out improper provider directory information that causes patients to believe a dentist is in-network when the dentist is not. The disclosure regulations apply to any policies issued, renewed, modified or amended on or after one year after the effective date of the regulations—which means they go into effect starting on Dec. 7, 2023.

The plan disclosure requirements had previously applied only to comprehensive health insurance plans, but that is now amended to include stand-alone dental insur-

NYSDA Directory

OFFICERS

James E. Galati, President	1758 Route 9, Halfmoon, NY 12065
Anthony M. Cuomo, President-Elect	667 Stoneleigh Ave., Ste 301, Carmel, NY 10512
Prabha Krishnan, Vice President	11045 Queens Blvd., Ste 108, Forest Hills, NY 11375
Frank C. Barnashuk, Secretary-Treasurer	3435 Main St., UB School of Dental Medicine, Buffalo, NY 14214
Steven Gounardes, Speaker of the House	133 70th St., Brooklyn, NY 11209

BOARD OF TRUSTEES

Kevin A. Henner, Immediate Past President	163 Half Hollow Rd., Ste 1, Deer Park, NY 11729
Brendan P. Dowd, ADA Trustee	3435 Main St., UB School of Dental Medicine, Buffalo, NY 14214
NY – Maurice L. Edwards	30 East 60th St., Ste 401, New York, NY 10022
2 – John P. Demas	8814 Fort Hamilton Pkwy, Brooklyn, NY 11209
3 – Steven L. Essig	Emblem Health, 1873 Western Ave., Albany, NY 12203
4 – Wayne S. Harrison	8 Medical Arts Ln., Saratoga Springs, NY 12866
5 – Margaret Madonian	600 Oswego St., Ste B., Liverpool, NY 13088
6 – Luis T. Mauleon	501 N. Cayuga St., Ithaca, NY 14850
7 – Theresa A. Casper-Klock	33 William St., Ste 1, Auburn, NY 13021
8 – Raymond G. Miller	1965 Como Park Blvd., Lancaster, NY 14086
9 – Gary M. Scharoff	1255 North Ave., Ste A1H, New Rochelle, NY 10804
N – Frank J. Palmaccio	875 Old Country Rd., Ste 101, Plainview, NY 11803
Q – Viren L. Jhaveri	14031 Cherry Ave., Apt. 18, Flushing, NY 11355
S – Guenter J. Jonke	2500 Nesconset Hwy., Bldg 24A, Stony Brook, NY 11790
B – Amarilis Jacobo	824 E. 181st St., Bronx, NY 10460

COUNCIL CHAIRPERSONS

Council on Awards	**Richard Andolina** 74 Main St., Crossroad Professional Building Hornell, NY 14843
Dental Benefit Programs	**Patricia M. Hanlon** 4 Lyme St., Wading River, NY 11792
Dental Education & Licensure	**Joseph Gambacorta** 8 Grosvenor Rd., Buffalo, NY 14223
Dental Health Planning & Hospital Dentistry	**Sean McLaren** 522 E Moreno Dr., Rochester, NY 14626
Dental Practice	**Lois A. Jackson** 505 Laguardia Pl., Apt L4, New York, NY 10012
Ethics	**Nick J. Vittoria** 859 Connetquot Ave., Ste 1, Islip Terrace, NY 11752
Governmental Affairs	**Robert F. Schaefer** 110A W. Utica St., Oswego, NY 13126
Membership & Communications	**Claudia Mahon-Vazquez** 18 Biltmore Dr., Shoreham, NY 11786
Nominations	**Kevin A. Henner** 163 Half Hollow Rd., Ste 1, Deer Park, NY 11729
Peer Review & Quality Assurance	**Barry Sporer** 80 Park Ave., Ste 1C, New York, NY 10016
Professional Liability Insurance	**David J. Reed** 1998 Empire Blvd., Webster, NY 14580

OFFICE

Suite 602, 20 Corporate Woods Blvd., Albany, NY 12211
(518) 465-0044 | (800) 255-2100

Gregory D. Hill	Executive Director
Lance R. Plunkett	General Counsel
Michael J. Herrmann	Assistant Executive Director Finance and Administration
Grazia A. Yaeger	Assistant Executive Director Marketing and Communications
Mary Grates Stoll	Managing Editor
Jenna Bell	Director of Meeting Planning
Betsy Bray	Director of Health Affairs
Briana McNamee	Director Governmental Affairs

ance plans. The items that must be disclosed are outlined on the following page.

In addition, if the stand-alone dental plan is considered to be a managed care plan, then the following disclosures must also be made:

(1) a description of the grievance procedures to be used to resolve disputes between an insurer and an insured, including: the right to file a grievance regarding any dispute between an insured and an insurer; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which insureds may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;

(2) where applicable, notice that an insured enrolled in a managed care product or in a comprehensive policy that utilizes a network of providers offered by the insurer may obtain a referral or preauthorization for a healthcare provider outside of the insurer's network or panel when the insurer does not have a healthcare provider who is geographically accessible to the insured and who has the appropriate training and experience in the network or panel to meet the particular healthcare needs of the insured and the procedure by which the insured can obtain such referral or preauthorization;

(3) where applicable, notice that an insured enrolled in a managed care product or a comprehensive policy that utilizes a network of providers offered by the insurer with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral; and

(4) where applicable, notice that an insured enrolled in a managed care product or a comprehensive policy that utilizes a network of providers offered by the insurer with (A) a life-threatening condition or disease, or (B) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist.

The disclosures are quite extensive. While there are stand-alone dental insurance plans that were making some of these disclosures, not all were doing so voluntarily. Now they have no choice, but must disclose these items.

With respect to the insurer providing improper directory information, patients are to be held harmless from paying more than the in-network cost such directory information would have indicated was available. In addition, the dentist must be reimbursed for the out-of-network services rendered. Therefore, if a patient who is covered under any dental or medical plan that uses a network of healthcare providers receives a bill for out-of-network services resulting from the plan providing inaccurate network status information to the patient, the plan shall not impose on the patient a copayment, coinsurance or deductible for the service that is greater than the copayment, coinsurance or deductible that would be owed if the patient had received services from a participating provider. The plan shall apply the out-of-pocket maximum that would have applied had the services been received from a participating provider.

In addition, where the plan provides inaccurate network status information to a patient, the plan shall reimburse the provider for the out-of-network services regardless of whether the patient's coverage includes out-of-network services. The dentist cannot suffer a financial loss under this regulation. Even where the dentist refunds excess money paid to the patient, the insurer must then pay the dentist the sum refunded in accordance with the prompt claims payment rules of the New York State Insurance Law.

There is a distinction between comprehensive health insurance plans and stand-alone dental plans on improper provider directory information. For stand-alone dental plans, they must provide network status information to a patient in writing

through print or electronic means, if the patient consents to electronic communication, within three business days of the patient requesting the information by telephone or through electronic means, if available. For comprehensive health insurance plans, the deadline is just one business day.

The new regulation defines what providing improper provider directory information means. It is where: 1) the plan represents in the provider directory posted on its website that a non-participating provider is participating in the plan's network; 2) the plan provides information, upon a patient's request made by telephone or through electronic means, if available, that a non-participating provider is participating in the plan's network; 3) the plan fails to provide information in writing through print or electronic means, if the patient consents to electronic communication, regarding a specific provider's participating status within the timeframes established in the regulation; or 4) the plan represents in the hard copy provider directory that a provider is participating in the plan's network and the provider is non-participating as of the date of publication of the hard copy provider directory.

It should be noted that insurers had argued that this burden of providing accurate directory information should be placed on the healthcare provider, but DFS declined to do so, stating that it regulated insurers and not healthcare providers. The plan must include in its hard copy provider directory a notification that the information contained in the directory was accurate as of the date of publication and that a patient should consult the provider directory posted on the plan's website to obtain the most current provider directory information.

There is also a distinction between comprehensive health insurance plans and stand-alone dental plans on the effective date of the provider directory part of the new regulations. For stand-alone dental plans, the provider directory regulations apply to policies that are issued, renewed, modified or amended on or after one year after the effective date of the regulations—which means the regulations go into effect on Dec. 7, 2023. For comprehensive health insurance policies, the provider directory regulations apply to policies that are issued, renewed, modified or amended on or after Dec. 7, 2022. Part of the reasons for the discrepancy in the effective dates is that stand-alone dental plans have a lot of catching up to do in comparison to comprehensive health insurance plans.

Not Done Yet

A busy end to 2022—and the governor is not done. As of Dec. 12, not all bills had even been delivered to her for action. However, nothing directly involving dentistry remains, although there are still some employment law matters to be decided, particularly a statewide pay transparency law similar to the one that took effect in New York City on Nov. 1, and the wrongful death reform bill that would greatly expand liability for wrongful death.

Required Disclosures

As of Dec. 7, 2023, all stand-alone insurance plans must abide by the following regulations.

(1) a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(2) a description of all prior authorization or other requirements for treatments and services;

(3) a description of utilization review policies and procedures, used by the insurer, including:

- (A) the circumstances under which utilization review will be undertaken;
- (B) the toll-free telephone number of the utilization review agent;
- (C) the time frames under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;
- (D) the right to reconsideration;
- (E) the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;
- (F) the right to designate a representative;
- (G) a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision;
- (H) a notice of the right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this chapter, of the external appeal process established pursuant to title two of article forty-nine of this chapter and the time frames for such appeals; and
- (I) further appeal rights, if any;

(4) a description prepared annually of the types of methodologies the insurer uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between an insurer and a health care provider;

(5) an explanation of an insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatments or services;

(6) an explanation, where applicable, of an insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network of providers or by any provider without required authorization, or when a procedure, treatment or service is not a covered benefit;

(7) where applicable, a description of procedures for insureds to select and access the insurer's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(8) where applicable, a description of the procedures for changing primary and specialty care providers within the insurer's network of providers;

(9) a description of how the insurer addresses the needs of non-English speaking insureds;

(10) notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization;

(A) where applicable, notice that an insured shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy;

(11) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, telephone number, and digital contact information of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

(12) a description of the method by which an insured may submit a claim for health care services;

(13) with respect to out-of-network coverage:

(A) a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(B) the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(14) information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services;

(15) provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, and members of the insurer;

(16) provide a copy of the most recent annual certified financial statement of the insurer, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(17) provide information relating to consumer complaints compiled pursuant to section two hundred ten of this chapter;

(18) provide the procedures for protecting the confidentiality of medical records and other insured information;

(19) provide a written description of the organizational arrangements and ongoing procedures of the insurer's quality assurance program, if any;

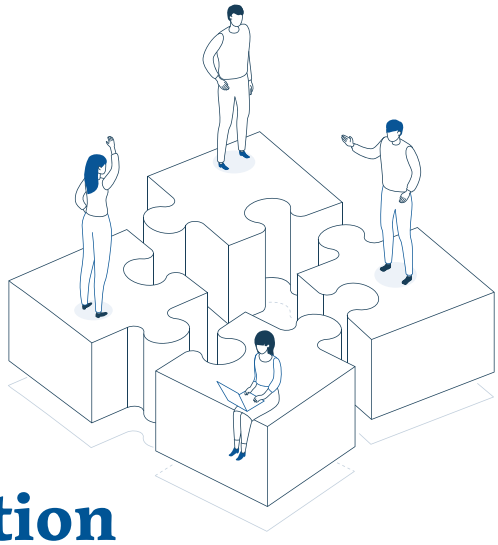
(20) provide a description of the procedures followed by the insurer in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(21) upon written request, provide specific written clinical review criteria relating to a particular condition or disease including clinical review criteria relating to a step therapy protocol override determination pursuant to subsection (c-1), subsection (c-2) and subsection (c-3) of section forty-nine hundred three of this chapter, and, where appropriate, other clinical information which the insurer might consider in its utilization review and the insurer may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the insurer, the insured or prospective insured shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the organization. Such clinical review criteria, and other clinical information shall also be made available to a health care professional as defined in subsection (f) of section forty-nine hundred of this chapter, on behalf of an insured and upon written request;

(22) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the insurer for participation in the insurer's network for a managed care product;

(23) disclose whether a health care provider scheduled to provide a health care service is an in-network provider; and

(24) with respect to out-of-network coverage, disclose the approximate dollar amount that the insurer will pay for a specific out-of-network health care service. The insurer shall also inform the insured through such disclosure that such approximation is not binding on the insurer and that the approximate dollar amount that the insurer will pay for a specific out-of-network health care service may change.



Comparing Design Thinking and Operations Management in Dental Education

There are different ways of solving problems. Two methods are design thinking and operations management. An overview of each of these methods and description of how they might be useful in dentistry and dental education is presented.

Ellen Lee, D.D.S.; Brian Chin, M.B.A.; Ningshu Lyu; Yueqi Gao; Yutong Fan; Bryan Gu; Kevin Kim

Design thinking and operations management are two different methods of solving problems. Design thinking is listening to everyone involved and then developing a solution to the problem. Operations management involves breaking a problem into steps and then determining how to maximize the efficiency of each step to solve the problem.

Design thinking was originally used for architecture and engineering[1] and is now used in healthcare and medical education. Operations management originally was used by businesses to increase their profits by looking at each step involved in production.[2] It employs quantitative methods to evaluate problems and find solutions. This process can be applied to dentistry.

Discussion

Design thinking is a way of problem-solving that can be used to find solutions to complex problems. It involves everyone in the process. The process of design thinking uses empathy, defining the problem, ideating or brainstorming, prototype development and testing. It is a human-centric approach to a problem.[3] This can be a continuous process so that a solution can be found for the problem that involves many stakeholders.

Design thinking uses empathy to fully understand a problem so that a better solution can be obtained.[4] Empathy involves understanding the needs of all of the people involved with a problem.

Design thinking involves hearing all sides of a problem. In this way, the problem that needs solving can be better identified. Define is the next step after the problem is understood. The right problem needs to be stated so that there will be a solution corresponding to the problem. Define involves expressing a statement of the problem. This is a clarification of what the problem is. Brainstorm or ideate is the phase when all possible solutions are discussed. This is before actually evaluating which solutions are the best. Multiple solutions can be proposed for the problem. Prototype is the development of possible solutions. This is where the determination of which solutions will actually be beneficial is made. After this is done, it may be necessary to go back to the brainstorming or ideate phase. The process of developing solutions and testing may need to be repeated many times.

Prototype is testing some solutions to see which ones will and will not work. The final stage is testing the best solutions. Test is when all stakeholders offer feedback. This may also require several revisions to get the desired outcome.

The Whole Picture

Design thinking has been used by businesses to find solutions to challenging problems.[5] It is the process of looking at ways to invent and improve products and services by envisioning the problem as a whole and trying to take out any personal biases to solving a problem. This method also focuses on both product/service producer and user, trying to optimize benefits for both to bring out the full potential for the specific goods or services.[6]

Design thinking has been used in medical education[7] and also for health care.[8] Altman[8] reviewed studies where design thinking was used in different healthcare settings, including chronic obstructive pulmonary disease, diabetes, caregiver stress, post-traumatic stress disorder, nursing handoffs and drug-inter-

TABLE 1

Design Thinking	
Empathy	Human Centered, Qualitative
Define	Clarify the Problem
Ideate	Brainstorm all possible solutions
Prototype	Test some possible solutions
Test	Final Testing of Best Solutions

TABLE 2

Operations Management	
Customer Focused	
Quantitative Method	Test hypotheses in a quantitative way
Optimize all processes for maximum profit	Continuous improvement to eliminate waste

action alerts. They concluded that design thinking showed promise by having providers and patients involved, but that there were limitations and not all results were successful.[8] Many healthcare problems are complex and solutions are not always readily apparent. This is where design thinking can be used.

Design thinking is usually understood to be a creative and analytical process that gives people the chance to experiment, build and test models, get feedback, and rethink or redesign. Integrated dental and medical care is a newer approach to health care.[9] This is one area where the dental curriculum may need to be adjusted. Design thinking is one way to incorporate this new model of care delivery into the dental school education. Teaching the design-thinking process to students can help improve the experience of patients when the students become dentists. It can help in the clinical decision-making process for learners and practitioners.

Lower Costs, Better Access

Operations management is concerned with maximizing the efficiency of all processes in a business or organization. By evaluating all the steps involved in a business, waste can be eliminated and the company's profits may increase.[2] It uses quantitative methods to evaluate problems and find solutions.[10]

Healthcare costs are very high, and operations management techniques have been used to decrease cost and improve healthcare access. In dentistry, operations management can look at every step involved in patient management. This can be analyzed to see where costs could be controlled. In addition, bottlenecks in the delivery of patient care could be identified and rectified. Robinson[11] described using operations management techniques to improve the flow of patients at the dental school clinic in the University of Kentucky. As a result, this project reduced 25% of patients' average time spent at the clinic within 90 days, improved satisfaction by 21% and reduced negative comments by 24%.

Operations management can be used to improve the patient experience in health care.[12] Healthcare operations management involves all of the interactions of patients with their healthcare providers. Operations management techniques can be used to help control costs, which is a major challenge in dental education.[13] The best way to allocate resources can be guided by operations management. These techniques can be used to control the cost of educating dental students while ensuring they are well-equipped to deal with patients' problems. Students who learn operations management techniques can apply them to improve patient experiences in their future jobs.

Conclusion

Design thinking and operations management are two methods that can be used to solve problems in dentistry and dental education. Students who learn both methods will be able to incorporate these ideas in future jobs for the benefit of patients and themselves.

All authors have disclosed no relevant relationships. Queries about this article can be sent to Dr. Lee at el84@nyu.edu.

