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JUNE 16, 2003 VOLUME 34, NO. 12

'It's a myth'

Dr. Carmona nixes smokeless 'alternative'

By Craig Palmer

Washington—U.S. Surgeon General Richard Carmona, M.D., mounted the bully pulpit June 3 to "help refute this dangerous idea" that smokeless tobacco is a good alternative to smoking.

■ ADA joins coalition against smokeless tobacco, page six

"It's a myth," he told Congress. "It is not true. I think what we don't do is trade one carcinogen for another." Dr. Carmona, dressed in Public Health Service uniform whites for his first appearance before a

See MYTH, page seven

Photo courtesy House Energy & Commerce Committee

Toxic idea: Trading one carcinogen for another is dangerous, Dr. Carmona tells Congress.

Photo by Airman Angelique Smythe, U.S. Air Force

Special welcome: Dr. Gary Piorkowski meets his son Jake, age 23 days. The lieutenant colonel returned to Kansas last month from duty in the Middle East. Story, page 22.

Oral cancer

ADA's campaign enters third phase

By Karen Fox

■ Survey results from first phase of awareness campaign, page 16

With a renewed call for dentists to examine patients for signs of early cancer, the ADA is launching the third phase of its oral cancer awareness campaign this month in partnership with CDx Laboratories.

The Association introduced the oral cancer awareness campaign in 2001 to bring information about the disease to members and the general public. With CDx support, the highly visible public service advertising campaign encouraging people to see their dentists for oral cancer screening focused on 11 cities nationwide.

As a reminder that oral cancer can strike patients of all ages, the new phase of the ADA campaign targets dentists with the tagline: "You thought oral cancer was just an older man's disease. Not always."

"While those at greatest risk for oral cancer are typically over 40 with a history of smoking and/or alcohol use, we are seeing reports of an increase in populations traditionally considered at lower risk," said Dr. T. Howard Jones, ADA president. "Dentists and hygienists need to be aware of these trends so that oral cancer screening is performed routinely for patients at new or recall visits."

Recent data point to an increased incidence of oral cancer among women—up from 15 percent to one-third of oral cancers diagnosed in the last 45 years. The prevalence of smoking among women is one reason. Cancer is also an age-related disease, and in the United States there are 50 percent more women over age 64 than men in the same age group.

See CANCER, page 17

Women's oral health

Congressional briefing presents current research, generates support

By Craig Palmer

Washington—In puberty, everything's in overdrive, a young woman's oral health threatened by the sheer intensity of life. Gum disease and premature birth visit an unhealthy relationship on her childbearing years. And chronic disease and medications wreak their own vengeance on the oral health of older women.

It was the first congressional briefing ever on "Women's Oral Health: Implications Across the Lifespan," or "Your Mother Used to Tell You to Watch Your Mouth/She Didn't Know How Right She Was," a June 5 presentation of the

See WOMEN, page four

BRIEFS

Can you spell HIPAA?

Don't worry. It's not on the test. (Maybe it should be.)

Take the 20-question test—which comes with the DVD and VHS of the ADA HIPAA seminar that toured the country earlier this year—and get five continuing education credits.

HIPAA: Privacy for Dental Professionals, breaks down the privacy rule under the Health Insurance

Portability and Accountability Act of 1996 into manageable tasks. Dental staff members who fill out the test get the continuing education credit, a grade and a letter of completion printed on ADA letterhead. Check with state dental associations for eligibility. The ADA will charge a $20 administration fee for each test submitted.

To order the DVD or VHS, call the ADA Department of Salable Materials at 1-800-947-4746 or log on to "www.adacatalog.org". ■

INSIDE

New dentists

Conference set for Baltimore. **Story, page 21.**

Chat with ADA HIPAA experts June 26

By Joe Hoyle

Mark your calendar: June 26 is the day to get answers to your HIPAA privacy rule questions.