REFERENCES

1. Dam RF, Siang TY. The History of Design Thinking. https://www.interaction-design.org/literature/article/design-thinking-get-a-quick-overview-of-the-history. Accessed August 12 2022.
2. Hayes A. Operations Management (OM) Definition. 8/29/2021, https://www.investopedia.com/terms/o/operations-management.asp#:~:text=Operations%20management%20(OM)%20is%20the,the%20profit%20of%20an%20organization Accessed August 13 2022.
3. Plattner H. An introduction to design thinking: Process guide. Stanford, CA: Hasso Plattner Institute of Design at Stanford University.
4. Roberts JP, Fisher TR, Trowbridge MJ, et al. A design thinking framework for healthcare management and innovation. Healthcare 2016 Mar;4(1):11-14.
5. Han E. 5 Examples of Design Thinking in Business. Harvard Business School Online. https://online.hbs.edu/blog/post/what-is-design-thinking Accessed Sept 13 2022.
6. Linke R. Design Thinking, Explained. MIT Sloan, 14 Sept. 2017, https://mitsloan.mit.edu/ideas-made-to-matter/design-thinking-explained Accessed Sept 13 2022.
7. McLaughlin JE, Wolcott MD, Hubbard D, et al. A qualitative review of the design thinking framework in health professions education. BMC Medical Education 2019;19:98.
8. Altman M, Huang TTK, Breland JY. Design thinking in health care. Preventing Chronic Disease 2018 Sep27;15:E117.
9. MacNeil R, Hilario H. Input from practice: reshaping dental education or integrated patient care. Frontiers in Oral Health 2021;2:659030.
10. Mueller RM, Thoring K. Design Thinking Vs Lean Start Up: A Comparison of Two User Driven Innovation Strategies. 2012 International Design Management Research Conference.
11. Robinson FG, Cunningham LL, Turner SP, et al. Improving a dental school's clinic operations using lean process improvement. J Dent Educ 2016; 80(10):1170-1179.
12. Mahdavi M, Doshmangir L, Jaafaripooyan E. Rethinking health services operations to embrace the patient experience of the healthcare journey. The International Journal of Health Planning and Management. 2021;36(6): 2020–2029.
13. Formicola AJ, Bailit HL, Weintraub JA, et al. Advancing dental education in the 21st century: Phase 2 Report on Strategic Analysis and Recommendations. J Dent Educ 2018;82(10), eS1–eS32.

Ellen Lee, D.D.S., is a clinical assistant professor, Department of Cariology and Comprehensive Care, New York University College of Dentistry, New York, NY.

Brian Chin, M,B,A., New York University Stern School of Business, New York, NY.

Ningshu Lyu, Yueqi Gao, Yutong Fan, Bryan Gu and **Kevin Kim** are dental students at New York University College of Dentistry, New York, NY.

NYSDA Names Briana McNamee to Government Relations Post

BRIANA MCNAMEE, a government relations specialist, has joined the staff of the New York State Dental Association as director of governmental affairs. Ms. McNamee's appointment became official in December.

Ms. McNamee's previous government relations experience includes positions with the New York State School Boards Association and most recently, the 6,000-plus-member New York Library Association. She also does legislative and outreach work for the Athletic Brewing Co.

Earlier in her professional career, Ms. McNamee held staff positions with several representatives in the New York State Legislature.

Ms. McNamee received a bachelor of arts in political science frim the University at Albany and a master of business administration from the State University. She is a certified CrossFit trainer.

Ethics Council Announces Disciplinary Action

ON OCT. 27, 2022, the NYSDA Council on Ethics issued an order to suspend Dr. Catherine Boulos (License No. 045193) from membership for two (2) years, with said suspension completely stayed; and a two (2) year probation with six (6) hours of continuing education in ethics by the end of the probationary period.

After a full hearing on Oct. 7, 2022, the Council on Ethics found that Dr. Boulos had been disciplined for professional misconduct by the New York State Education Department Board of Regents and, as such, was in violation of Paragraph B of Section 20 Chapter X of the NYSDA Bylaws. Dr. Boulos did not appeal the council's decision within the requisite 30-day timeframe to the American Dental Association (ADA). The decision of the NYSDA Council on Ethics thereby became final and effective as of Nov. 26, 2022.

Santa's Helpers

NYSDA staff gave Santa a helping hand in 2022 by "adopting" two needy families through the Albany County Department of Social Services Adopt a Family program. Staff purchased items from gift lists provided by Social Services, then wrapped each item for delivery in time for Christmas.

In Memoriam

NEW YORK COUNTY
Robert Wolfe
New York University '63
411 Walnut Street, #9161
Green Cove Springs, FL 32043
October 28, 2022

THIRD DISTRICT
Allan Nahman
New York University '88
1021 Western Avenue
Albany, NY 12203
March 24, 2022

FIFTH DISTRICT
William Dallas
University at Buffalo '57
1200 Jewell Drive, #309
Watertown, NY 13601
December 21, 2022

Leonard Fishman
Temple University '56
2625 E. Lake Road
Skaneateles, NY 13152
November 20, 2022

SEVENTH DISTRICT
Ephraim Lewis
University of Pennsylvania '50
335 Nunda Boulevard
Rochester, NY 14610
November 4, 2022

EIGHTH DISTRICT
Pasquale Bochiechio
University at Buffalo '76
145 Belmont Avenue, #1
Buffalo, NY 14223
September 2, 2022

Michael Ferrick
University at Buffalo '65
8921 Veranda Way, #324
Sarasota, FL 34238
November 27, 2022

Albert Kielich
University at Buffalo '55
106 Bradfield Drive
East Amherst, NY 14051
July 27, 2022

Evaluating Repeat Dental Emergency Visits Related to Third-Molar Pathologies in Urgent Dental Care Center

Armando Uribe Rivera, D.D.S, M.S.; Linda Rasubala, D.D.S, Ph.D.; Gilbert H. Schulenberg, D.D.S.; Changyong Feng, Ph.D.; Hans Malmstrom, D.D.S.; Yan-Fang Ren, D.D.S, M.P.H., Ph.D.

ABSTRACT

Introduction: **Individuals with symptomatic third-molar pathologies frequently seek dental care at emergency departments or urgent dental care centers. This is becoming a public health problem when repeat dental emergency appointments are sought for treatment of symptomatic, contralateral wisdom teeth.**

Method: **We designed a retrospective review study of adults 18 years and older with an initial dental emergency visit related to third-molar pathology at a single dental urgent care center, at the University of Rochester.**

Conclusion: **Suboptimal oral health is a predictor for future emergency dental visits due to pathology of remaining third molars.**

Third-molar disorders, including loss of dental structure secondary to dental caries, pericoronitis and pain, to name a few conditions, are considered dental problems with high incidence in the young adult population.[1,2] Symptoms and comorbidities secondary to these non-traumatic dental emergency issues often require that patients be treated temporarily with pain medications, including opioid drugs, as well as antibiotics, antidepressants and anti-inflammatory analgesics until definitive treatment can be rendered later.[3]

Unfortunately, patients who present to emergency departments for non-traumatic dental emergencies frequently fail to keep subsequent definitive treatment appointments, leaving them prone to unexpected and/or repeat returns to urgent dental care centers or emergency departments.

Dental emergencies related to third-molar disorders are likely an underestimated public health issue. Moreover, it is important to highlight that there is a dearth of information in the dental and medical literature regarding third-molar-related emergencies and clinical outcomes in the U.S.[3]

The National Hospital Ambulatory Care Survey reported there were approximately 139 million emergency room visits in 2017 and of these, over 1.7 million (1.3%) were due to diseases of the teeth and supporting structures, resulting in a financial burden related to disability and sick days of billions of dollars.[3-5] Key factors to identify and evaluate at first urgent care dental visits related to third-molar abnormalities will provide patients with appropriate referrals, which could result in decreased numbers of return visits to urgent dental care centers or emergency departments. Therefore, our primary hypothesis is that adults with third-molar-related emergencies have significantly greater proportions of repeat dental emergency visits with the same diagnosis affecting contralateral third molars compared to adults with repeat dental emergency visits with different pathologies affecting opposite side third molars.

Our secondary hypotheses include: 1) "adults with lower third-molar abnormalities and repeat emergency dental visits have significantly earlier returns to dental emergency departments compared to adults with upper third-molar pathologies"; and 2)

"adults with third-molar pathologies and repeat emergency dental visits whose type of dental insurance did not change have significantly earlier returns to dental emergency departments compared to those whose type of dental insurance changed."

In addition, another research question to be addressed is: What characteristics in demographics, including age, gender and type of insurance, are associated with third-molar pathologies and repeat visits to dental emergency departments with the same diagnosis affecting the opposite side third molar?

Methods

Study Design

We fashioned a cross-sectional study of adults 18 years and older who had repeat emergency dental visits related to third-molar pathologies. Due to the retrospective nature of this study, it was granted an exemption for informed consent for this study, in writing, by the University of Rochester IRB (STUDY#00004780). Patients in the experimental group had third-molar pathologies and repeat dental emergency visits of the opposite third molar with the same diagnosis.

Data from these subjects were obtained within a seven-year period. The primary outcome variable was the proportion of repeated diagnoses of third-molar abnormalities in both visits at the Urgent Dental Care Department. Secondary outcome variables were the number of years between first and second urgent care visits, type of insurance and demographics, including age and gender. Subjects were grouped into two categories. Group 1 included those whose initial urgent dental care visit involved a pathology in the upper third molars. Group 2 included those whose initial urgent care dental visit involved an abnormality in the lower third molars.

Subject Selection

In collaboration with the Informatics Department at Eastman Institute for Oral Health (EIOH), we used Axium databases from patients at Howitt Urgent Dental Care Department EIOH at the University of Rochester. We analyzed the electronic dental records of males and females age 18 and older who met inclusion criteria, including: Axium diagnosis of irreversible pulpitis; periapical periodontitis; pericoronitis; necrosis of the pulp and impacted teeth related to upper and lower third molars, as recorded at the Urgent Dental Care Department. As a comparison group (controls) we selected patients who had the aforementioned Axium diagnosis and different third-molar pathologies from first to second urgent dental care visits.

Sample Size and Statistical Analysis

In collaboration with the Biostatistics Department at the Clinical and Translational Science Institute of the University of Rochester,

we performed pilot data analysis of 86 subjects for estimation of the confidence interval of the proportion of repeat third-molar diagnoses for first and second urgent dental care visits (primary hypothesis). It was determined that a sample size of 204 subjects produced a two-sided 95% confidence interval, with a width equal to 0.1 when the sample proportion was 0.860.

The analysis of the primary outcome variable, including the proportions of repeat dental emergency visits with the same third-molar diagnosis at the Urgent Dental Care Department involved a Pearson's chi-square test. The analysis of the secondary outcome variables included: 1) median of years between first and second urgent care visits in those grouped by upper and lower third-molar abnormalities; and 2) median of years between first and second urgent care visits in those grouped by change of insurance. These comparisons involved a Wilcoxon rank-sum test. For modeling the effect of age, gender and change of insurance on the repeated urgent dental care visits, with the same diagnosis in third molars, a logistic regression was used. All statistical analyses used a two-tail test at a significance level of <0.1.

TABLE 1.
Patient population grouped by affected third molar at initial dental urgent care visit. Demographics, including mean and standard deviation and proportions of type of gender. Third-molar diagnosis, including proportions of pulp and periapical lesions and other pathologies. Dental insurance, including proportions of patients with Medicaid, self-paid and private insurance. Change of dental insurance status, including proportions of those with no change in dental insurance, self-paid to insurance, insurance to self-paid, private insurance to Medicaid and Medicaid to private insurance.

N=274	Group 1	Group 2
Age	30(+8.72)	29(+8.12)
Gender		
Female(%)	75(27.4%)	81(29.6%)
Male(%)	56(20.4%)	62(22.6%)
Third Molar Diagnosis		
Pulp or Periapical lesion	115(42%)	82(30%)
*Other	16 (5.8%)	61(22.3%)
Dental Insurance		
Medicaid(%)	71(26%)	83(30.3%)
Self-paid(%)	46(16.8%)	43(15.7%)
Private(%)	14(5.10%)	17(6.2%)
Change of Dental Insurance Status		
No change	95(34.7%)	109(39.8%)
Self-Paid to Insurance	22(8%)	18(6.56%)
Insurance to Self-Paid	7(2.5%)	10(3.64%)
Private to Medicaid	2 (0.7%)	5(1.8%)
Medicaid to Private	1 (0.3%)	1(0.3%)

*Other. Pericoronitis, pain secondary to impacted third molars, chronic or acute periodontitis. Group 1.Upper Third Molar Pathologies 2. Lower Third Molar Pathologies.

TABLE 2.
Logistic regression to evaluate influence of patient's demographics, including age, gender and dental insurance on repeat dental urgent care visits related to third-molar pathologies.

ODDS RATIO ESTIMATES				
Effect	Point Estimate	95% Wald Confidence	Interval	P-value
Age	1.021	0.987	1.055	0.2301
Gender (Female)	1.464	0.805	2.664	0.212
Change Insurance	1.363	0.72	2.582	0.3415

Results

Demographics

Two hundred and seventy-four subjects were included in the analysis. Of these, 153 (56%) were females and 118 (43%) were males with median (range) age of 27 (16 to 73) years. One hundred-and ninety-seven patients (72%) had a diagnosis of pulp or periapical lesions in the affected third molar and 97 (35%) subjects had a diagnosis of other than pulp or periapical lesion pathologies, including pericoronitis, pain related to impacted third molar, and acute or chronic periodontitis.

One hundred and fifty-four (56.2%) patients had Medicaid dental insurance; 89 (32.5%) were uninsured patients; and 31 (11.3%) had private dental insurance. Most of the patients in this study did not change insurance status when comparing their first urgent dental care visit to their second visit [n=204 (74.5%)]. However, 40 (14.6%) subjects were uninsured at their first urgent dental care visit and had dental insurance at their second visit; 17 (6.2%) subjects had dental insurance at their first emergency dental visit and were uninsured at their second visit; 7 (2.5%) subjects had private dental insurance at their first emergency dental visit and had Medicaid dental insurance at their second visit. Demographic data broken down by groups are shown in Table 1.

Comparison of proportions of repeat dental emergency visits with same opposite side third-molar diagnosis to ones with different opposite third-molar pathologies

Among the 274 patients, when comparing the proportion of repeat dental emergency visits due to the same diagnosis in the opposite side third molar compared to the ones due to different pathology in the opposite side third molar, most of the repeat emergency dental visits involved the same diagnosis for both third molars (75.5%) versus those that involved different pathologies for both third molars (25.5%). Of note, this comparison was highly significant (p <0.0001) (Figure 1).

Comparison of earlier repeat dental emergency visits grouped by upper and lower third molars

Most repeat emergency dental visits were related to abnormalities

involving lower third molars (n=143) compared to those related to upper third molars (n=133). When comparing the times, in years, of repeat emergency dental visits, secondary to opposite side third molars, it was surprising that individuals with lower third molars returned sooner for an emergency dental visit at [median (range)] 0.46 (0.01 to 7.8) years, compared to 0.88 (0.01 to 7.5) years for those with upper third-molar abnormalities. This comparison was marginally significant (p 0.08) (Figure 2).

Comparison of earlier repeated dental emergency visits grouped by change of insurance status

Most of the subjects (n=204) did not change insurance at the repeated emergency dental visit. This was followed by those (n=40) who were uninsured at their first visit and had dental insurance at the time of the repeated emergency dental visit. Seventeen patients had dental insurance at their first visit and were uninsured at the repeated visit. Seven patients had private dental insurance at their first visit and had Medicaid dental insurance at their second emergency dental visit. Only two patients had changed dental insurance status, from Medicaid to private insurance, at the time of the repeated emergency dental visit.

When comparing the times in years of repeating an emergency dental visit secondary to opposite side third molars and dental insurance status, individuals with change of dental insurance repeated their emergency dental visits earlier at [median (range)] 0.47 (0.01 to 7.8) years compared to 0.80 (0.01 to 7.5) years, compared to those with no change of dental insurance. However, this comparison was not significantly different (p 0.42) (Figure 3).

Repeat emergency dental visits related to third-molar pathologies and characteristics in patient's demographics

The regression analysis results on the impact of characteristics of demographics on repeat emergency dental visits with the same diagnosis of opposite third molar showed that age, gender and change of insurance did not have a significant impact on this type of repeat emergency visits (Table 2).

Discussion

The primary intent of this study was to evaluate the proportion of patients who had repeat emergency dental visits with the same diagnosis in the opposite third molar compared to the one from the third molar at the first emergency visit. The findings in this study suggested that greater proportions of patients repeated their emergency dental visits related to third-molar pathologies with the same diagnosis in the opposite third molar when compared to patients with repeat emergency dental visits with different diagnoses in the opposite third molar. However, there is a dearth of scientific literature regarding repeat emergency visits and third-molar pathologies in dental urgent care centers. Most studies focus on dental emergencies in hospital settings. Several studies about dental care in

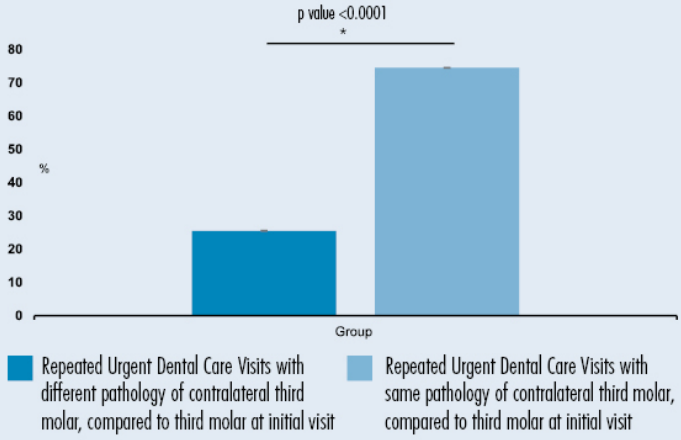


Figure 1. Graphic representation of patients grouped by same or different pathology in contralateral third molar compared to third molar, affected at initial visit. Y-axis represents proportions. Graph in light blue represents those with same pathology affecting contralateral third molar at second visit compared to third-molar pathology at initial visit. Graph in dark blue represents those with different pathology affecting contralateral third molar at second visit compared to third-molar pathology at initial visit.

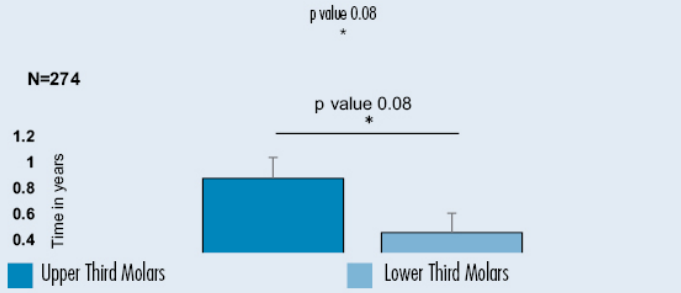


Figure 2. Graphic representation of patients in study grouped by third-molar location in oral cavity. Y-axis represents time in years when patients repeat dental urgent care visit. Dark blue graph represents those with upper third-molar pathologies. Light blue graph represents those with lower third-molar pathologies.

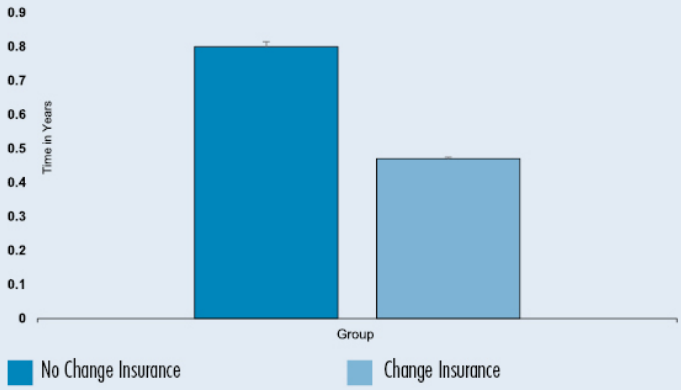


Figure 3. Graphic representation of patients whose dental insurance changed at repeat dental urgent care visit compared to dental insurance at initial visit. Y-axis represents time in years between initial and repeat visit at urgent care center. Dark blue graph represents those with no changes in dental insurance at second urgent care visit. Light blue graph represents those with changes in dental insurance at second urgent care visit.

hospital emergency departments suggested that of the over 10,000 visits in one year involving five hospitals in Minnesota, ~19% of the patients repeated visits for dental abnormalities.[6]

Other reports involving military medicine estimated that of 765 emergency dental visits at two expeditionary medical support facilities, ~35% involved abnormalities in third molars, including pain secondary to pericoronitis.[7] Different from our study, the former report did not record the cause of repeat dental visits related to third-molar pathologies. In addition, the latter study did not show the proportions of earlier repeat emergency dental visits related to third-molar pathologies. Unlike our study, this research aimed at other clinical outcomes.

Whether or not lower third molars are associated with more pathologies compared to upper third molars, there is a scarcity of scientific evidence regarding this topic. Our study showed that patients with lower third-molar abnormalities had significantly earlier repeat visits to urgent care departments than patients with upper third-molar abnormalities. The outcomes in this study on the trend in time to event, which was defined as when the onset of asymptomatic opposite side third molars became symptomatic, suggested that further research should focus on this topic. It is possible that we can address this question from a larger sample of patients with asymptomatic third molars becoming dental issues in the future.

Dental insurance is paramount when considering oral health status and repeat emergency dental visits.[8] In a previous study, Lee et al. reported that repeat emergency dental visits were more frequent among African-Americans between 18 and 44 years old, uninsured or with Medicaid insurance, when compared to private insurance holders or Medicare insurance patients and other races.[9] We suggested that patients who changed their dental insurance, disregarding Medicaid, private or to uninsured status, were associated with earlier, repeat third-molar emergency visits than those who did not change insurance status. However, this comparison was not significant and a larger sample size will provide more data on this topic.

In addition, it is important to highlight that most of our patient population has Medicaid insurance and this can be detrimental when considering emergency dental visits. For example, Choi et al. suggested that the probability for emergency dental visits within 12 months increased in those with Medicaid insurance, low-income and poor oral health.[10] Thus, we believe that dental insurance is one of the few elements that can indicate trends in third-molar-related repeated emergency visits.

There are several limitations to our study. Most of the patients who visited the Urgent Care Department at the University of Rochester were not regular patients of the Eastman Dental Center. We could not review dental appointment notes from outside Eastman Dental Center general practitioners, which could have influenced the oral health of these patients, specifically, third-molar status. This can create bias in the results of our study. However, as we mentioned above, future research on regular patients at Eastman Dental Center and Oral Surgery clinics should be focused to determine the time-to-event after the patients' first emergency third-molar visit, when the opposite third molar becomes symptomatic in a more controlled setting.

Other limitations of this study were that none of our study population received a comprehensive dental exam, which can predict high risk of oral diseases and related third-molar pathologies. Also: 1) the lack of information about the patient's compliance on follow-up visits when a referral to higher level of care for third molar extractions was provided; and 2) the bias created with third-molar diagnosis made from different dentists in the same patient at the second emergency dental visit.

Future studies should focus on determining the patient's major reasons for not following up with a higher level-of-care specialist; the impact of dental insurance on the dental treatment decision of the patients, which predisposes them to repeat emergency dental visits related to third-molar pathologies; and the impact of third-molar diagnosis made by a different dentist at the second dental visit on the emergency dental treatment.

In summary, a more comprehensive examination of the oral health of our patients with third-molar pathologies should be completed. This can be used to anticipate a second emergency visit for

the same diagnosis in the opposite third molar. Attention should be given to the third-molar site and type of dental insurance when the patient has a symptomatic third molar. These factors can possibly influence the patient's decision to treat the affected wisdom tooth at a scheduled appointment rather than in a walk-in visit.

More research should focus on time-to-event when one of the third molars becomes symptomatic on the opposite side for those considered regular patients in oral surgery or general practitioner practices.

The authors thank Mrs. Neha Naik, Axium specialist, and Drs. Camilo Leal-Escobar and Hashemi Mandana, residents at Eastman Institute for Oral Health, for their technical assistance with patient data retrieval, collection and management for this manuscript. Queries about this article can be sent to Dr. Rivera at aur@bu.edu.

REFERENCES

1. Patel S, Mansuri S, Shaikh F, Shah T. Impacted mandibular third molars: a retrospective study of 1198 cases to assess indications for surgical removal, and correlation with age, sex and type of Impaction—a single institutional experience. J Maxillofac Oral Surg 2017;16(1):79-84.
2. McCoy JM. Complications of retention: pathology associated with retained third molars. Atlas Oral Maxillofac Surg Clin North Am 2012;20(2):177-95.
3. Sun BC, Chi DL, Schwarz E, Milgrom P, Yagapen A, Malveau S, et al. Emergency department visits for nontraumatic dental problems: a mixed-methods study. Am J Public Health 2015;105(5):947-55.
4. Lewis CW, McKinney CM, Lee HH, Melbye ML, Rue TC. Visits to US emergency departments by 20- to 29-year-olds with toothache during 2001-2010. J Am Dent Assoc 2015;146(5):295-302 e2.
5. Niska R, Bhuiya F, Xu J. National Hospital Ambulatory Medical Care Survey: 2007 emergency department summary. Natl Health Stat Report 2010(26):1-31.
6. Davis EE, Deinard AS, Maiga EW. Doctor, my tooth hurts: the costs of incomplete dental care in the emergency room. J Public Health Dent 2010;70(3):205-10.
7. Dunn WJ, Langsten RE, Flores S, Fandell JE. Dental emergency rates at two expeditionary medical support facilities supporting operations enduring and Iraqi Freedom. Mil Med 2004;169(7):510-4.
8. Zivkovic N, Aldossri M, Gomaa N, Farmer JW, Singhal S, Quinonez C, et al. Providing dental insurance can positively impact oral health outcomes in Ontario. BMC Health Serv Res 2020;20(1):124.
9. Lee HH, Lewis CW, Saltzman B, Starks H. Visiting the emergency department for dental problems: trends in utilization, 2001 to 2008. Am J Public Health 2012;102(11):e77-83.
10. Choi MK. The impact of Medicaid insurance coverage on dental service use. J Health Econ 2011;30(5):1020-31.

Armando Uribe Rivera, D.D.S, M.S., is a clinical assistant professor at Boston University OMFS.

Linda Rasubala, D.D.S, Ph.D., is associate professor, Eastman Institute for Oral Health, Howitt Urgent Dental Care Department, University of Rochester, School of Medicine and Dentistry, Rochester, NY.

Gilbert H. Schulenberg, D.D.S., is in the private practice of oral and maxillofacial surgery.

Changyong Feng, Ph.D., is professor, Department of Biostatistics and Computational Biology, Department of Anesthesiology, University of Rochester, School of Medicine and Dentistry, Rochester, NY.

Hans Malmstrom, D.D.S., is professor, Eastman Institute for Oral Health, and director, General Dentistry Department, University of Rochester, School of Medicine and Dentistry, Rochester, NY.

Yan-Fang Ren, D.D.S, M.P.H., Ph.D., is professor, Eastman Institute for Oral Health, and director, Howitt Urgent Dental Care Department, University of Rochester, School of Medicine and Dentistry, Rochester, NY.

Cultural Gingival Tattoo Diagnosis and Origins

A Case Report

Austin J. Shackelford, D.M.D.; Carleigh R. Canterbury, D.D.S.; Scott M. Peters, D.D.S.

ABSTRACT

Background: **Cultural gingival tattooing is the practice of placing pigmented material into the maxillary anterior gingiva as a means of aesthetic enhancement, medicinal therapy or assimilation in some African and Middle Eastern nations.**

Case Description: **This is a report of a 47-year-old female from Senegal who presented with cultural gingival tattooing for cosmetic purposes. The patient's maxillary facial gingiva displayed a gradient of blue-gray-black pigment that extended from the right maxillary second molar to the left maxillary second molar.**

Clinical Relevance: **There are many systemic and local causes of pigmentation in the oral cavity, many of which require laboratory testing or biopsy for definitive diagnosis and resultant appropriate therapy. In contrast, cultural gingival tattooing is a clinically recognizable entity in the context of an appropriate patient history. While this entity is clinically diagnostic, it can pose a hurdle in routine oral cancer screening, as it has the potential to obscure other pathoses.**

Case Report

A 47-year-old Senegalese female of Wolof descent presented to our institution for a comprehensive examination. The patient denied any oral or odontogenic pain. She reported a non-contributory medical history and had no prescribed medications. The patient also denied the use of tobacco products, alcohol or illicit drugs. Extraoral examination was unremarkable, with no evidence of facial asymmetry, swelling, trismus or lymphadenopathy. Intraoral examination revealed a diffuse, blue-gray-black pigmentation on the maxillary facial gingiva extending from the right maxillary second molar to the left maxillary second molar (Figure 1).

The pigmentation was predominantly present in a gradient, such that the darkest blue-black areas appeared superiorly along the alveolar mucosa and mucogingival junction, while inferiorly, the free gingival margin lacked obvious pigmentation. Physiologic pigmentation was also noted on intraoral exam and seen scattered throughout the oral mucosa inclusive of areas involved by the blue-black pigmentation previously described. The remaining hard and soft tissues were within normal limits.

Upon inquiry, the patient reported that she had undergone multiple sessions of gingival tattooing for aesthetic purposes in her home country of Senegal. Her last session of tattooing had taken place approximately 20 years prior. The patient remarked that she would like to have the tattoo reinforced with new pigment to cover the areas that now appeared faded.

Discussion

Cultural gingival tattooing is the practice of impregnating pigmented material into the maxillary facial gingiva. The tattooing is

a practice that originates primarily in the Sahel region of Africa, extending from Senegal in the West to Sudan in the East.[1] There are approximately eight Western African ethnic groups that practice cultural tattooing, including Wolof, Serer, Diola, Mandinka, Fulani Laobe, Kanuri and Soninke, which are primarily located within the countries of Senegal, Mauritia, Guinea-Bissau, Nigeria, Niger, Chad and Mali.[2] While a majority of cases have been studied in these Western groups, there have been reports of the practice in Eastern Africa, namely, the Eritrean ethnic group, and into the Middle East as well.[2,3]

A majority of gingival tattooing in these ethnic groups are performed on preteen and teenaged females in their first and second decades of life. Of note, there are reports of males participating in tattooing, but to a lesser degree and limiting the pigment to the gingiva adjacent to the maxillary right and left canines. [3-6]

Up to 80% of women who participate in the tattooing ritual will repeat the procedure at least once, while 20% will undergo the procedure three times or more in their lifetime.[3,7]

Bukar et al. found that 97.7% of women with gingival tattoos had them done before marriage.[8] Previous authors have also shown that the hue and pigment intensity of the tattoo acts as a surrogate marker of the age of the tattoo. Gbane et al. analyzed a cohort of 52 women with gingival tattoos in the Ivory Coast and determined that tattoos with a primarily bluish hue were likely less than a year old; those with a gray-blue color were present from one to three years; primarily gray was indicative of three to six years old; and tattoos with a gray-to-pink transition were likely more than six years old.[9,10]

There are a variety of reasons for cultural gingival tattooing, including aesthetics, assimilation and homeopathic remedies for dental disease and pain management.[2-4,6,11-13] The most reported reason for women to partake in gingival tattooing is aesthetics.[2-4,6,11,14] The ethnic groups participating in the tattooing believe that the natural pink-to-red color of the gingiva represents an unhealthy appearance, thus, the blue-black pigment used helps to conceal the physiologic color.[3] Furthermore, the dark tattoo pigment also provides color contrast with the teeth, making them appear whiter, which is also considered a desirable characteristic.[2,14]

The importance of the aesthetic effect of pigmentation on the gingiva extends beyond the life of the teeth. Tinklepaugh and Norton reported a case of a Senegalese woman who had the acrylic gingival component of her partial denture fabricated with dark pigment to match her pre-existing gingival tattoo, thus, keeping the continuity of color between the tattooed gingiva and the prosthesis.[1]

A case of gingival tattooing performed as a means of cultural assimilation has also been reported in the literature. Hohenleutner and Landthaler reported a 26-year-old Caucasian female who underwent cultural gingival tattooing after moving to Sen-

Figure 1. Diffuse, blue-gray-black pigmentation on the maxillary facial gingiva extending symmetrically from right second molar to left second molar. Pigmentation transitions from blue-black superiorly to blue-gray inferiorly. Blue-gray pigment transitions to normal pink hue at marginal gingiva. Physiologic (racial) pigmentation is scattered throughout oral mucosa, including tattooed portions of the gingiva. (A) Anterior view along with view of patient's (B) left maxillary gingiva and view of patient's (C) right maxillary gingiva.

egal to live with her Senegalese husband, where the tattooing was performed for beautification or as a tribal mark. The marriage did not last and the tattoo was later removed via laser therapy.[12]

Gingival tattooing has also been employed as a therapeutic agent, believed to achieve healing of the gingiva and dental tissues.[2,3,6,11,13,15] Brooks et al. reported a patient who used gingival tattooing in an attempt to alleviate dental pain in the anterior maxillary region.[3] Although unsuccessful in alleviating the pain, the patient opted for extension of the tattoo posteriorly as they believed this would reduce the chance of the pain spreading. Gingival tattooing has also been reported to having been performed in patients not experiencing pain but, rather, seeking improved overall health of the gingiva and to reduce generalized gingival bleeding.[2]

The socioeconomic significance of gingival tattooing remains unclear and may vary by region. Telang and Ditre found that gingival tattooing was not considered indicative of socioeconomic status by their Ethiopian subject.[6] In contrast, Gaye et al. studied members of the Wolof people in Senegal and determined that gingival tattooing was a sign of elegance, nobility and beauty, attributes often associated with higher socioeconomic status in Western culture.[14]

There are a wide variety of instruments and materials used in the practice of gingival tattooing. Sharp instruments are required to deliver the pigment beneath the epithelium and into the underlying connective tissue. The most commonly reported natural instruments used are the thorns from *Balanites aegyptiaca*, also known as the desert date tree.[3,8] On the other end of the spectrum, patients report having the tattooing done in a dental office with sterile needles.[2,6]

The source of the pigment used in the practice of gingival tattooing also varies and includes powder from the plants *Durata stramonium, Julgans regia, Acacia nilotica*, generalized burnt plant material, khol powder, charcoal, and soot from a lantern or clay.[2,3,5,6,8,12,13] Patients report having the pigment placed on the gingiva, then, without the use of anesthesia, having the sharp instrument(s) pierce the tissue and implant the pigment.[8] The procedure is most often performed in a home setting, but is sometimes done by a medical professional in a sterile setting.[2]

Although there are many histopathologic entities that can cause pigmentation of the gingiva, the characteristic pattern and symmetric distribution of the pigment seen in cultural tattooing is typically clinically diagnostic. In addition to the characteristic appearance, most patients upon interviewing will acknowledge the practice of gingival tattooing, further confirming that the pigmentation of the gingiva is an intentional process. In this context, biopsy is not indicated unless the clinician detects other pathology of concern that happens to occur within the tattooed region. In fact, the clinician should closely evaluate and even photograph the region of tattooing for close comparison during routine oral cancer screenings, as the tattooed region has the potential to obscure subtle pathology of the gingiva.

To this point, while rare, the maxillary gingiva does represent a high-risk site for mucosal melanoma, which can initially present as an asymptomatic, flat, variably pigmented lesion. Should the clinician detect any significant changes to the tattooed region outside that of typical aging, a biopsy would be indicated. If a biopsy were to be taken of a cultural gingival tattoo, it would demonstrate dark granules in the connective tissue and, in some cases, a foreign-body inflammatory response.[3] This biopsy finding is in stark contrast to that of melanoma, which would show atypical melanocytes with cellular pleomorphism, hyperchromatic nuclei, and prominent nucleoli within the epithelium above the epithelial-connective-tissue junction and also invading into the underlying connective tissue.[16]

In the circumstance that the patient does not disclose a history of intentional tattooing, physiologic (racial) pigmentation is another consideration on the differential diagnosis. Physiologic pigmentation is most commonly found on the gingiva, but also can be found anywhere in the oral cavity and often presents in a diffuse pattern.[17] Areas of physiologic pigmentation can and frequently will be interspersed within an oral tattoo, as was the case with our patient (Figure 1). Similar to cultural gingival tattooing, physiologic pigmentation classically presents in a clinically identifiable pattern and does not require biopsy. However, in cases that appear atypical, or should the patient desire removal of an area of pigment, a biopsy may be performed. A biopsy of physiologic pigmentation will demonstrate an increase in melanin pigment in the absence of an increased number of melanocytes.

Other considerations on the differential in the absence of clinical history or in the presence of an atypical appearance of a gingival tattoo include melanoacanthoma and smoker's melanosis. Melanoacanthoma (melanoacanthosis) is considered a benign reactive lesion that demonstrates dendritic melanocytes dispersed throughout the epithelium.[10] Smoker's melanosis is another benign inflammatory condition that can appear similar to a cultural gingival tattoo. It is most commonly seen on the labial gingiva and is more common in females, though a lack of smoking history would easily negate this diagnosis as a possibility.[18] Biopsy is not usually indicated when correlated with the patient's social behavior, but if performed, would resemble physiologic pigmentation.[18]

Conclusion

Cultural gingival tattooing is the practice of impregnating a variety of natural dyes into the maxillary gingiva, and is primarily performed on women of Africa's Sahel region for aesthetics and healing. Cultural gingival tattooing should be considered in the differential diagnosis in the presence of a diffuse, symmetric and uniform pattern of pigment present on the maxillary facial gin-

giva. This entity may be clinically diagnosed when correlated with patient history, thus saving the patient from unnecessary biopsy in many cases. However, the clinician should be cognizant and diligently assess for the possibility of a concurrent lesion within the area of the tattoo, as this may pose a hurdle in the early detection of a precancerous or cancerous lesion histologically.