The ADA and Academy of General Dentistry will sponsor an online HIPAA chat from 7 p.m. to 9 p.m. CDT so members of both organizations can go directly to the ADA experts with questions about the privacy rule and electronic transactions.

"Based on our calls and recent articles in the popular press, there's a lot of HIPAA hysteria that's limiting access to quality health care," said Robert Lapp, Ph.D., director of the Department of Dental Informatics and one of the ADA experts who will answer questions. "For example, general practitioners can still send X-rays to specialists for treatment purposes. HIPAA doesn't change good patient care. Hopefully, we can help our members determine what's prudent and what's excessive."

Dr. Lapp will be joined by Colleen Johnson, an ADA attorney and director of the Contract Analysis Service in the Division of Legal Affairs, for the Internet chat hosted by Dr. Howard Gamble, chair of the AGD Council on Communications.

Anticipated topics for the two-hour question-and-answer session include electronic transactions, business associate agreements, patient complaints, issues with "HIPAA hucksters" and other matters connected with the privacy rule.

To participate in the HIPAA chat, ADA members will need to be registered for members-only content on ADA.org and complete a short registration form on the AGD Web site to establish a username and password for the chat. More information on the registration process will be available soon on ADA.org.

To ensure access to the chat, it is suggested that ADA members take the time to register before June 26.

"Implementation of HIPAA privacy practices has raised many questions so this will be a great opportunity to share our experience with many of our members," Dr. Lapp said.

Following the live chat, a transcript of the questions and answers will be available on

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‘Best news from ADA ever’

Racketeering suit yields positive response

By James Berry

Judging from the early feedback, ADA members and the larger dental community heavily favor the Association’s most recent lawsuit against insurance companies.

Dr. Robert C. English of Marble, Texas, described the suit as “the best news I have gotten from the ADA ever” in an e-mail sent May 20, one day after the Association filed a federal racketeering complaint against three major insurance carriers, their subsidiaries or affiliates.

Filed in Miami U.S. District Court, the class-action civil suit alleges that the companies conspired to “deny, reduce and delay” payments to dentists under contract to the plans.

Named as defendants are:

- Cigna Corp., its subsidiary Cigna Dental Health Inc., and Cigna affiliate, Connecticut General Life Insurance Co.;
- MetLife Inc. and its affiliate, Metropolitan Life Insurance Co.;
- Mutual of Omaha Insurance Co.

“If you need special funding to complete this fight, I want to be the first in line to contribute,” wrote Dr. English, urging the ADA to “pull out all the stops and go for a total win.”

“Bravo for the ADA!!” wrote Dr. Stanley E. Wong, faxing a note, complete with exclamation points, from San Jose, Calif.

“I agree wholeheartedly with the purpose of this legal action,” added Dr. Wong.

Vermont’s Kenneth Pearson called the ADA May 29 to tell Association leaders that he was “absolutely thrilled” to witness the ADA’s aggressive action against insurance companies on behalf of the profession and its patients.

And Dr. John Fallis of Celina, Texas, said in a fax that he hoped the ADA’s litigation would mark “the beginning of radical improvement in reimbursement” to practitioners.

“Bravo for stepping out to confront the abuse we all have experienced for years,” wrote Dr. Fallis.

An attorney in the ADA’s Division of Legal Affairs took a call from a former ADA member who hailed the suit and said he was thinking about restoring his membership because of it.

In addition to individual dentists, the Association also has heard words of support and encouragement from state leaders, including Elza Harrison, executive director of the Maryland State Dental Association, and Noel Bishop, executive director of the Connecticut State Dental Association.

On May 21, ADA President T. Howard Jones received a letter from Dr. James G. Richeson Jr., president of the Academy of General Dentistry.

Dr. Richeson said AGD’s Council on Dental Care receives “dozens of complaints” each year about insurance carriers “abusing” the reimbursement process.

Noted Dr. Richeson, “We were very happy to see that the American Dental Association has put the insurance industry on notice with the recent class-action lawsuit against several carriers that these abuses will no longer be tolerated.”