The authors have declared no conflicts of interest. Nor have they received any commercial funding. Queries about this article can be sent to Dr. Shackelford at austinshackelford@atsu.edu.

REFERENCES

1. Tinklepaugh AJ, Norton SA. Traditional gingival tattooing of maxillary denture. Arch Dermatol 2011;147(11):1334-1335.
2. Rawal SY, Burrell R, Hamidi CS, Kalmar JR, Tatakis DN. Diffuse pigmentation of maxillary attached gingiva: four cases of the cultural practice of gingival tattoo. J Periodontol 2007;78(1):170-176.
3. Brooks JK, Reynolds MA. Ethnobotanical tattooing of the gingiva: literature review and report of a case. J Am Dent Assoc 2007;138(8):1097-1101.
4. Goertz J, Goos M. Traditional tattooing of the gingiva: an Eritrean folk medicine practice. Arch Dermatol 1988;124(7):1018-1019.
5. Scully C, Hegarty A. Prevention of oral mucosal disease. The Prevention of Oral Disease 2003;167.
6. Telang GH, Ditre CM. Blue gingiva:an unusual oral pigmentation resulting from gingival tattoo. J Am Acad Dermatol 1994;30(1):125-6.
7. Al-Shawaf M, Ruprecht A, Gerard P, Al-Abed A. Gingival tattoo:an unusual gingival pigmentation—report of four cases. J Oral Med 1986;41(2):130-3.
8. Bukar A, Danfillo IS, Adeleke OA, Ogunbodede EO. Traditional oral health practices among Kanuri women of Borno State, Nigeria. Odontostomatol Trop 2004;27(107):25-31.
9. Gbane M, Assoumou M, Abouattier-Mansilla E. A clinical study of gingival tattooing (in French). Odontostomatol Trop 1998;21:28-32.
10. Neville BW, Damm DD, Allen CM, Chi AC. J Oral Maxillofac Pathol 2015. Elsevier Health Sciences. 282-283.
11. Chauhan NS, Shanthi G, Singh V, Shrivastav A, Khare S. Cultural practices involving teeth and orofacial soft tissues–a review. J Indian Assoc Pub Health Dent 2011; (18 SUPPL III): 984.
12. Hohenleutner U, Landthaler M. Traditional tattooing of the gingiva: successful treatment with the argon laser. Arch Dermatol 1990;126(4):547-547.
13. Ashri N, Gazi M. More unusual pigmentations of the gingiva. Oral Surg Oral Med Oral Pathol Oral Radiol 1990;70(4):445-449.
14. Gaye F, Kane AW, Ndoye/Diop A, Mbaye M. Orodental esthetics in the traditional setting in Senegal (in French). Odontostomatol Trop 1995;18:19-22.
15. Fongnzossie EF, Tize Z, Nde PF, Biyegue CN, Ntsama IB, Dibong SD, Nkongmeneck BA. Ethnobotany and pharmacognostic perspective of plant species used as traditional cosmetics and cosmeceuticals among the Gbaya ethnic group in Eastern Cameroon. S Afr J Bot 2017;112:29-39.
16. Woo SB. Oral Pathology E-Book: A Comprehensive Atlas and Text 2016. Elsevier Health Sciences.
17. Eisen D. Disorders of pigmentation in the oral cavity. Clin Dermatol 2000; 18(5):579-587.
18. Müller S. Melanin associated pigmented lesions of the oral mucosa: presentation, differential diagnosis, and treatment. Dermatol Ther 2010; 23(3):220-229.

Austin J. Shackelford, D.M.D., is an oral and maxillofacial pathology assistant professor, Arizona School of Dentistry & Oral Health, Mesa, AZ.

Carleigh R. Canterbury, D.D.S., is an oral and maxillofacial pathology assistant professor, Arizona School of Dentistry & Oral Health, Mesa, AZ.

Scott M. Peters, D.D.S., is oral and maxillofacial pathology assistant professor, Columbia University College of Dental Medicine, New York, NY.

Read, Learn and Earn
CE
CONTINUING EDUCATION

Diagnosis and Management of Nasopalatine Duct Cyst

A Report of Two Cases and Literature Review

Feiyi Sun, D.D.S.; Harry Dym, D.D.S.

ABSTRACT

The nasopalatine duct cyst (NPDC) is one of the most common non-odontogenic, non-neoplastic developmental cysts. It arises from the epithelial remnants of the nasopalatine duct within the incisive canal and crosses the midline of the anterior maxilla. Most cases are asymptomatic and are discovered either by chance on radiographs or present as a soft-tissue swelling, with pain or drainage in the palate. The present study describes the diagnosis and surgical management of two NPDC cases seen at the Department of Oral and Maxillofacial Surgery at the Brooklyn Hospital Center.

The incisive canal is a funnel-shaped, narrow, bony structure that connects the nasal and oral cavities. The canal starts superiorly at each side of the nasal septum, extends inferiorly and ends palatally to the two maxillary central incisors underneath the incisive papilla. The incisive canal commonly takes form as either a "Y" or "V" shape, given its bilateral termination superiorly at the base of the nasal septum, known as the foramina of Stenson, and its single endpoint at the incisive foreman.[1,2] However, anatomic variances of the incisive canal have been reported, as the canal can exist as one single canal, two parallel canals or a "Y"-shaped canal with two or more nasal openings. The dimension of the canal is generally greater in males, and the length of the canal decreases with increasing age. The mean value of the length of the canal is approximately 11 mm.[3]

Neurovascular structures traveling through the incisive canal include the nasopalatine nerve, which provides the sensory input to the mucosa of the hard palate from the maxillary central incisors up to the maxillary canines bilaterally. This neurovascular bundle also gives vascular supplies to the same area via the anastomosis between the posterior septal branch of the sphenopalatine artery and the greater palatine artery.[4]

The traditional view on the formation of the incisive canal during embryogenesis is based upon a popular theory that the canal is the central point of fusion between the primary and secondary palates. It represents a rare form of a cleft palate.[5] However, Radlanski et al. reported that the incisive canal develops solely from the primary palate within the premaxilla, and the associated neurovascular structures are derived from the mesenchymal tissue.[6]

One should not confuse the incisive canal with the nasopalatine duct, as the duct is one of the major components inside the incisive canal aside from the neurovascular bundle. In most mammals, the nasopalatine duct serves to facilitate the passage of pheromones between the oral and nasal cavities. The duct terminates near the vomeronasal organ in the nasal cavity to transmit

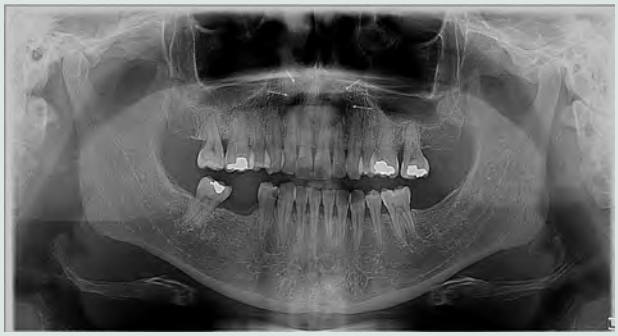


Figure 1. Panoramic X-ray of Patient One showing well-defined, unilocular, radiolucent lesion at anterior maxilla indicated by white arrows.

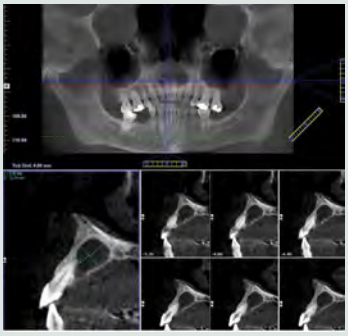


Figure 2. Cone beam CT of Patient One showing ovoid-shaped, unilocular cyst at anterior maxilla with perforated palatal cortex. 2D dimension of cyst on this cut measures around 9.9 mm x 12.2 mm.

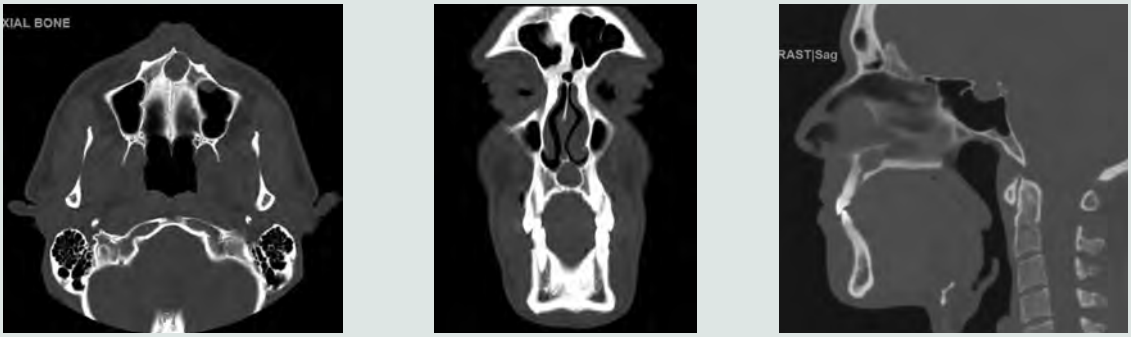


Figure 3. CT maxillofacial axial, coronal, sagittal view of Patient Two. Well-circumscribed, ovoid radiolucent lesion within anterior maxilla with thin sclerotic border measuring approximately 1.6 cm x 1.4 cm x 1.3 cm was appreciated.

neural signal to the central nervous system. In humans, the nasopalatine duct can be blocked following birth. The duct, however, can remain patent at times to maintain communication between the oral and nasal cavities. The vestigial form of the nasopalatine duct can lead to the development of a NPDC in the anterior maxilla.[7,8,9]

NPDC was first described by Meyer in 1914 and was believed to arise from epithelial remnants of the nasopalatine duct. The lesion shares other names, such as anterior midline cyst, maxillary midline cyst, anterior middle palatine cyst and incisive duct cyst. According to the classification of the World Health Organization (WHO), NPDC is regarded as a developmental, epithelial, non-neoplastic and non-odontogenic cyst occurring in about 1% of the population.[10] It is one of the most common non-odontogenic cysts that occur in the anterior maxilla. Radiographically, it may appear as a well-demarcated, heart-shaped, unilocular radiolucency apical to the roots of maxillary central and lateral incisors.

Clinically, patients are often asymptomatic but may sometimes present with a soft-tissue elevation at the anterior palate.[11] It is usually discovered during a routine dental examination and can be confused with periapical lesions of dental origin. Patients presenting with NPDC can be incorrectly treated with endodontic therapy of the maxillary anterior teeth. Misdiagnosis of NPDC is not uncommon due to its anatomic location near the apices of the maxillary anterior teeth. Therefore, it is important to recognize NPDC and avoid giving the wrong treatment to patients who may have healthy maxillary anterior teeth.

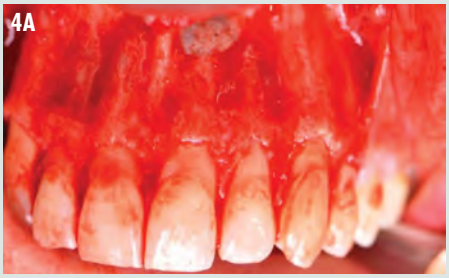
This study reports two cases of NPDC that were diagnosed and treated at the Department of Oral and Maxillofacial Surgery at the Brooklyn Hospital Center.

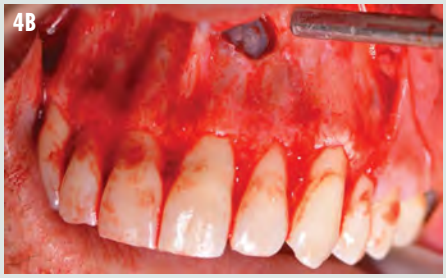
Case Reports

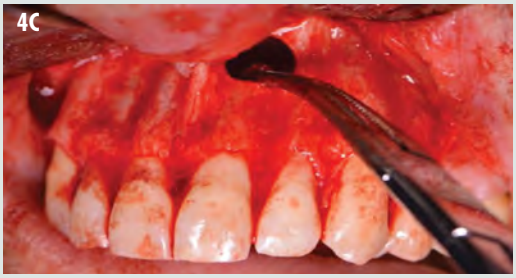
Patient One

The patient, a 34-year-old Hispanic female with no significant past medical history, presented to the dental clinic for a routine checkup. Clinically, the patient was asymptomatic, with vital anterior maxillary teeth. There was no facial or palatal vestibule swelling or depression at the anterior maxilla. On the panoramic X-ray, a well-demarcated, unilocular radiolucent lesion at the anterior maxilla extending from apex of tooth #7 to #10 was appreciated as an incidental finding (Figure 1). On the cone beam CT scan, the cystic lesion appears to be ovoid-shaped with thinning and perforation of the palatal cortex (Figure 2).

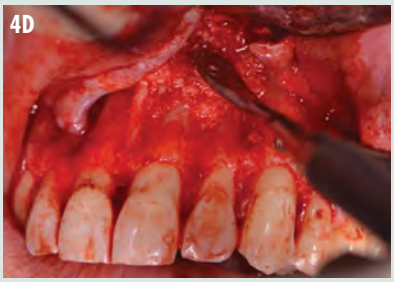
The patient was taken to the OR for enucleation and curettage of the cyst at the anterior maxilla. Access to the cystic lesion was gained from the palatal side due to the palatal perforation. A surgical handpiece was used to uncover the cyst to facilitate the removal of the cystic lining. A curette was used to completely enucleate the cyst. One cc of corticocancellous bone was placed into the cystic cavity and covered with platelet-rich fibrin membranes, which were fabricated using the patient's own blood. A

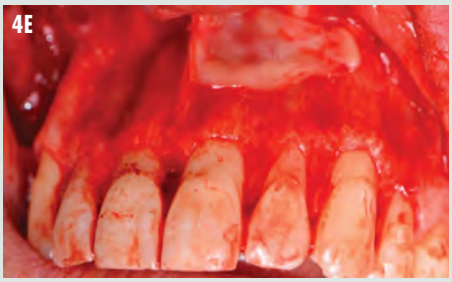


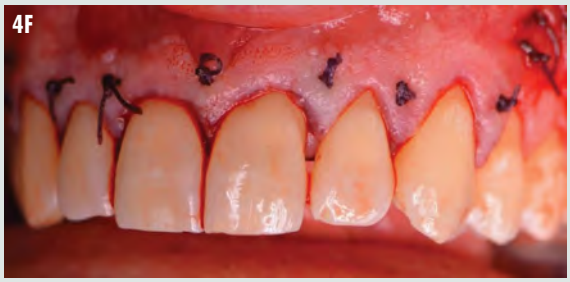




Figures 4A-F. Intraop pictures of Patient Two. A: Exposure of cyst after raising of full thickness buccal mucoperiosteal flap. B: Removal of thin cortical bone to expose cystic lining. C: Removal of entire cystic lining. D: Application of corticocanellous bone graft material. E: Placement of PRF membranes. F: Primary closure of surgical site.







primary closure was achieved at the surgical site using dissolvable 3-0 vicryl sutures.

On the follow-up appointment one week after the procedure, the patient denied any sensory changes, swelling or bleeding. The maxillary anterior teeth remained vital.

Patient Two

The patient is a 37-year-old Caucasian male with no significant past medical history referred by his previous general dentist for evaluation of a cyst at the anterior maxilla and possible root canal therapy of teeth #8 and #9. He reported a fall and trauma to the anterior maxilla around two years ago. The patient was clinically asymptomatic, with vital teeth #8 and #9, as well as the rest of the anterior maxillary teeth. There was no facial or palatal soft-tissue swelling or depression.

On the panoramic X-ray, it was difficult to appreciate a well-defined, radiolucent, unilocular lesion at the anterior maxilla. A CT maxillofacial without contrast was ordered to further evaluate the extent of the cyst, and a well-circumscribed ovoid radiolucent lesion within the anterior maxilla with a thin sclerotic border measuring approximately 1.6 cm x 1.4 cm x 1.3 cm was appreciated (Figure 3).

The patient was subsequently taken to the OR for enucleation and curettage of the cyst at the anterior maxilla. The access to the cystic cavity was made from the facial side due to the thinning of the buccal cortex (Figure 4). After careful removal of the cystic lining and a thorough curettage inside the cystic cavity, 1 cc of corticocancellous bone was placed, along with PRF membranes, on top. The surgical site was closed primarily using dissolvable 3-0 vicryl sutures.

The patient did not report any postoperative complaints on the follow-up appointment. However, teeth #8 and #9 were found non-vital following the surgery. A root canal therapy of the two teeth was recommended.

Histopathological Examination

Microscopic examination of Patient One revealed a benign cystic lining composed of flatten cuboidal (Figure 5a), whereas that of Patient Two revealed a benign cystic lining composed of squamous epithelium (Figure 5b). Both findings were consistent with nasopalatine duct cyst.

Discussion

The NPDC is one of the most common developmental, non-neoplastic and non-odontogenic cysts of the oral cavity, occurring in around 1% of the population. During fetal development, when bones of the anterior maxilla start to fuse and form the incisive canal, the nasopalatine duct, which communicates between the nasal cavity and anterior palate, starts to degenerate as well. In addition to the neurovascular bundle, which includes the nasopalatine nerve and vascular anastomosis from the posterior septal branch of the sphenopalatine artery and the greater palatine artery, the incisive canal also carries the degenerated epithelial remnants of the nasopalatine duct.

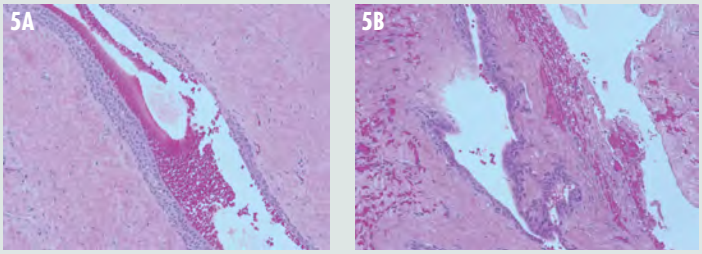
The stimulus for cyst formation from the remnants is unclear. Some believe that it may derive from spontaneous proliferation of embryonic tissue remains, while others believe causative factors lie in dentoalveolar trauma, local infection, ill-fitting denture, and genetic or racial predilection. Mucous glands within the epithelial lining have also been speculated for cyst formation due

to mucin secretion.[6,10,11] In our study, Patient Two reported a history of trauma to the anterior maxilla due to a fall.