The AGD president assured Dr. Jones and other ADA leaders that the Academy “fully supports” the lawsuit.

Dr. Jones also heard from Dr. M. Christine Benoit, immediate past president of the Rhode Island Dental Association, who said the suit against “big insurers” was earning praise from members in her state.

“Dentists have been dominated by insurance company whims for so long,” said Dr. Benoit. “On behalf of the Rhode Island Dental Association, thank you and the ADA Board, staff and Legal for this initiative.” ■

AAOMS changes meeting site

Rosemont, Ill.—The American Association of Oral and Maxillofacial Surgeons announced that its annual meeting will take place Sept. 10-13 in Orlando, Fla. The 85th annual meeting originally planned to convene in Toronto.

The AAOMS board of trustees moved the annual meeting site in response to member concerns about potential risks from the severe acute respiratory syndrome (SARS) outbreak in Toronto.

All educational sessions, special events and exhibition will be held as planned in Orlando. AAOMS will send members, exhibitors and other interested parties headquarters hotel information and other site-related details.

For more information, a revised advance program or to register for the meeting, log on to “www.aaoms.org” or call 1-847-678-6200. ■

Women

Continued from page one

American Dental Association and the Society for Women's Health Research in cooperation with the Congressional Caucus for Women's Issues.

Association leaders commended The Colgate-Palmolive Company compendium, "Women and Dentistry," offered with briefing materials as a resource for congressional and government policy makers. The Association and Colgate-Palmolive have partnered to elevate an understanding about differences in the oral health needs of women and men.

The luncheon briefing in the Rayburn House Office Building on a bright spring day attracted some 50 Capitol Hill staffers and oral health advocates, the backdrop a House Science Committee hearing room pictured with the drama of space exploration photographs.

As much a public update, in a highly visible forum, of research relevant to the oral health of women, the briefing offered a snapshot from the growing database of sex-based research on basic biological and physiological differences between women and men and how those differences affect health and disease.

The intent of the Association in offering the briefing was to generate interest in women's oral health among lawmakers and encourage continued support for the broad-based research relating oral to general health while informing good health.

Research shows, for example, that women are especially susceptible to periodontal disease at certain stages of life, according to the ADA and the American Academy of Periodontology.

"Today, we are going to talk about a fascinating area of research, women's oral health and how oral health affects a woman's overall health throughout her life," ADA Trustee Kathleen Roth said in introducing the clinician/research panel.

"What many people do not realize is that the mouth is a mirror of disease," said Dr. Roth. "Dental decay and gum disease are infections, and without treatment, infections can lead to serious health complications. Research shows us that oral health is linked to such preventable diseases as diabetes, heart disease and pre-term birthweight."

A cosponsored event: Phyllis Greenberger addresses a motivated crowd as president and CEO of the Society for Women's Health Research.

Emphatic: Mary J. Berg, Pharm. D., of the University of Iowa and director of SWHR, notes how women respond to medications.

Photos by Anna Ng Delort

First women of dentistry: Dental leaders share a lighter moment. (From left) Rear Adm. Dushanka V. Kleinman, chief dental officer, U.S. Public Health Service; Dr. Linda C. Niessen, Baylor College of Dentistry; Dr. Kathleen Roth, ADA 9th District trustee; Dr. Marjorie K. Jeffcoat, ADA editor and incoming dean of the University of Pennsylvania School of Dental Medicine; and Dr. Barbara J. Steinberg, Drexel University College of Medicine.

Overlapping goals: Dr. Niessen (from left) finds common ground on health care issues with Krysta Jones, American College of Obstetricians and Gynecologists, and Anne DeBiasi, Children's Dental Health Project.

- Dr. Barbara Steinberg, Drexel University College of Medicine, focused on the effects of hormonal changes and eating disorders on the oral health of adolescents;
- Dr. Marjorie Jeffcoat, incoming dean, University of Pennsylvania School of Dental Medicine, reported on recent research on the correlation between gum disease and pre-term, low birthweight pregnancies;
- Dr. Linda Niessen, Baylor College of Dentistry, discussed the effects of menopause, osteoporosis, medications and trauma on the oral health of older women;

Rear Adm. Dushanka Kleinman, U.S. Public Health Service chief dental officer, summarized current research on women's oral health at the National Institute of Dental and Craniofacial Research and other National Institutes of Health.

The panelists fielded questions from Hill staffers and health advocates on access to care for women, periodontal treatment for pregnant women, fluoride for older women and mom's oral health in relation to that of her children. ■

Women's oral health resources

By Craig Palmer

Washington—Women are especially susceptible to periodontal disease at certain stages of life, according to research reported by the American Dental Association in cooperation with the American Academy of Periodontology.

"Women & Gum Disease: What You Should Know," an ADA publication summarizing recent research, is among resource materials on women's oral health offered by the Association and the Society for Women's Health Research at a Capitol Hill briefing June 5.

To order the six-page brochure "Women and Gum Disease: What You Should Know" (Item #P081) or to obtain a sample, contact the ADA Customer Service Center at 1-800-947-4746 or log on to the ADA Catalog Web site ("www.adacatalog.org") to view the brochure and place your order. The price per quantity for ADA members is $22/50, $39/100, $165/500 and $268/1000.

Also in the package of resource materials offered to congressional staff and health advocates at the briefing:

- "Women and Dentistry," a compendium of proceedings from a symposium sponsored by The Colgate-Palmolive Co. and published by Dental Learning Systems Co., Inc.;
- "Women's Oral Health Resource Guide," produced by the National Center for Education in Maternal and Child Health, Georgetown University, single copies available from HRSA Information Center, P.O. Box 2910, Merrifield, Va., 22116; phone 1-888-Ask-HRSA or 1-888-275-4772; fax 1-703 821-2098; e-mail "ask@hrsa.gov"; Web site "www.ask.hrsa.gov";
- Women's health information prepared by the Society for Women's Health Research, briefing co-sponsor with the ADA, on disease differences between men and women, leading causes of illness and mortality in women and recent legislation relating to women's health research, 1828 L St. N.W., Suite 625, Washington, D.C. 20036; phone 1-202-223-8224; Web site "www.womenshealth.org". ■

'Tight-adherence genes,' periodontal disease linked

By Craig Palmer

Tight-fitting genes are a must for bacteria bent on destructive gum disease, say researchers investigating pathogens associated with infections of the heart, brain and urinary tract.

Without "tight-adherence genes," *Actinobacillus actinomycetemcomitans* is just another coccobacillus with little hope of colonizing let alone surviving to wreak havoc in the mouths of children and adolescents, Dr. Daniel Fine and colleagues reported May 19 in Proceedings of the National Academy of Sciences.

The research compared bacterial strains programmed by so-called "tight-adherence genes" to altered strains lacking genes of tenacity to determine whether the altered mutants could still cause disease resembling localized aggressive periodontitis in humans.

The paper, "Tight-adherence Genes of *A. actinomycetemcomitans* Are Required For Virulence in a Rat Model," appeared online at "www.pnas.org/papbyrecent.shtml").

Localized aggressive periodontitis was formerly described as localized juvenile periodontitis. *A. actinomycetemcomitans* is a Gram-negative coccobacillus associated with LAP and infections of the heart, brain and urinary tract.

The study by researchers with the University of Medicine and Dentistry of New Jersey and Columbia University was supported in part with grants from the National Institute of Dental and Craniofacial Research and National Institute of Allergy and Infectious Diseases.

"Continued investigations into the adherence properties and virulence factors of *A. actinomycetemcomitans* in this animal model should contribute to a better understanding of the initial stages of LAP and infectious disease

ViewPoint

Letters

Orthodontic programs

This letter addresses concerns related to the May 19 article, "Corporate Funding." The article discussed a new paradigm in corporate funding of dental education as provided by the Orthodontic Education Company Inc. to the University of Colorado dental school and the new orthodontic program at Jacksonville University.