In an analysis of 334 cases of NPDCs, Swanson et al. reported a mean age of 42.5 years, with no significant difference between the ages of males or females, and blacks or whites at time of diagnosis.[12] Most literature indicated that NPDCs have a slight male predilection while remaining equal in different races. Socioeconomic status can play an important role when reporting cases of NPDCs, as people who visit dentists regularly are more likely to be diagnosed and managed.[12]

NPDCs are usually clinically asymptomatic. Patients with the cyst might experience soft-tissue elevation and fluctuance at anterior palate. Associated pain, swelling and drainage may be reported. Paresthesia of the anterior palate can occur as a result of pressure on the nasopalatine nerve. Mobility and displacement of teeth are rare.[10]

Vitality and percussion tests of the anterior maxillary teeth should be performed to avoid unnecessary endodontic treatment. Radiographically, an ovoid-shaped, well-defined, unilocular radiolucency with a sclerotic boarder can be appreciated. Sometimes, a heart-shaped radiolucency can be seen as a result of superimposition of the anterior nasal spine.



Figures 5A-B. Histological slides of cystic lining from Patient One (A) and Patient Two (B).

A prominent incisive canal can often mimic the radiographic findings of a NPDC. Most literature supported that a NPDC should be considered when the radiolucent area is more than 6 mm of diameter at the midline of the anterior maxilla.[10,11] The clinical and radiographic findings of the two patients in this study were very consistent with the literature. Both patients were asymptomatic clinically with insignificant findings from the soft tissue and dentition. The radiographic findings for both patients revealed a unilocular, well-demarcated radiolucent lesion that is greater than 6 mm at the anterior maxilla.

A histopathological study of the cyst confirms the diagnosis of NPDC. The type of epithelial lining from the nasopalatine duct can be variable, depending on its relative proximity to the nasal and oral cavity. The superior part of the duct usually contains ciliary cylindrical cells that are consistent with nasal epithelium. The lining type

can switch to cuboidal epithelium as the duct travels inferiorly and eventually to squamous epithelium as it reaches the oral cavity.[10,13]

Abrams et al. reported that 82% of the 61 NPDCs were of squamous epithelium, followed by pseudostratified columnar and cuboidal.[14] However, it is also common that the epithelial lining has a combination of either stratified and pseudostratified squamous, transitional, columnar, cuboidal or ciliated columnar epithelium.[15] In this study, the cystic lining from Patient One was cuboidal epithelium, while that from Patient Two was squamous epithelium.

Differential diagnosis must be established before definitive treatment. Odontogenic cysts, such as radicular cyst, lateral periodontal cyst and odontogenic keratocyst (OKC), odontogenic tumor, such as ameloblastoma, and non-odontogenic tumors, such as central giant cell granuloma and central hemangioma, should be included as the differentials when tentatively diagnosing NPDCs based on clinical and radiographic presentations.[10,13] There have been reports of misdiagnosing OKC crossing the midline at the anterior maxilla as NPDC.[16] It is, therefore, critical for the clinician to include other lesions of the midline maxillary region in the differential diagnosis to help guide proper and timely management of the patients.[10]

The treatment of NPDCs involves enucleation and curettage of the cyst, although a few reports in the literature support marsupialization of large cysts. The recurrence rate of NPDC after proper surgical management is extremely low.[10,11] The neurovascular bundle within the incisive canal can cause profuse bleeding during surgery. Paresthesia of the anterior palate is also possible due to nasopalatine nerve injury during the procedure. There was no profuse bleeding or reported paresthesia for the two patients in this study. However, Patient Two's maxillary central incisors were tested non-vital in subsequent follow-ups. Platelet-rich fibrins were applied in both cases to accelerate wound healing and reduce postoperative pain and infection.[17]

Conclusion

NPDCs occur in 1% of the population, with a slight male predilection and no racial predilection. It is often seen in patients between 30 and 60 years of age. The clinical presentation of NPDCs can be asymptomatic or include pain, swelling and drainage from the anterior palate. A well-circumscribed, unilocular, ovoid- or heart-shaped radiolucent lesion crossing the midline of the anterior maxilla is appreciated on radiographs. Histopathological findings include squamous, cuboidal, columnar or respiratory cells, or a combination of these.

A correct diagnosis must be established to avoid improper treatment. NPDCs should be surgically managed with enucleation of curettage in a timely fashion to prevent complications, such as malignant transformation of the epithelial lining.

Queries about this article can be sent to Dr. Sun at fayesun1227@gmail.com.

REFERENCES

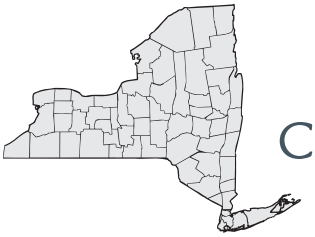
1. Lake S, Iwanaga J, Kikuta S, Oskouian, RJ, Loukas M, Tubbs RS. The incisive canal: a comprehensive review. Cureus 2018;10(7), e3069. https://doi.org/10.7759/cureus.3069.
2. Jacob S, Zelano B, Gungor A, Abbott D, Naclerio R, McClintock MK. Location and gross morphology of the nasopalatine duct in human adults. Arch Otolaryngol Head Neck Surg 2000;126(6):741-748. doi:10.1001/archotol.126.6.741.
3. Bornstein MM. Morphology of the nasopalatine canal and dental implant surgery: a radiographic analysis of 100 consecutive patients using limited cone-beam computed tomography. Clinical Oral Implants Research 2011;22(3):295-301. doi:10.1111/j.1600-0501.2010.02010.x.
4. Miwa Y, Asaumi R, Kawai T, et al. Morphological observation and CBCT of the bony canal structure of the groove and the location of blood vessels and nerves in the palatine of elderly human cadavers. Surg Radiol Anat 2018;40:199–206. https://doi.org/10.1007/s00276-017-1952-6.
5. Vâlcu M. The lateral incisive canals of the adult hard palate: aberrant anatomy of a minor form of clefting? Rom J Morphol Embryol 2011;52(3):947-949.
6. Radlanski RJ, Emmerich S, Renz H. Prenatal morphogenesis of the human incisive canal. Anat Embryol 2004;208:265–271.https://doi.org/10.1007/s00429-004-0389-y.
7. Shimp KL, Bhatnagar KP, Bonar CJ, Smith TD. Ontogeny of the nasopalatine duct in primates. Anat Rec A Discov Mol Cell Evol Biol 2003;274(1):862-869. doi:10.1002/ar.a.10101.
8. Jacob S, Zelano B, Gungor A, Abbott D, Naclerio R, McClintock MK. Location and gross morphology of the nasopalatine duct in human adults. Arch Otolaryngol Head Neck Surg 2000;126(6):741-748. doi:10.1001/archotol.126.6.741.
9. Falci SG, Verli FD, Consolaro A, Santos CR. Morphological characterization of the nasopalatine region in human fetuses and its association to pathologies. J Appl Oral Sci 2013;21(3):250-255. doi:10.1590/1679-775720130008.
10. Escoda Francolí J, Almendros Marqués N, Berini Aytés L, Gay Escoda C. Nasopalatine duct cyst: report of 22 cases and review of the literature. Med Oral Patol Oral Cir Bucal 2008;13(7):E438-E443. Published 2008 Jul 1.
11. Aldelaimi TN, Khalil AA. Diagnosis and surgical management of nasopalatine duct cysts. J Craniofac Surg 2012;23(5):e472-e474. doi:10.1097/SCS.0b013e318258764b.
12. Swanson KS. Nasopalatine duct cyst: an analysis of 334 cases. Journal Oral and Maxillofacial Surgery 1991;49(3):268-271. doi:10.1016/0278-2391(91)90217-a.
13. Shylaja S, Balaji K, Krishna A. Nasopalatine duct cyst: report of a case with review of literature. Indian J Otolaryngol Head Neck Surg 2013;65(4):385-388. doi:10.1007/s12070-011-0242-6.
14. Abrams AM, Howell FV, Bullock WK. Nasopalatine cysts. Oral Surg Oral Med Oral Pathol 1963;16:306-332. doi:10.1016/0030-4220(63)90295-0.
15. Gnanasekhar JD. Misdiagnosis and mismanagement of a nasopalatine duct cyst and its corrective therapy. A case report. Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology and Endodontics 1995;80(4):465-470. doi:10.1016/s1079-2104(05)80372-5.
16. Neville BW. Odontogenic keratocysts of the midline maxillary region. Journal of Oral and Maxillofacial Surgery 1997;55(4):340-344. doi:10.1016/s0278-2391(97)90121-x.
17. Munoz F, Jiménez C, Espinoza D, Vervelle A, Beugnet J, Haidar Z. Use of leukocyte and platelet-rich fibrin (L-PRF) in periodontally accelerated osteogenic orthodontics (PAOO): Clinical effects on edema and pain. J Clin Exp Dent 2016;8(2):e119-e124. Published 2016 Apr 1. doi:10.4317/jced.52760.

Dr. Sun

Dr. Dym

Feiyi Sun, D.D.S., is a resident, Department of Oral and Maxillofacial Surgery, The Brooklyn Hospital Center, Brooklyn, NY.

Harry Dym, D.D.S., is chair, Department of Dentistry/Oral and Maxillofacial Surgery, The Brooklyn Hospital Center, Brooklyn, NY.



Component NEWS

SUFFOLK COUNTY

Giving Veterans a Smile

William Bast, D.M.D.

The Stephen B. Gold Dental Clinic at St. Charles Hospital was proud to continue its tradition of hosting "Give Vets a Smile Day," on Nov. 3, offering veterans free dental services. Through the tireless efforts of the clinic coordinator, dental assistants, hygienists, residents and several local dentists, who generously donated their time, the clinic was able to treat 25 veterans and provide them with much-needed, extensive dental care.

LI Women's Dental Symposium

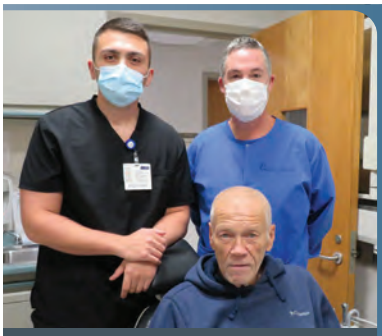
The Nassau and Suffolk County Dental societies hosted our 13th annual LI Women's Dental Symposium on Nov. 4. This year, we honored Reneida Elisa Reyes, D.D.S., M.P.H., and featured Nicole McGrath-Barnes, D.D.S., FACD, as keynote speaker. We collected over 200 pounds of food, which was donated to LI Cares, and raised $1,000 for Kindersmile.

General Membership Meeting

At the Nov. 16 General Membership Meeting, we enjoyed a large buffet dinner and honored our veteran members. We welcomed new members to Suffolk County and benefitted from a two-credit CE program presented by Martin Dominger, D.D.S., M.D., entitled "Peer Review—A True Member Benefit." We collected six bags of groceries to donate to LI Cares.

Don't Miss a Thing

We continue to make a significant push to better communicate and connect with our members using methods that more easily integrate with their lifestyle. You can find us on Facebook, Twitter, Instagram, LinkedIn and, even, Spotify, in addition to our traditional www.SuffolkDental.org presence.



John Hansen was one of 25 veterans to receive free dental care at St. Charles Hospital in November from volunteers, including SCDS member and resident Travis Mackey, left, and hygienist James Caldroney.

SUFFOLK COUNTY

Attendance topped 100 at 13th annual Long Island Women's Dental Symposium in November.

SUFFOLK COUNTY

November General Membership Meeting featured dinner, CE and honors for veteran members.

NASSAU COUNTY

Still Celebrating

Eugene Porcelli, D.D.S., Executive Director

Well, the holidays are behind us, but the celebrating isn't over yet! On Jan. 21, we held our Officers' Installation Gala. This year, it was an extra special event, as we also celebrated Nassau County Dental Society's 75th Anniversary, its Diamond Jubilee. An evening of good food, good friends and dancing ensued, capped off by a special presentation of our 75-year history. Attendees received a Commemorative Journal to take home with them.

Our Calendar was Full

We had a very busy fall at NCDS. Between Sept. 14 and Dec. 12, we provided over 38 hours of continuing education for our

members, had a shredding and recycling event, two oral cancer screenings for the public, the ADA House of Delegates in Houston, over two dozen committee and council meetings, and the dedication of our board room to Mark J. Feldman, D.M.D. The dedication ceremony was attended by over 50 of our Board members, past presidents and dignitaries from around the state.

Kudos to Dr. Frank Murphy, our 1991 NCDS president, who drove down from New Hampshire for the event. Thanks also to Greg Hill, NYSDA's new Executive Director, who came from Albany, and NYSDA President Jim Galati, who came from the Saratoga area.

But it's no time to rest as we continue to build out our course offerings for 2023. Everything is listed on our website, and it's easy to register online. Please visit the website often, as more courses are added frequently at this time of year.

Record-breaking Year?

We are also preparing for our Give Kids A Smile (GKAS) event, which takes place on Friday, Feb. 10. This year we will return to the Cradle of Aviation Museum after a two-year hiatus due to COVID. Our GKAS record of examining close to 1,500 children in one day may be in jeopardy! From the way things are shaping up, we might break that record this year.

To volunteer, go to our website, www.nassaudental.org, and look for the green banner at the top of the home page.

GLIDM on the Horizon

Finally, the Greater Long Island Dental Meeting will take place April 25 and 26 at the Huntington Hilton. This year's edition promises to be better than ever, with a larger variety of courses, including unique hands-on sessions.

On hand for dedication of Mark J. Feldman Board Room are, from left: NCDS Executive Director Gene Porcelli; Dr. Feldman's sons Eric and Sean; and NCDS President Joe Brofsky.

NASSAU COUNTY

Board room dedication ceremony brought together NCDS members, leaders past and present, and dignitaries from around the state.

We will be using an app this year for a smother registration process. There will even be a band on Tuesday night. Register for the fun, the bargains and the CE—all at a value that can't be beat!

Here's to higher temperatures and lower inflation in the coming months.

SEVENTH DISTRICT

Dental Teams Hone Communication Skills

Becky Herman, Executive Director

The Seventh District held its all-day continuing education event and annual meeting on Oct. 28. Dr. Robert Maguire presented "The Economics of Great Communication" to a packed room of dentists, hygienists, assistants and office staff. Dr. William Hurtt, 2022 business chair, presented Dr. Christopher Calnon, district president, with a plaque and gift to recognize his year of service.

2022 President Christopher Calnon, left, is recipient of plaque and gift recognizing his year of service. Making presentation is 2022 Business Chair William Hurtt.

SEVENTH DISTRICT

Honoring Our Veterans

The district recognized military service members in attendance at the Annual Meeting in October. Dr. Fred Clasquin; Dr. Robert Maguire, CE presenter; and Dr. William Hurtt, 2022 business chair, received a specially crafted 7th District challenge coin. District President Christopher Calnon thanked them for their service.

Winning Photo

In an effort to increase our Facebook followers, new dentists (those who graduated in the last 10 years) were asked to submit a

Seventh District *cont.*

favorite photo of a summer or fall memory/activity for a chance to win a $75 Amazon gift card. Dr. Alexa Hill was the winner of the contest with her photo of a group attending the Red Hot Chili Peppers concert this past summer.

New Website Launched

The Seventh District Dental Society launched a new website on Nov. 30. Members can now register for events online, view meeting files and their personal classified posts through a revised member dashboard. New features include a member spotlight; an "in memoriam" page, acknowledging friends and colleagues who have passed away; and a "partnering with us" page to thank our educational partners and corporate sponsors.

MCDS Hosts Scholarship Luncheon

The Monroe County Dental Society (MCDS) hosted its annual scholarship luncheon at the end of last year for dental students who had been legal residents of the county prior to entering dental school.

Each year, MCDS reaches out to dental school deans to extend an invitation to their 2nd, 3rd and 4th year dental students. Students are asked to complete an application and submit a letter of recommendation from the dean. They are then invited to attend an in-person luncheon at the district office to meet with a committee consisting of a diverse group of general and specialist dentists, who speak with the students about the profession, share information about practicing in the Seventh District and outline benefits of being involved in organized dentistry. The hope is that by connecting with students early, they will be encouraged to return to the area to practice and become involved members of the district. Financial grants are awarded to deserving students in the range of $300 to $600.

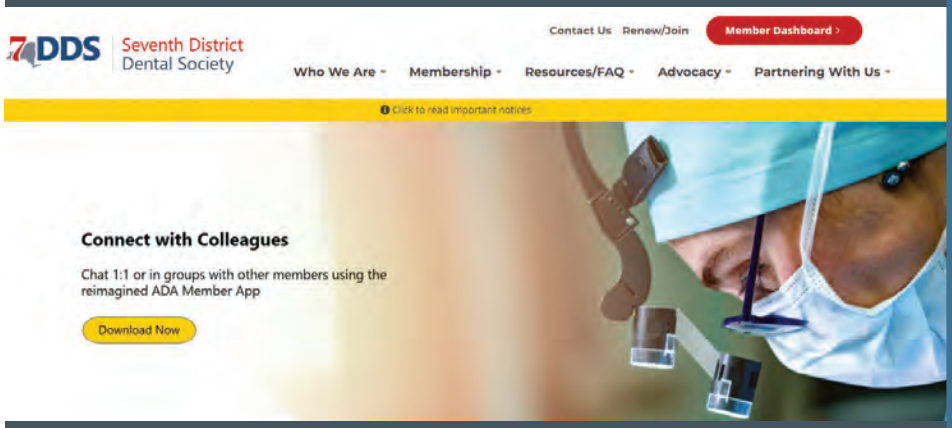
The 2022 luncheon was held on Dec. 20. Seven students, five dentists and the executive director of the Seventh District Dental Society attended.

Counties' Favorite Charities Receive Donations

Each year, the district allocates $500 for each county to select a charity to support during the holiday season. In 2022, Cayuga County donated to the Sts. Peter and John Episcopal Church soup kitchen. The soup kitchen provides meals for hungry and needy families in the county. Monroe County contributed to the Boys and Girls Club of Rochester, an after-school program where passionate, caring professionals foster a sense of belonging for the youth in Rochester and help shape their path toward a great future.

Steuben County decided to donate to the Hornell Turning Point Pantry to support its holiday dinner drive. And Wayne County purchased gift cards to be distributed to families and children in need through the Wayne County Department of Social Services.

New dentists gather in December to celebrate holiday season at Three Heads Brewery in Rochester



Seventh District's new website provides members with more options for connecting, communicating and staying informed.

EIGHTH DISTRICT

Memorial Lecture Looks at Digital Dentistry

Kevin J. Hanley, D.D.S.

The Eighth District Dental Society held the 2022 Dr. Rick Fink Memorial Lecture on Dec. 2 at the Grapevine Banquet Center in Depew. Dr. Susan McMahon presented "The Next Dimension: Digital Dentistry, CBCT, 3D Printers, and More. How Dentists Thrive Today." This course reviewed new restorative materials and their indications for use, step-by-step procedures for the best esthetic restoration outcomes, current technology options, rational purchasing of these options, and relieving stress with day-to-day procedures using simple solutions.

Attendees earned seven MCE hours and left with new knowledge to put into practice immediately.

Santa Claus Comes to Town

The Eighth District's annual Children's Christmas Party took place Dec. 3 at the Transit Valley Country Club in East Amherst. A lavish brunch was served. The children took part in craft projects. A magician entertained the crowd with feats of legerdemain to the oohs and aahs of the audience. And, finally, the man of the hour, Santa Claus, arrived with stockings full of gifts for the children.

It was another successful party, leaving everyone looking forward to next year's holiday event.

Installation Brunch

The Erie County Dental Society held its annual Installation Brunch on Sunday, Jan. 15, at Jazzboline Restaurant @ The Reikart House in Amherst. Master of Ceremonies Dr. Raymond Miller delivered the oath of office to: President Dr. Matthew Walla, Vice President Dr. Amanda Cryan, Secretary Dr. Martin Gorkiewicz, Assistant Secretary Dr. Katherine Pauly and Treasurer Dr. Karl Neuhaus.

Drs. Gregory Farber, Rosanne Modica and Frank Sindoni were recognized as life members of the society. Dr. Chester Gary received the Frank J. Store Award for his contributions to the society, dentistry and the community.

EIGHTH DISTRICT

Youngsters take delight in show of magic — and, of course, Santa AKA Dr. James Hoddick — put on at annual Christmas party in December.

President's Reception

The Eighth District Dental Society will hold its annual President's Reception on Saturday, Feb. 4, at The Thirty Six, One Seneca Tower, Buffalo. Dr. James Hoddick will serve as master of ceremonies for the evening. The officers being installed are: Dr. Joshua T. Hutter, president; Dr. Robert A. Bochiechio, president-elect; Dr. Joseph M. Rumfola, vice president; Dr. Michael D. Ehlers, secretary; and Dr. Joseph S. Modica, treasurer.

Nine members of the district will be awarded life membership status. They are Dr. Paul Calabrese, Dr. Kathleen Marie Casacci, Dr. Gregory A. Farber, Dr. Andrew C. Kohl, Dr. Kimberly R. Meabon, Dr. Rosanne Modica, Dr. Gregory P. Potempa, Dr. David R. Powers and Dr. Frank T. Sindoni. Dr. Joseph Gambacorta will be honored as the outgoing president.

Music will be provided by Essence Unplugged. It promises to be an elegant evening for all attending.

Lifesaving Measure

The Erie County Dental Society will hold "Basic Life Support for Health Care Providers" on Monday, Feb. 6, at the society office. This course will fulfill the New York State course requirements for CPR retraining. Participants will be required to complete both a written and skills test to be certified.

Four MCE hours will be awarded to those successfully completing the course, and their CPR registration will be good for two years.

Learn and Ski

The Erie County Dental Society will hold its annual Ski Day at Holimont Ski Club in Ellicottville on Friday, Feb. 10. Dr. Maryann Mobarhan will discuss "Sequencing of Full Mouth Rehabilitation with a Direct Resin Application Technique."

Full-mouth rehabilitation can be a challenging process for both providers and patients. The process of changing a plane of occlusion, vertical dimension and esthetics requires planning and sequencing. This lecture will demonstrate how direct resin application can be utilized as a short- or long-term method to stage and sequence the complex treatment of a worn dentition.

Eighth District *cont.*

During breaks in the lecture, attendees will hit the slopes for some wonderful skiing.

Endodontic Lecture

The Resurgence Brewing Company will be the venue for the Erie County Dental Society's business meeting and seminar on Tuesday, Feb. 21. The lecture topic that evening will be "The Art and Science of Endodontic Diagnosis." Dr. Ariyan Ravangard will discuss the importance of an accurate endodontic diagnosis to ensure proper treatment for the patient. A methodical approach combining both subjective and objective findings must be utilized. Dr. Ravangard will review various testing techniques, as well as use of CBCT in the diagnosis of endodontic conditions. The basics of endodontic diagnosis and treatment options will also be reviewed.

BRONX COUNTY
Job Fair 2023

Laurence Schimmel, D.D.S.

The Bronx County Dental Society is excited to present the 2023 Job Fair, sponsored by MLMIC and Cloud Dental. The fair will be held from 6:30-9:30 p.m., March 9, at Maestro's catering hall in the Bronx. It is open to all dental faculty and residents working at our Bronx hospitals, Queens dental residents, and D3 and D4 students at Touro Dental College.

All BCDS members are welcome, as this will be a great place for those looking for an associate or thinking of transitioning toward retirement. This is also a good way to show our young dentists the value of membership in organized dentistry. And there will be companies there specializing in practice transitioning to assist both members and residents.

Please call Joy at (718) 733-2031, or email her at bronxdental@optonline.net for more information about the Job Fair.

January Stated Meeting

On Jan. 24, the BCDS presented a lecture entitled "Drilling Down on the 'Gram." Dr. Brittany McCrorey, D.D.S., M.P.H., introduced various social media platforms and explained how they can be used as instruments to connect to and educate patients. She also provided tips for effectively using social media to build professional brands and foster current and new patient relationships.

Dr. McCrorey is associate director of the GPR program and performance improvement compliance officer of the BronxCare Health System Dental Department.

February Stated Meeting

BCDS's Stated Meeting Feb. 28, will feature a presentation entitled "Qualified Retirement Plan Design for Dental Practices," delivered by Andrew E. Roth, Esq. Mr. Roth will discuss ways dentists can withstand the headwinds generated by the current economy while maintaining the ideal qualified retirement plan designed for a specific dental practice. Some topics that will be discussed are IRS plan limits for 2023, types of qualified retirement plans, legal updates, defined contribution plans and defined benefit plans.

Mr. Roth is a partner at Danziger and Markhoff, LLP, with over 35 years of experience as an ERISA attorney.

NINTH DISTRICT
ADA 2022 Meeting

Olga Lombo-Sguerra, D.D.S.

Wrapping up the end of the calendar year, the Ninth kept working at the district, state and national levels.

Present for the most recent ADA House meeting, which took place in Houston Oct. 13-18, were our three ADA delegates: Renuka Bijoor, D.D.S. (W), Stephen Ossen, D.M.D.

Association's 2023 officers are from left: Vice President Renuka Bijoor; President-Elect Duraid Sahawneh; President Daniel Doyle; Immediate Past President Stephen Ossen; Secretary-Treasurer Bharat Joshi.

Annual Meeting presenter Dr. Jonathan Esquivel, left, with 2022 Program Committee Chair Leonard Kobren.

(W), and Gary Scharoff, D.D.S. (W). Also in attendance were our three ADA Alternate delegates: Daniel Doyle, D.M.D. (P), Edward Miller, D.M.D. (W), and Duraid Sahawneh, D.D.S. (W).

Delegates to that meeting passed a major resolution—the Strategic Planning Task Force—which will enable the ADA to address business more efficiently and immediately. The ADA is trying to be more agile and nimble; this resolution adds a layer between the House of Delegates and the Board of Trustees. The House of Delegates will determine the "what," "where" and "when," and the Strategic Forecast Committee will assess and alter what needs to be adjusted to get us there. Simply, the House of Delegates will set forth a plan; the Strategic Forecasting Committee will determine how to get there.

General Meeting

Our last meeting of the year, at the Westchester Country Club in Rye on Nov. 16, included the installation of the following 2023 officers (Executive Committee):

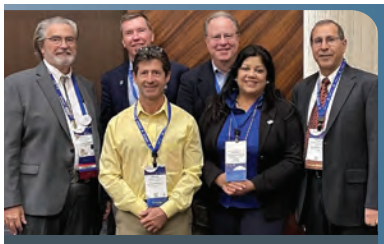
- President: Daniel C. Doyle, D.M.D., Putnam County
- President-Elect: Duraid F. Sahawneh, D.D.S., Westchester County
- Vice President: Renuka R. Bijoor, D.D.S., M.P.H, Westchester County
- Secretary-Treasurer: Bharat Joshi, D.D.S., Westchester County
- Immediate Past President: Stephen M. Ossen, D.M.D., Westchester County

The meeting also included a very enlightening seminar given by Dr. Jonathan Esquivel, D.D.S., a prosthodontist who is associate professor and director of implant dentistry, Department of Prosthodontics, Louisiana State University School of Dentistry. He presented "RDIP: A Morpho-Therapeutic Approach to Predictable Implant Dentistry."

The Ninth's webinar series has been offering a full slate of lectures throughout the spring and fall, with a few being offered in the winter. Lectures are added as they are scheduled. Please visit our website to register: www.ninthdistrict.org.

Providing Guidance

On Jan. 25, the Ninth sponsored a Mentoring Event with Touro students from D3 and D4 classes at Capitan Lawrence Brewery in Elmsford. It was a great opportunity for experienced dentists to guide the students on future endeavors.



Ninth District delegation to ADA House Meeting in Houston last year includes NYSDA President-Elect Anthony Cuomo, Vice President Duraid Sahawneh, President-Elect Daniel Doyle, President Stephen Ossen, NYSDA Trustee and 9th past president Gary Scharoff, Secretary-Treasurer Renuka Bijoor.

NINTH DISTRICT

Smile, Kids

Our annual Give Kids A Smile event will take place on a yet-to-be-determined date in February. It will be held at the Head Start in New Rochelle. We look forward to expanding this program to other Head Start locations this year.

Team Approach

Our next General Meeting will be on Wednesday, March 15, at the Villa Borghese in Wappingers Falls. It will feature a presentation by Al Haitham Al Shetawi, D.M.D., M.D., a 9th member who is an oral and maxillofacial surgeon in Poughkeepsie and chief of service, Division of Oral & Maxillofacial Surgery, and attending surgeon, Division of Surgical Oncology at the Department of Surgery, Vassar Brothers Medical Center. He will present: "Oral Cancer from A to Z and Other Mixed Oral Surgery Topics for the Dental Team."

Mark Your Calendars

Plans are underway for a June New Dentist Mixer and Lecture and Ice Cream Social at the Touro College of Dental Medicine in Hawthorne.

Lastly, the 9th Membership & Communications Committee will host its annual Social and "Frills & Drills" event the evening of Wednesday, May 17, at The Manor in Briarcliff Manor.

For information on these and other programs, please visit our website at: www.ninthdistrict.org; or call the office at (914) 747-1199.

SECOND DISTRICT

Dr. Flagiello Heads Roster of 2023 Officers

Alyson Buchalter, D.M.D.

The Second District Dental Society is excited and honored to welcome Dr. Raymond Flagiello as our president for 2023. Dr. Flagiello is a 1987 graduate of Georgetown University School of Dentistry. He is proud of his private practice in Dogan Hills, Staten Island, which he established in 1992.

Dr. Flagiello has been a very active member of the SDDS for many years. Starting as a member of the Board of Trustees of our branch society, Richmond County, he rose through the ranks to become society president. He then joined the Board of Trustees of the SDDS, served on many SDDS committees and was appointed to the NYSDA Council on Governmental Affairs. He is also currently secretary of EDPAC, NYSDA's political action committee. In October 2022, Dr. Flagiello was inducted into the International College of Dentists, for his service to dentistry and the community.

But, Dr. Flagiello will tell you all of those accolades pale beside his family. He and his wife of 29 years, Meredith, have three grown children—Rachel, Mia and Olivia—whom he could not be prouder of. Olivia, a recent graduate of the Fashion Institute of Technology, is an assistant buyer

2023 President Raymond Flagiello repeats oath of office administered by past president Craig Ratner.

SECOND DISTRICT

Second District *cont.*

for Ross Department Stores. Mia, a recent graduate of the University of Massachusetts, is a manager at the Downtown Marriott in New York City. Rachel is scheduled to graduate this year from St. Matthews University School of Veterinary Medicine.

The SDDS also welcomes our new line officers. They are: President-elect Dr. Tricia Quartey-Sagaille, Vice President Dr. Paul Teplitsky, Secretary Dr. Valerie Venterina, and Treasurer Dr. Phyllis Merlino.

Craig Ratner, Award Winner

On Sunday, Jan. 8, the SDDS held its annual Installation of Officers and Awards Luncheon. It was a fabulous party held at the stately University Club in Manhattan. Along with dignitaries from across all levels of the tripartite, we celebrated the installation of Dr. Flagiello and his 2023 line officers.

A highlight of the afternoon was when Dr. Craig Ratner was awarded the SDDS's highest honor—our Distinguished Service Award. Only 14 individuals in our 155-year history have been so honored.

Dr. Ratner has held virtually every office in our society. He was president in 2008, editor of the Bulletin from 2005-2014, currently chairs the Awards Committee and in 2017, created the now-renowned SDDS Student Loan Forgiveness Program.

And that was just the beginning. On the state level, he served on the Council on Dental Practice, rising to chair that council. He was a member of the NYSDA Board of Trustees for six years and before that was a member of the NYSDA Board of Governors. He ultimately rose to the office of president of NYSDA in 2020 and during his tenure, he guided New York State dentists through the worst of the COVID-19 crisis. On the national level, he was a member of and, ultimately, chair of the ADA Council on Dental Practice, as well as a member of the ADA Standards Committee on Dental Informatics.

This covers only the highlights of his service to our organization, details of which are too numerous for this space. Congratulations, Dr. Ratner, from all your fellow SDDS members.

Well-deserved Recognition

The luncheon also continued Second District's tradition of recognizing members whose efforts on behalf of the SDDS are truly appreciated. Honored at the luncheon were Drs. Steven Moss and Paul Teplitsky, for their years of service on the Greater New York Dental Meeting's Organization Committee; Drs. Babak Bina, Joseph Merola, Philip Buccigrossi and Lorna Flamer-Caldera, for their time spent on the SDDS Board of Trustees; Dr. Mitchell Mindlin, for his service as a member of the NYDSA Board; Dr. John Demas, for contributions to the NYSDA Council on Dental Practice; Dr. Sari Rosenwein, for serving on the NYSDA Council on Nominations; and the 14 SDDS members who reached Life Member status. Thank you, all!

Finally, all the members of the SDDS took a moment to thank our outgoing president, Dr. Michael Donato, for his superb leadership this past year. His many accomplishments are appreciated and will not be forgotten.

We at SDDS are lucky to have so many amazing people giving their time, energy and expertise to leading our organization. We are truly blessed.

Craig Ratner applauds newly installed officers, from left: President-elect Tricia Quartey-Sagaille; Secretary Valerie Venterina; Treasurer Phyllis Merlino.

Distinguished Service Award winner Craig Ratner, left, with President Ray Flagiello.

NEW YORK COUNTY

January Installation

Vera W.L. Tang, D.D.S.

NYCDS members showed up in large numbers to witness and celebrate the Installation of Officers on Jan. 5 at The Latham Hotel. The society will be well-represented in 2023

by President Mina C. Kim, President-Elect Suchie Chawla, Vice President Vera W. L. Tang, Secretary Andrew S. Deutch, Treasurer Egidio A. Farone and Immediate Past President Ioanna G. Mentzelopoulou. Special thanks to past president Lois Jackson for serving as the installing officer.

In addition to the many members present, NYCDS was pleased to host the following distinguished guests: ADA past trustee Paul Leary; current ADA Trustee Brendan Dowd; ADA past second vice president and New York State Dental Foundation Chair Maria Maranga; NYSDA President James Galati; NYSDA Vice President Prabha Krishnan; NYSDA Speaker of the House Steven Gounardes; NYSDA Executive Director Gregory Hill; and, NYSDA Board members Maurice Edwards and Mitchell Mindlin.

Also in attendance were: Second District President Raymond Flagiello, Treasurer Phyllis Merlino and Executive Director Bernie Hackett; Suffolk County Executive Director Bill Panzarino; and from the Greater New York Dental Meeting, General Chair Richard Oshrain, General Chair Elect John Young, new General Manager Tom Loughran and members of the Organization Committee and Troubleshooters.

Special Olympics Special Smiles Founder Addresses Members

At its November General Membership Meeting, NYCDS was pleased to have the new executive director of the New York State Dental Association, Gregory Hill, introduce himself to members and share his vision for the Association. Dr. Deborah Weisfuse received the Mark Mintzer Award for Service for her years of service to NYCDS and to the profession. Dr. Weisfuse was the first female president of NYSDA, spearheaded an ADA award-winning Give Kids A Smile program, and filled many volunteer and leadership roles seeking to improve oral health in communities around the world.

2023 officers are, from left: Secretary Andrew Deutch; President-Elect Suchie Chawla; President Mina Kim; Vice President Vera W.L. Tang; Treasurer Egidio Farone; Immediate Past President Ioanna Mentzelopoulou.

NEW YORK COUNTY

Newly installed President Mina Kim with ADA Trustee Brendon Dowd and New York State Dental Foundation Chair Maria Maranga.

The evening's lecture was delivered by Steven Perlman, D.D.S., M.Sc.D., DHL (honorary). For over 40 years Dr. Perlman has devoted much of his private practice, as well as his teaching, to the treatment of children and adults with physical and intellectual disabilities. He created Special Olympics Special Smiles, an oral health initiative for the athletes of Special Olympics International, established in 1993. He currently serves as the organization's senior global clinical advisor.

Dr. Perlman chose as his topic a subject dear to him: "Policy, Advocacy and Treatment for Those with Special Healthcare Needs and How It All Began." His lecture shed light on the unique needs of this community and the duty dental and medical professionals have to take extra measures to ensure that its members receive quality healthcare.

Path to Practice Ownership with a Twist

New dentists enjoyed a special evening featuring an informational panel program followed by a hands-on session with a mixologist on Nov. 3. Rob Malandruccolo, vice president, NY&CT regional manager (dental division), and Jarrett Mathews, vice president, regional sales manager, dental practice sales and acquisitions, with Bank of America Practice Solutions, and Melody Lins, associate attorney at the National Dental Law Group at Mandelbaum Barrett, PC, were the panelists and provided insights into the necessary financial steps and legal "best practices" when starting or acquiring a practice. After their presentation, everyone had an opportunity to mix a specialty cocktail with guidance from a mixologist.

Taken all together—the drinks, the information imparted and the conversations taking place—it was clear, the program was a hit!