The article quotes me as saying "AAO has no concerns about the source of funding for Colorado's orthodontic program … [and is] only interested in whether accreditation standards are followed…" In the text of the article immediately preceding the quote, the reporter wrote, "Despite the questions surrounding the OEC funding, the AAO is not opposed to the university's plans."

My quote seems to have been taken out of context and used to imply AAO support of the reporter's statement, in spite of the fact that this is not consistent with the AAO's recent actions.

It is public knowledge that the AAO lodged a formal complaint with the U.S. Department of Education and the ADA Commission on Dental Accreditation. These complaints outline our belief that the commission is not adhering to, among other things, Standard 1-1 of the Accreditation Standards for Advanced Specialty Education in Orthodontics and Dentofacial Orthopedics by granting preliminary provisional approval status to the Jacksonville University specialty education program in orthodontics and dentofacial orthopedics.

The AAO fully supports initiatives designed to address funding issues for accredited dental schools. We have created the largest foundation in dentistry that funds dental education, and have organized summit meetings with the ADA, ADEA and dental specialty groups designed to leverage resources to support the issues related to finances within the accredited schools.

James E. Gjerset, D.D.S., M.S.D.
Immediate past president
American Association of Orthodontists
St. Louis

Editor's note: The Commission on Dental Accreditation will review the AAO complaint and related issues at its Aug. 1 meeting.

SARS

I was concerned to note that the recommendations for SARS in the April 21 ADA News ("ADA Develops SARS Q&A for Dentists") did not contain any recommendations for the control of dental aerosols.

You noted that the Centers for Disease Control and Prevention recommendations for medical treatment of SARS patients included avoiding procedures that create aerosols, such as coughing. However, there was no mention of the potential for the production of infectious aerosols during the treatment of a prodromal patient who may have contracted SARS but not yet developed symptoms.

Numerous studies have shown that dental procedures such as the use of a high-speed drill, ultrasonic scaling and air polishing produce copious amounts of contaminated droplets and aerosols. There is a likelihood that the droplets from a patient who is in the two-to-10 days incubation period for SARS could be contaminated with the coronavirus suspected of causing SARS.

Personal protection barriers such as masks will prevent a large percentage of contaminated droplets from entering the respiratory tract of dental workers, but masks have been shown to leak and are often worn improperly. Masks offer no protection when they are removed after completing a procedure, and true aerosols can remain in the air for up to 30 minutes after they are produced.

Contaminated droplets and aerosols are easily controlled at the source (the mouth) by the use of a high-volume evacuator. The use of a large-bore high-volume evacuator, not a saliva ejector, during dental procedures has been shown to reduce aerosols and droplets by 90 percent or greater. Because aerosols and droplets from dental procedures have been shown to be universally contaminated with bacteria—and, in the case of root planing using ultrasonic scalers, contaminated with blood—the use of a high-volume evacuator during most dental procedures should be a universal precaution.

The advent of SARS merely adds a more dangerous component to an already existing risk and underscores the need for the routine use of a high-volume evacuator.

Stephen K. Harrel, D.D.S.
Dallas

Editor's note: For an update on SARS, see page 20.

Women researchers

Washington—Women in research still have time to apply for a grant from the Women's International Science Collaboration Program to conduct research in an international setting. The application deadline is July 15.

The program is sponsored by the American Association for the Advancement of Science and the National Science Foundation. Grants help offset travel and living expenses for a U.S. scientist to visit a partner country. For more information on eligibility requirements, participating countries and application procedures, log on to "www.aaas.org/international/wisc/". ■

Coalition heard at hearings

Health groups urge Congress to reject smokeless tobacco safety claims

Government

By Craig Palmer

Washington—A broad-based coalition of dental and public health organizations including the ADA urged Congress at the opening of a new round of tobacco safety hearings to reject industry efforts to promote smokeless products as "healthier" alternatives to cigarettes.