Mentorship Mixer a Resounding Success

On Nov. 14, NYCDS, in conjunction with the NYU College of Dentistry, held a Mentorship Mixer, which was attended by approximately 40 member dentists and 50 NYU dental students. The purpose of the evening was to enable the students (D1s

New York County *cont.*

thru D4s) to speak with dentists in order to obtain advice about "real world" dentistry, residency programs, specialties, etc.

The program was divided into four segments of 30 minutes each. The first portion was set up for socializing. It was followed by a period of "speed dating," where every five minutes, students had to speak to a different dentist. During the third segment, students and dentists met in pre-assigned groups. And, lastly, students met with groups of different specialists and general dentists.

The immediate feedback from participants was that the event was an excellent program of networking for all involved. A similar event will be held in the future in conjunction with the Columbia College of Dental Medicine.

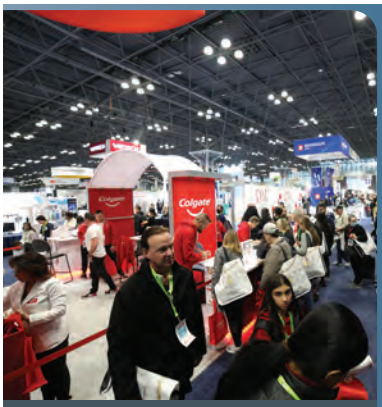
Special Olympics Special Smiles

On Dec. 3, several members, as well as NYU dental students and local high school students, volunteered at the Special Olympics Special Smiles event at the Javits Center. A big thank you to President-Elect Mina Kim (now NYCDS president) for spearheading this event, and to all our volunteers who helped make it a success!

NYCDS members and other volunteers helped athletes with disabilities achieve healthier smiles at Special Olympics at Javits Center in December.

NEW YORK COUNTY

Seen at November General Membership Meeting, from left: NYSDA Executive Director Gregory Hill; guest lecturer Dr. Steven Perlman; Mark Mintzer Award recipient Dr. Deborah Weisfuse; 2022 President Dr.Ioanna Mentzelopoulou.



NEW YORK COUNTY

Exhibit Hall at 2022 Greater New York Dental Meeting.

The 98th Greater New Year Dental Meeting

The Greater New York Dental Meeting is rebounding robustly from COVID. The 98th Meeting, which concluded in November, registered 33,468 attendees, including 12,188 dentists, 2,028 dental students, 2,113 dental assistants and 2,211 dental hygienists from 162 countries.

The GNYDM continues to be the largest dental convention and event in the United States. Dental professionals visited over 930 exhibit booths and received special access to discounts on new products and equipment. The GNYDM education program included more than 280 seminars, hands-on workshops and essays, with programs in Spanish and Portuguese.

It was a great week of business, learning and networking.

Continuing Education

The 2023 Winter/Spring CE program features new courses and returning favorites. Highlights include our popular Speed Learning event, which brings six speakers and six different topics on one fast-paced day. We are also pleased to have the widely published speaker Dr. Michael Ghalili teach "The Latest & Most Current Approach to Esthetic Dentistry: Techniques, Materials, and Philosophy" appearing on our program on Feb. 8.

Upcoming Continuing Education Schedule

- Wed. Feb. 8: "The Latest & Most Current Approach to Esthetic Dentistry." ***In-person***
- Wed. Feb. 15: "Infection Control for the Dental Practice." ***In-person***
- Wed. Feb. 15: ACD Mentoring Lecture Program: "Life After Residency." ***Via Zoom***
- Wed. Feb. 22: "Basic Life Support/CPR Certification." ***In-person***
- Wed. Mar. 15: ACD Mentoring Lecture Program: "Working Human."
- Wed. Apr. 12: "Dominate Your Marketing Online." ***In-person***
- Wed. April. 19: "Basic Life Support/CPR Certification." ***In-person***
- Wed. Apr. 19: ACD Mentoring Lecture Program: "NYCDS Mentoring"
- Wed. Apr. 26: Speed Learning: 6 Speakers, 6 Hours, 6 Credits.

Visit www.nycdentalsociety.org for the latest course and registration information.

Read, Learn and Earn
CONTINUING EDUCATION

Read, Learn and Earn

Readers of *The New York State Dental Journal* are invited to earn three (3) home study credits, approved by the New York State Dental Foundation, by properly answering the following 20 True or False questions, all of which are based on articles that appear in this issue.

When you have completed the questionnaire, return it to the New York State Dental Foundation, along with the appropriate fees: $60/dentists; $40/hygienists. Nonmember fees are: $120/dentists; $80/hygienists. All those who achieve a passing grade of at least 70% will receive verification of completion. Credits will automatically be added to the CE Registry for NYSDA members.

For a complete listing of online lectures and home study CE courses sponsored by the New York State Dental Foundation, visit www.nysdflearning.org.

Evaluating Repeat Dental Emergency Visits Related to Third-Molar Pathologies in Urgent Dental Care Center—Page 18-23

1. Suboptimal oral health is a predictor of future emergency visits due to pathology of remaining third molars.
   ❑ T or ❑ F
2. Patients who present to emergency departments for dental treatment usually turn into reliable dental patients.
   ❑ T or ❑ F
3. In 2017, 1.7-million emergency room visits were related to diseases of the mouth and supporting structures.
   ❑ T or ❑ F
4. The data for the article was obtained over a period of two years.
   ❑ T or ❑ F

❑ *Enclosed is a check for the full amount. Members' fees are $60/dentists; $40/hygienists. Nonmember fees are $120/dentists; $80 hygienists. (Make checks payable to the New York State Dental Foundation.) Mail to NYSDF, 20 Corporate Woods Boulevard, Suite 602, Albany, NY 12211. Questionnaires must be received within 90 days of Journal publication.*

Please charge my: ❑ VISA ❑ MasterCard ❑ American Express

Card # _____

Expiration Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

E-mail _____

ADA # _____

License # _____

NYSDA Member? ❑ yes or ❑ no

Local/State Dental Society _____

5. The study had 274 subjects who participated.
❑ T or ❑ F
6. Most repeat emergency room dental visits were related to abnormalities involving lower third molars.
❑ T or ❑ F
7. The study showed that change of insurance coverage had a significant impact on the time of repeat emergency visits.
❑ T or ❑ F
8. The study showed that patients with lower third-molar abnormalities had significantly earlier repeat visits to urgent care departments than patients with upper third-molar abnormalities.
❑ T or ❑ F
9. The authors felt that dental insurance is not one of the few elements that can indicate trends in third-molar-related repeat emergency visits.
❑ T or ❑ F
10. A lack of patient information outside of Eastman Dental Center was a limitation of the study. However, the study provides a basis for future research in this area.
❑ T or ❑ F

Diagnosis and Management of Nasopalatine Duct Cyst—Page 28-32

1. The nasopalatine duct cyst (NPDC) is an uncommon non-neoplastic, non-ondontogenic developmental cyst.
❑ T or ❑ F
2. Most cases of NPDC are asymptomatic.
❑ T or ❑ F
3. NPDCs have the potential to be painful and drain into the palate.
❑ T or ❑ F
4. The incisive canal ends under the incisive papillae.
❑ T or ❑ F
5. The nasopalantine duct, in humans, is always patent.
❑ T or ❑ F
6. NPDC occurs in approximately 1% of the population.
❑ T or ❑ F
7. Misdiagnosis of NPDC is not uncommon due to anatomic location near the apices of the maxillary teeth.
❑ T or ❑ F
8. NPDC may be treated by enucleation and curettage.
❑ T or ❑ F
9. The stimulus for a NPDC cyst formation is clearly understood.
❑ T or ❑ F
10. A correct diagnosis of NPDC must be established to avoid improper treatment.
❑ T or ❑ F

2022 ANNUAL INDEX

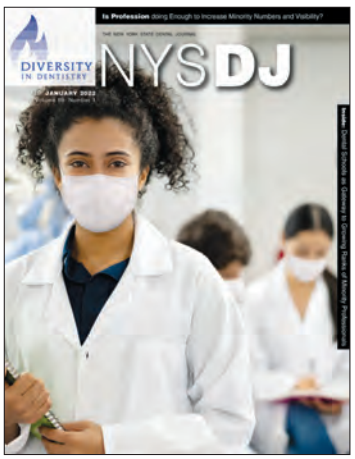
KEY:

J-January	JJ-June/July
F-February	AS-August/September
M-March	O-October
A-April	N-November
MY-May	D-December

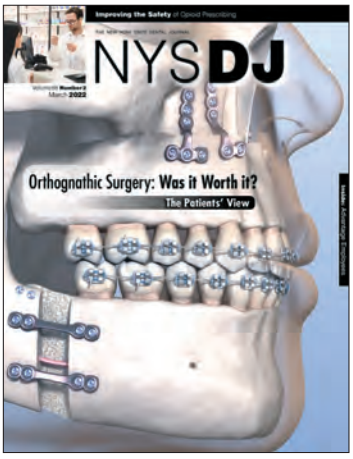
AUTHOR INDEX

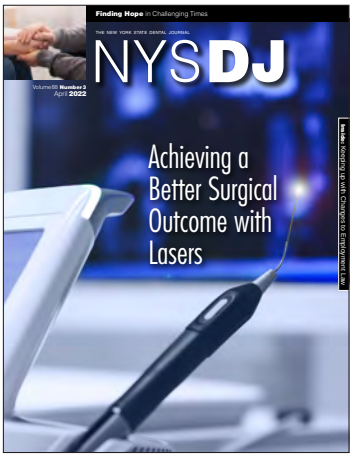
SUBJECT INDEX

A



2022 ANNUAL INDEX





2022 ANNUAL INDEX

2022 ANNUAL INDEX

2022 ANNUAL INDEX

N

O

P

2022 ANNUAL INDEX

CLASSIFIED INFORMATION

Online Rates for 60-day posting of 150 words or less — can include photos/images online: Members: $200. Non-Members: $300. Corporate/Business Ads: $400. Classifieds will also appear in print during months when Journal is mailed: Jan, March and July.

FOR SALE

FINGER LAKES: Come live where others vacation. General practice for sale. 4-day workweek and no evening or weekend hours. Referring out all specialty procedures. Reliable, long-term team with great systems in place. Up-to-date facility and equipment. Low overhead with little competition. Community has low cost of living with lots of outdoor recreational opportunities. Great place to raise family. Real estate available for purchase. Make an offer. Contact: dentalofficeforsale315@gmail.com.

UPSTATE: Charming, long-established, quality, general practice located in gorgeous upstate NY. Turnkey opportunity has it all. Revenue near $1M; low overhead. Brand new equipment, including 2 Belmont chairs, NV laser, Dentrix/Dexus technology throughout. Steady stream of new patients; robust hygiene department; and prime location on busy main street. Seller refers out most specialty services providing additional revenue potential for buyer keeping these services in-house. Standalone, 2,170-square-foot beautiful facility feels extra spacious with high ceilings and large windows. Four ops with room to expand 1 more if wanted. Additional 1,120 square feet of space has separate entrance and could be turned into dental lab, space for dental specialist or anything else. Plenty of onsite parking. Real estate for sale or lease. Flexible post-transition options available. Don't miss this exceptional opportunity. Contact Catherine Etters at Legacy Practice Transitions for details: Catherine@LegacyPracticeTransitions.com; or (610) 520-9677.

BRONX: Well set up, beautiful dental office for sale in heavily populated area of Bronx. 3 operatories, sterilization room, lab, dark room, reception area and private room. Digital X-ray, computer and equipment all in good running condition. Contact: (718) 379-4800; or email: singhdds@optimum.net.

NORTHERN NEW YORK: Excellent general practice opportunity. Well-established family practice transitioning to retirement. Located minutes to Canada and short drive to Adirondacks. Family outdoor activities nearby, including water/snow skiing, fishing, hiking, mountains and hunting. Successful privately owned practice, owned by current practicing dentist. Full-support administrative staff, dental assistants and full-time hygienists. Pleasant working conditions; exceptional staff; and many valued patients. Great opportunity for outdoor enthusiast with their family to establish dental career with successful future. We will work beside you to help ensure success. Once-in-a-lifetime opportunity for new graduate or experienced dentist looking to take advantage of great outdoors. We look forward to talking with you. Contact for more info: (315) 769-5811; email: frontoffice@drcarlscruggs.com.

ALBANY COUNTY: Bethlehem. Growing community close to downtown Albany on bus line, near major highways leading to NYC. Modern-feel office with four ops, Dentrix Ascend, Dexis, pan, Diode laser and more. Two full-time hygienists along with valued team working 4-days/week with systems in place and excellent collection policies. No HMOs or state insurance. Excellent opportunity for any dental entrepreneur. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call: (315) 430-0643. #NY2712.

HAMPTONS: Well-established FFS Endodontic practice. $432K in collections. Practice asking price $300K. 783-square-foot real estate; asking price $500K. For details contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3056.

WESTERN NEW YORK: Very attractive and well-established Endodontic practice. Features 3 modern, well-designed operatories, sterilization center and patient workflow with great function, 3D and digital technologies. Growing PPO practice located in highly desirable area with off-street parking surrounded by all local amenities. Highly profitable with low overhead and skilled team to support patients and transition. To discuss details, contact Dental Practice Transitions Consultant Brian Whalen at (716) 913-2632; or email: brian.whalen@henryschein.com. #NY3042.

SYRACUSE SUBURBS: General practice conveniently located off main road in Liverpool. Open 2.5 days/week with 4 days of hygiene. Healthy patient base with 50% commercial insurance, 20% self-pay and 30% state insurance. Located in small medical building with 4 ops in second-floor rental space, with plenty of parking. Grossing $608K with room to grow with help of longstanding staff. For details contact Henry Schein Dental Practice Transitions Consultant Donna Bambrick at (315) 430-0643; or email: donna.bambrick@henryschein.com. #NY291.

TOMPKINS COUNTY: Well-established, high-quality general practice available to transition to new owner or stay on as part of team. Located in Ithaca suburb, this beautiful standalone, 15-year-old building of 2,544 square feet has five ops, digital X-rays; utilizes Eaglesoft software and completely paperless. Revenue over $700K. One FT and one PT Hygienist. Real estate also for sale. Growing patient base; practice draws increasing number of new patients with strong mixture of FFS. Great opportunity with doctor willing to stay on as part-time associate. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3071.

EASTERN SUFFOLK COUNTY: Well-established GP family practice. Located in standalone, 1,300-square-foot building with parking. Includes 2 large operatories and plumbed for third. Grossing $500K. For details contact Dental Practice Transitions Consultant Chris Regnier by email: chris.regnier@henryschein.com; or call (631) 766-4501. #NY3078.

ROCHESTER: Great opportunity near hospital. Four large ops, great patient base and 6.5 days of hygiene. Refers out all endo, oral surgery, perio, ortho and implants. Revenue average $450K. One doctor will stay on for transition if needed. Located in busy medical park. Participation in insurance is 80%, with some state insurance. Reasonably priced. Utilizing Softdent. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3080.

ORANGE COUNTY: GP office currently staffed by full-time veteran associate for sale. Minutes from main highway and features 5 ops, 2,000 square feet utilizing Dentrix software, intraoral camera and imaging system. Grossing $630K. 80% PPO insurances and 20% FFS. For information contact: Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3088.

FLUSHING: Well-established general practice with 4 ops. Fully digital with A-Dec dental chairs, pan/ceph and CEREC. Room to grow with specialties. For details contact Henry Schein Dental Practice Transitions Consultant Chris Regnier by email: chris.regnier@henryschein.com; or call (631) 766-4501. #NY3091.

FINGER LAKES REGION: Well-established GP family practice with highly motivated seller. Located in standalone 1,350-square-foot building with 5 ops and space to add on. Building available for sale with practice purchase. Full staff, including 2 doctors, each working 2 days/week and referring out most specialty procedures. 5,500 active patients (<2 years) with healthy new patient flow. Hygiene booked out. Beautiful high-visibility area with top school district. Doctor will stay for transition if necessary. Gross collections just under $700K. For details contact Dental Practice Transition Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or email: (315) 430-0643. #NY3147.

MIDTOWN MANHATTAN: Beautifully designed 4-op private general practice grossing just over $1M. 2,000-square-foot paperless office running Dentrix and Dexis software on 7 brand new networked computers. Full digital systems, including AC, COVID special air-filtration system, intraoral camera, imaging system and CariVu. Strong hygiene and dedicated staff. Seller will stay on to support during transition. Contact Dental Practice Transition Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3132.

BROOME COUNTY: Great opportunity to practice in small community. A "steal" at $250K for practice and $100K for building with two rental apartments and large parking lot with land to add on. Revenue $645K on 4-day workweek. Exceptional practice with committed staff, wonderful equipment, new pan, big windows in each of six 6 operatories. 2,000 loyal active patients and mix of 65% insurance and 35% FFS. Refers out all endo, implants and perio. For details contact Dental Practice Transition Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3137.

NASSAU COUNTY: Well-established pediatric/ortho practice established 24 years. Six treatment rooms and space to add 3 more. 50% FFS and 50% PPO. Fully digital using pan, digital X-rays and iTero scanner. For details contact Dental Practice Transition Consultant Chris Regnier by email: chris.regnier@henryschein.com; or call (631) 766-4501. #NY3138.

WHEATFIELD: Niagara County general practice. Profitable, updated, digital practice with mix of 70% PPO and 30% FFS. Three great ops with plenty of room to add fourth. Set in 1,600-square-foot modern building with abundance of off-street parking. Refers out endo, implants, ortho, perio and some oral surgery, which offers great opportunity and upside for new owner. For details contact Dental Practice Transitions Consultant Brian Whalen at (716) 913-2632; or email: Brian.Whalen@henryschein.com. #NY3166.

NORTH SYRACUSE: Small city beauty. General FFS practice with 4 ops in 900 square feet of 2,000-square-foot commercial professional building. Softdent, 10 new computers, new 2D pano, new sensors, intraoral cameras and new autoclave. 4 days per week with full-time hygienist. 2021 revenue $612K with earnings average of 40%. Real estate also for sale. Open lot parking with the rental bringing in $26K per year. Walking distance of high school and hospital. Not far from major college. Waterway for sports activity close by. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3173.

SYRACUSE: Four-location GP with removable prosthetics lab in one location that takes care of all locations and outside practices. One can be purchased or all four. Practices have 1 or 2 providers with hygienist and supporting staff in leased spaces. Practices are on Dentrix Ascend with digital equipment. Handicap accessible; plenty of parking. Revenues range from $600K to $1.5M+ with mix of PPO/FFS. Great opportunity. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3175.