This time the congressional focus is on the relative risks of various tobacco products or to what extent a hierarchy of harm serves the public health by permitting promotion of any tobacco as "less harmful," "healthier" or "safer" than another.

"The truth is that there is no safe form of tobacco," the 19-member coalition said in letters to House committees holding hearings on the relative safety of various products including chewing tobacco, snuff and other smokeless tobaccos as the industry steps up efforts to market alternatives to cigarettes.

"It is more important than ever that we spread the word that just because a product is labeled 'smokeless' that it is not harmless or a safe alternative to smoking," said the coalition of professional and advocacy organizations. "We must be diligent in educating the youth of America that smokeless tobacco is a dangerous and addicting substance that poses an overall threat to one's health and could result in death.

"It is evident that marketing spit tobacco as a healthier alternative would have a negative effect on public health."

The letter uses the terms "spit tobacco" and "smokeless tobacco" to describe non-smoking products. "We recommend you publicly state the health risks of all forms of tobacco use," the coalition told Congress.

The House Commerce and Government Reform committees scheduled separate hearings June 3 on "harm reduction" issues, or "minimizing harms and decreasing deaths without completely eliminating tobacco and nicotine use" as the Commerce Committee said in a hearing notice. The committee invited testimony from U.S. Surgeon General Richard Carmona, whose predecessors established the record of tobacco's harm, and Federal Trade Commission Chair Timothy Muris, whose agency regulates advertising.

Mr. Muris

"This hearing provides an opportunity to examine whether commercial advertising is an appropriate form to highlight less harmful alternatives to cigarette smoking," said Rep. Cliff Stearns (R-Fla.), who chairs the commerce, trade and consumer protection subcommittee.

"Harm reduction presents both promise and uncertainty," said Rep. Tom Davis (R-Va.), chair of the Government Reform Committee, which examined the possible public health impact and regulatory challenges of "reduced risk" tobacco products. "There is still much we do not know about tobacco-related illness, nor do we fully understand why people smoke cigarettes in the first place. Finding answers to these questions is a critical component of harm-reduction efforts. Another core concern is that while these products may be able to remove a degree of risk for users, the notion of a 'safer' product could prove damaging to the population as a whole." ■

FTC reports on smokeless advertising

By Craig Palmer

Washington—The Federal Trade Commission offered Congress a status report on the industry's renewed attempt to market smokeless tobacco products as "less harmful" than cigarettes.

In Feb. 2002 the United States Smokeless Tobacco Co. petitioned the FTC for an advisory opinion regarding the acceptability of communicating in advertising a harm reduction claim for smokeless tobacco. USST withdrew the petition last August, saying it would give the Commission information from scientific conferences relevant to the petition.

On May 9, 2003, USST "provided this additional information to the Commission, and asked that the Commission place this new information on the public record and hold a 'public forum' to discuss these issues," Timothy Muris, FTC chair, told Congress.

"The agency is committed to reviewing advertising for potential reduced risk tobacco products on a case-by-case basis to try to ensure that the information consumers receive about reduced risk products is truthful and non-misleading," Mr. Muris said. He gave no indication of how the FTC will handle the industry request. ■

Myth

Continued from page one

Representatives, said he would continue using the bully pulpit established by a long line of Surgeons General to make the case that all tobacco products are hazardous to health.

A 1986 Surgeon General's report formed the basis for current regulation of chewing tobacco, snuff and other non-smoking products, concluding that:

- Smokeless tobacco represents a significant health risk;
- Smokeless tobacco can cause cancer and a number of non-cancerous oral conditions;
- Smokeless tobacco can lead to nicotine addiction and dependence;
- Smokeless tobacco is not a safer substitute for cigarette smoking.

"No matter what you may hear today or read in press reports later, I cannot conclude that the use of any tobacco product is a safer alternative to smoking," Dr. Carmona told a packed House Commerce Committee hearing. "This message is especially important to communicate to young people, who may perceive smokeless tobacco as a safe form of tobacco use."

A broad-based coalition of dental and public health organizations, including the American Dental Association (Story, page six), urged Congress as hearings began to reject industry efforts to promote smokeless products as "safer" alternatives to cigarettes.

The smokeless tobacco industry has petitioned the Federal Trade Commission for an advisory opinion on whether it may advertise its products as a safer alternative to cigarettes. Two congressional committees took up the issues of "harm reduction" strategies at crowded full-day hearings June 3, taking testimony from government regulators, scientists, anti-tobacco advocates and industry representatives.

A National Cancer Institute witness told the House Government Reform Committee:

- All tobacco products are hazardous;
- There is no safe level of tobacco use;
- The only proven way to reduce the enormous burden of disease and death due to tobacco use is to prevent its use and to help users quit.

"In (the) NCI's view, a product would be 'harm reducing' if it actually reduces disease and death for both individuals and the population as a whole," said Scott J. Leischow, Ph.D., chief of the NCI tobacco control research branch. "This is an important distinction because even if a tobacco product is shown to reduce disease risk in an individual, the availability of products that claim reduced harm may have harmful consequences on the population."

Rep. Henry Waxman (D-Calif.), who participated in both hearings, said the tobacco industry had misled the FTC and the public 30 years ago with claims of "safer" low-tar cigarettes, "a deadly fraud and this deception continues today. The tobacco industry is now attempting another fraud on the American people. Today two committees are looking at what the industry wants. That's what Congress has come to."

Mr. Waxman suggested to FTC Chair Timothy Muris, who testified at the Commerce hearing, "this is a hearing for you, to impress on you" the interest in so-called reduced risk tobacco products.

The FTC deferred to the science, telling both committees that while there may be products that can reduce harm, these products may also harm the public. "Although a (FTC) determination that an individual risk reduction (advertising) claim is truthful and substantiated would end the Commission's deception inquiry, broader public health issues may remain," Mr. Muris testified.

"This debate on the public health effects of these alternative tobacco products is an important one the appropriate science-based agencies of the government need to address," the FTC chair said. ■

ADA, coalition letters tell Congress: 'There is no safe form of tobacco'

By Craig Palmer

Washington—The American Dental Association joined 18 professional and advocacy groups asking Congress for "leadership and influence in championing trusted information on the known health risks of spit (smokeless) tobacco use" against the push for reduced-risk tobacco products.

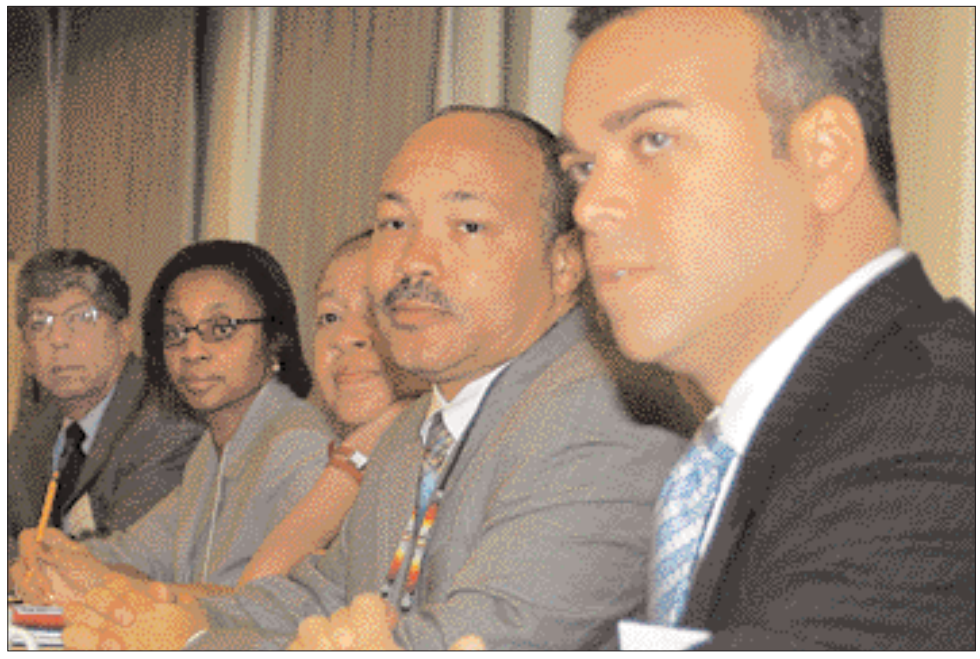
"There is no credible evidence that spit tobacco use is effective in achieving smoking cessation," dental and public health organizations said in letters to two House committees opening hearings this month on tobacco safety. (See story, page six.) "In fact, we know of no scientists who are willing to say that using spit tobacco is a safe alternative to smoking. The truth is there is no safe form of tobacco."