SUFFOLK COUNTY: Beautiful 1,300-square-foot general practice. 3 fully equipped treatment rooms and plumbed for 5 ops. 20% fee-for-service and 80% PPO. Active patient count 2,109 and only open three days/week. For details contact Dental Practice Transition Consultant Chris Regnier by email: chris.regnier@henryschein.com; or call (631) 766-4501. #NY3098

UPSTATE: Nestled in great family village community. Make offer for well-established Central New York general family practice close to main highways. Located near one of Top 100 Ranked Golf Courses by GolfWeek. 2021 gross collections $544K. Standalone 1,800-square-foot building for sale with practice purchase. Great curb appeal with large parking lot. 3 treatment rooms and space to add on. Refers out specialties. Practice utilizes DEXIS digital X-ray, digital panoramic X-ray, brand new patient chairs. High-profit margins. Healthy new patient flow. Contact Dental Practice Transition Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3235

BROOKLYN: Highly desirable, fully digital office with 3 ops in 1,400 square feet. Features digital Sirona panographic X-ray, intraoral camera, laser and Dentrix practice management software. Real estate also for sale and includes upstairs rental property with monthly income. Seller will also consider buyer-friendly lease. 22 hours/week and features 60% FFS and 40% out-of-network providers. Seller available to stay as needed. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3238

NORTH SYRACUSE: General practice in great location. Main road location with 4 ops in leased space of wonderful, small medical building with plenty of parking. MacPractice Software. All digital with great staff. Doctor will stay for one or two days per week. Takes some insurances; excellent potential for growth adding more days. Great patients surrounded by great neighborhoods. Revenue $325K. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3246

ERIE COUNTY: Great practice with 3 treatment rooms. All digital with collections of $413K. For details contact Dental Practice Transitions Consultant Brian Whalen at (716) 913-2632; or email: Brian.Whalen@henryschein.com. #NY3366.

WESTCHESTER COUNTY: 1,400-square-foot 3-op practice in prime upscale area. In practice for 68 years (29 years by current owner and 39 by previous owner). 80% PPO and 20% FFS. Near busy intersection with lots of foot traffic and walking distance from major grocery store and schools. Walking distance from Metro North train station, numerous restaurants and park with playground/pool. Very accessible to public transportation in all directions. Contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3254

INDEX TO ADVERTISERS

ORANGE COUNTY: Served dental needs of continually expanding area and surrounding communities for past 30 years. Located in 1,500-square-foot office building with mixed tenants. 4 fully equipped ops featuring contemporary, up-to-date equipment, including intraoral camera, imaging scanner, Picasso laser unit and Dentrix & Dexis. Skilled and caring team of experienced and very personable dental professionals. Diagnostic, preventive and restorative-driven practice with strong hygiene program. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3257

WESTCHESTER: Prosthodontist soon retiring and prepared to sell his 50% interest. Looking for buyer who can step in and maintain ongoing dual-office growth. Both offices sit in professional buildings with privately owned condos in great areas of county. Offices each have 5 ops inside 4,100 and 2,850 square feet, respectively. Both locations upgrading and expanding allowing revenue and procedure growth. Real estate for sale as part of buy-in, or favorable lease will be provided. Seller will stay on as needed. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3283

ROCHESTER: Family general practice in beautiful suburb with 2021 revenue of $255K+ and growth potential. Seller highly motivated. 1,400-square-foot space with affordable lease, great curb appeal and ample parking. 3 ops with potential 4th plumbed op. Single-doctor practice utilizes digital pano X-ray and Denoptix phosphor plates. Contact Dental Practice Transition Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3291.

SUFFOLK COUNTY: North Shore. 2 treatment rooms, plus one plumbed, with great visibility in desirable community. Dexis digital X-rays, digital pan and Easy Dental software. Open 4.5 days/week; referring out all specialty procedures. Gross revenue of over $483K with 35% FFS, 65% PPO. Strong hygiene program. Well-trained staff available for transition. Seller open to transition options. Will not last long. Location, location. For more information contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3294.

BROOKLYN: Terrific opportunity in highly desirable area. 65% PPO, 30% FFS and 5% indemnity insurance. Open 6 days/week and has very strong supporting staff. Sellers would like to stay as associates for agreed upon time. For details contact Dental Practice Transition Consultant Chris Regnier by email: chris.regnier@henryschein.com; or call (631) 766-4501. #NY3041.

BROOKLYN: Orthodontist practice in prime location. Four-treatment room, 100% FFS practice with 940-square-feet in professional building. Doctor in practice 22 years. Equipped with digital sensors and pan/ceph. Tremendous room for growth for doctor willing to work more than 1 day/week. For more information contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3325.

KINGSTON: 3 ops with Carestream software, digital sensors, digital scanner, CEREC mill and pan/ceph with phosphor plates. Doctor refers out most endo, all implant placements and perio. Great staff, including one highly trained in Sleep Study. Building on large lot also for sale. Rental apartments in building bring in extra income. For more information contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3327.

QUEENS: Nassau County border. Terrific family-oriented practice for sale. Highly desirable neighborhood of Floral Park, Queens. Located in freestanding building with 1,250 square feet. 3 fully equipped treatment rooms with digital X-rays and utilizing Easy Dental software. Building handicap accessible and offers easy street parking. Diagnostic, preventive and restorative-driven practice with strong hygiene program. Seller owns building and will provide buyer-friendly lease. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3370.

FOR RENT

MIDTOWN MANHATTAN: Beautiful dental office with 1-3 operatories available. Located across from MOMA in building with 24-hour doorman. Fully equipped and digital. Inquiries to: drhwass@yahoo.com.

WHITE PLAINS: Modern, state-of-the-art operatories available in large office with reception. Available FT/PT. Turnkey. Rent includes digital radiology with pan, equipment, Nitrous, all disposables. Start-up or phase down. Need a satellite or more space? Upgrade or down size. Contact us at (914) 290-6545; or email: broadwayda@gmail.com.

UPPER EAST SIDE: Operatory for rent in UES (Madison Ave / 60th St.) office. Modern, quiet, boutique private practice. Endodontic microscope, 2 digital scanners, materials, instruments available for rent. Inquiries by text or email: (646) 648-3242 or pyondds@gmail.com.

MIDTOWN MANHATTAN: Madison Avenue next to world-renowned St. Patrick's Cathedral. Beautiful, large, renovated office with in-house full-service dental lab. Shared front desk space, shared private doctors' office. Fully equipped with CS-9600 CBCT scanner. Large conference room with presentation dual TV/monitor. Please contact doctor directly at (646) 265-7949.

BROOKLYN: Dental office for rent at Grand Army Plaza near Prospect Park. Looking to rent 1-2 operatories full time or part time. Located on first floor of professional building with 24/7 doorman. One block from all public transportation. For more information, please contact (718) 783-4334; or email: mbsb70@gmail.com.

TRIBECA: 1-2 dental operatories available for rent full or part time. Good for specialists or GPs. Spacious, state-of-the-art, with large reception desk and large waiting room. Exposed brick, fully equipped, modern. Zoom light, digital X-ray, pan, ceph. Leather A-Dec chairs and equipment. Onsite CEREC scanner and mill. In-house lab. One block from almost all subway lines. Contact for details: dentalofficenyny@gmail.com.

MANHATTAN: Midtown Manhattan on Madison Avenue. 3 dental operatories for rent full time. Renovated, large, bright, modern dental operatories with windows available and full-service in-house lab. Fully equipped with CS-9600 CBCT scanner and X-ray system. Shared front desk, private Doctor's office as well as large conference room. Please contact doctor Anthony Ceccacci by phone: (646) 265-7949; or email: office@madisonavenuesmiles.com.

MIDTOWN MANHATTAN: Central Park South. Ready to use, recently renovated dental operatories/chairs available for rent. Flexible lease terms, i.e., per hour, per day, etc. Great street access with lots of foot traffic. Easy to commute to and from with public transport. Can provide dental assistants, billing services and insurance assistance, etc. if needed. Please call/text (917) 605-9496; or email: doc@centralparkdentalservices.com.

TRIBECA: Dental op with10-foot ceiling available for rent in brand new dental office. State-of-the-art dental chair with curing light, Cavitron, camera and monitor. X-ray machine and TV in op. Dentists will also have access to brand new reception desk, central air, 17-foot-long lab area. Inquiries to: patmoez@gmail.com.

SERVICES

DENTAL LEGAL SERVICES: Whether it be dentist purchasing or selling dental practice, buying, selling, or leasing office space, employment matters, partnership agreements or litigation, the Law Office of Alan C. Stein, PC, will zealously advocate for your rights. With over 25 years of legal experience in dental transactions, the Law Office of Alan C. Stein can handle the most complex of dental transactions to the most basic. "I'm not just married to a dentist……I live dentistry!" Zoom and in-person appointments available. Offices in Woodbury & Southampton, NY. Call the most trusted law firm for dentists today for your free consultation: (516) 932-1800. Find us online at: www.dentalattorney.net.

EQUIPMENT FOR SALE

NEW BURS FOR SALE IN BULK: Large quantities of new burs: friction grip, right angle, diamonds, finishing and polishers. Catalogue value $3,600. Amalgam–260 oz. Catalogue value $14,000. Need to sell in bulk packages. Inventory lists available. Contact for details: Thaddeus Pantera, DDS, FAGD, by phone: (716) 683-0992; or email: TPantDDS@aol.com.

OPPORTUNITIES AVAILABLE

UPSTATE: Fantastic and rare opportunity to join high-quality and rapidly growing dental group. Our facilities are modern and state-of-the-art with new equipment, digital X-rays and paperless charting. Seeking the right dentists to join team as we expand and grow. First-year and second-year salary minimum guaranteed with opportunity for earnings well above average. Flexible terms and can be tailored to fit your individual desires if determined to be right fit. Very competitive compensation methodology. Training available for precision-guided dental implant surgery. Very strong mentorship program for new and recent graduates. www.sitwell-dental.com. Contact John O'Brien, DDS, by email: jobrien1218@gmail.com; or call (518) 703-5321.

MIDTOWN MANHATTAN: If you have small practice and want to grow it stress-free without any rent, overhead or staffing issues, send us your CV. Opportunity available to become part of progressive practice in beautiful, relaxed office at 60th Street between Madison and Park Avenues. No excess patients here; strictly chance to grow your practice using our facility. Well-trained staff, organized business systems and over 35 years experience to mentor you. Two-doctor office looking for go-getter to build up and buy into equity position. Please send CV to: drk@nycsmilespa.com.

SOUTHERN TIER: Excellent associateship position with partnership opportunity (if desired) for the right general dentist. Join well-established FFS group practice in state-of-the-art facility. Modern implant, restorative and endodontic techniques employed using digital imaging, cone beam and digital scanning technology. Great location in growing University community. Planned retirement of current dentist creates immediate patient base. Inquire by email: columbiadentalgrp@gmail.com; or call (607) 765-85413.

UPSTATE NEW YORK: Plattsburgh. Opportunity to join busy private practice. Opening for General Dentist looking for practice to call home. Two existing individual dental practices have merged into one, as both local dentists have retired. Rare opportunity for new dentist to walk into full, productive patient schedule. Looking for environment to develop professionally, look no further. Seeking talented dental professional eager to evolve in their career. Without difficulties of managing business, you may focus solely on patients. Position offers full clinical autonomy with excellent patient clinical/administrative team and great support from owner; beautiful location close to Lake Champlain and 1-hour drive to Montreal and Burlington, VT; positive atmosphere and excellent loyal patient base; outstanding earning potential with flexible scheduling. Willing to discuss relocation expenses and TN Visa sponsorship, if needed. NYS license or license eligibility required. Please submit resume confidentially to: lakechamplaindentistry@gmail.com.

NORTHERN WESTCHESTER: Exciting opportunity for young professional looking for practice to call home leading to potential for partnership. Serious inquiries only. Northern Westchester modern private practice seeks motivated practitioner comfortable with treatment planning, full-mouth care and executing implant restorative cases. Mentoring by owner if needed, along with supportive team. Candidate must be interested in private practice business model with fee-for-service and limited insurance plans accepted. Please contact us via email to learn more: admin@poundridgecosmeticdentistry.com. We look forward to hearing from you.

CAPITAL DISTRICT: Full-time associateship in busy, 20-operatory practice with two other general dentists, one pediatric dentist, serving 6,000+ patients. Diverse patient pool offers plenty of opportunities to fine-tune your hand skills while learning more advanced techniques from senior doctors. Located just west of Albany, with great salary and benefits, including daily guarantee, 401k with match, profit sharing, disability/life insurance and more. Affordable lifestyle, great outdoors, family friendly, plenty to do. Fully updated practice in gorgeously rehabbed 1860s mansion that blends vintage architecture with modern technology. Big windows, crown molding, fireplace, extravagant chandelier, juxtaposed with brand-new A-Dec chairs, cabinetry. Start with bread-and-butter dentistry, then choose to stay in your comfort zone or grow into more specialized procedures. Open to new dentists or more experienced doctors looking for positive change. Choose level of autonomy that makes you comfortable. Learn more about this amazing practice and opportunity. Email: advisor@ada.org.

NYSDA Life Members

NYSDA Salutes its Newest Life Members

The New York State Dental Association recognizes its members who are achieving Life Member status in 2023. They have dedicated many years to the profession, and we are grateful for their continued participation in organized dentistry.

Each year, NYSDA grants life membership to dentists who as of Dec. 31 of the previous membership year have attained 30 consecutive or 40 nonconsecutive years of membership.

Please join us in congratulating and thanking the NYSDA members listed here for their years of dedication and support. These 136 dentists together have accrued more than 4,177 years of membership.

New York County
Ayroso, Crispin
Binder, Terri
Bovino, Brian
Celenza, Frank
Chaung, Frank
Farone, Egidio
Fine, Scott
Giglio, Ana
Gursky, Alyssa
Hashim, Charles
Lam, Nai-Yan
Levine, Maura
Moezinia, Patricia
Moncrieff, Reginald
Orlansky, Herbert
Pegler, Deena
Radin, Timothy
Scolnick, Jeffrey

Second District
Amen, Doreen
Donato, Michael
Greenfield, Barry
Hamid, Tarek
Kaufman, Mark
Leader, Ronald
Lupiano, Robert
Marcinczuk, William
Pasquale, Deborah
Rosenthal, Eugenia
Roubicek, Susan
Wong, Elaine
Zaborskis, Margaret
Zona, Joseph

Third District
DiCerbo, Marianne
Farooqui, Shagufta
Lyons, Christopher
Pilatich, Joseph

Fourth District
Jensen, Rosalynd
Potvin, Joseph
Rademacher, Diane
Spear, Anne-Marie

Fifth District
Cognetto, Norman
Danaher, Gerald
Deyulio, James
Fiorentino, Matthew
Goodwin, R Clark
Gormley, Kurt
Mortelliti, Gisella
O'Connor, Elizabeth
Passalacqua, Stephen
Simlote, Praveen
Stacy, Lynn
Yallowitz, Alan

Sixth District
Bouton, Pamela
Conte, John
Giordano, Louis
Kapur, Kristna
Lawas, Marcelle
May, Peter
Portela, Leida
Randolph, Charles
Salomons, David
Sambursky, Ronald
Thompson, Amy

Seventh District
Dass, R Ajay
DeStefano, Thomas
Eckermann, Ted
Hoyo, Manuel
Klee, Frederick
Mayer, Michael
Panara, Mary Ann
Prindle, Edgar
Shtoyko, Robert

Eighth District
Calabrese, Paul
Casacci, Kathleen
Farber, Gregory
Kohl, Andrew
Meabon, Kimberly
Modica, Rosanne
Potempa, Gregory
Powers, David
Sindoni, Frank

Ninth District
Caserta, Gregg
Como, John
DeFilippis, Dino
Desai, Swati
Ferguson, Kimberly
Honig-Berk, Ellen
Khavari, Alireza
Le Blanc, Lester
Lodolini, Gina
Lukaswitz, Mary Ellen
Lynch, John
Marino, Joseph
Mc Nerney, James
Ossen, Stephen
Racanelli, Vito
Rioseco, Robert
Simckes, Kenneth
Solomon, Ellen
Wachs, Eric

Nassau County
Abramson, Robert
Bloom, Michael
Conte, Gabriele
Cook, Allison
Dolin, James
Gambella, Daniel
Kaminer, Ron
Klein, Steven
Lamberta, Charles
Lederman, Gary
Mistretta, Michael
Morhaim, Sam
Pistocchi, Roger
Schildhaus, Douglas
Sherman, Gary
Valdinoto, Francis

Queens County
Go, Mario
Lehane, Ronald
Lestz, Richard
Mavromatis, Vasiliki
Schob, Kenneth
Wolfson, Seth

Suffolk County
Cosenza, Nancy
Epakchi, Saeed
Feigelson, Steven
Frost, Kathleen
Gruber, Ross
Maiorino, Robert
Portnoy, Joseph
Profera, Louis
Schindel, Robert
Schwartz, Scott
Shore, Stephen
Sloan, Michael
Witt, Steven

Bronx County
Lieberman, Darryl

Put the pliers down, let the pros do their job.

Some brokers just send you the candidate and leave all the heavy work to you - ***Would your patient pull their own teeth?***

Trust your practice sale to an ***experienced full service broker*** who has had hundreds of practice sales.

(877) 365-6786 • choicetransitions.com

CHOICE℠
Dental practice transitions
An NPT Company

UPPER/CENTRAL NY
Joseph A. Gaspari, DMD **x235**
Molly J. Gaspari, RDH **x235**

LONG ISLAND/BURROWS
Michael Schear **x237**

Considering selling to a DSO? Don't, until you read this.

"Choice walked me through the process, presented the best offers, and made the experience much less stressful by handling all the negotiations. In the end, I received more for my practice than I ever expected. The best part is that Choice provided all the consultation and services to me without charging any fees! If you are considering selling to a DSO, I highly recommend you contact Choice instead of directly contacting the DSOs."

Commission free. DSO Choice.

Call 774-DSO-INFO • choicetransitions.com

CHOICE℠
Dental practice transitions
An NPT Company

No one knows

better than MLMIC.

Choose NY's #1 dental liability insurance provider.

The NYSDA-MLMIC program provides New York dentists from Buffalo to the Bronx with localized risk management guidance, claims protection, and underwriting support. Our policyholders enjoy benefits and expertise not found anywhere else — supported by concierge-level service every step of the way.

For dental malpractice insurance in New York,
nothing compares to MLMIC.

Learn more at MLMIC.com/dental
Or, call (888) 392-0638

NYSDA | MLMIC
MLMIC Insurance Company
The NYSDA-MLMIC Program for Dental Professional Liability Insurance