Dr. James B. Bramson, executive director, signed for the American Dental Association.

Letters to the House Commerce and Government Reform committees also were signed by officials representing dental, public health and advocacy organizations including Oral Health America, the Association of State & Territorial Dental Directors, Johns Hopkins Urban Health Institute, American Association of Public Health Dentistry, The Forsyth Institute, American Dental Hygienists' Association, Campaign for Tobacco-Free Kids, The Yul Brynner Head and Neck Cancer Foundation, American Academy of Pediatric Dentistry and cancer, dental school, research and tobacco program representatives. ■

Reaching out

ADA committee addresses how to attract minorities to dentistry



By Karen Fox

While an undergraduate at Harvard University, Carla Guzman decided she wanted to become a dentist.

Taking the Dental Admissions Test would be challenging, and the 26-year-old Hispanic woman didn't expect dental school to be a cakewalk. But what she didn't plan for were the challenges she would face in preparing for dental school.

"The advisor at Harvard had never helped a student with pre-dental preparations before," said Ms. Guzman, who just completed her first year at the University of Maryland Dental School. "I ended up going to an advisor at George Mason University."

As a child, Dr. Erik Nelson, a dentist of Choctaw Indian heritage and member of the Society of American Indian Dentists, lived in a home with no running water.

"I was always motivated to reach for something higher," he said of his own career aspirations.

"But there is a risk," he said. "If you leave the reservation for college, you're seen as going to the 'white-man's world.' If you return to the community, there is a barrier there."

The experiences of Dr. Nelson and Ms. Guzman illustrate a common yet frustrating problem in dentistry: For a myriad of reasons, far too many minorities don't pursue careers in the dental profession.

To find out how the ADA can expand the pool of applicants to the nation's dental schools and encourage underrepresented minorities to think about dentistry as a career, the Council on Dental Education and Licensure convened the Ad Hoc Committee on Diversity to Attract Qualified Underrepresented Minorities into Dentistry May 28 at ADA headquarters.

Groups represented on the committee included the Society of American Indian Dentists, the Hispanic Dental Association, the National Dental Association, the American Dental Education Association and the American Student Dental Association. Dr. Nelson represented SAID, and Ms. Guzman ASDA. A representative from the W.K. Kellogg Foundation attended as a guest of the committee.

"Our goal was to develop ways the ADA can collaborate with other institutions and organizations to expand the pool of qualified, underrepresented minorities into dentistry," said Dr. Charles Sanders Jr., dean of the Howard University College of Dentistry and member of the Council on Dental Education and Licensure who chaired the ad-hoc committee.

Finding ways to reach out to underrepresented minorities is a key component of the ADA campaign launched in 2002 to attract and encourage qualified students into dental careers.

See REACHING, page 10

Career advising: Pictured from left above, committee members Drs. Indru Punwani, Zenaida Cofie, Henri Treadwell, Gregory Stoute and R. Ivan Lugo ponder ways to attract underrepresented minorities into dentistry. Dr. Charles Sanders Jr. (at the microphone) chairs the ad-hoc committee.

ADEA wins Kellogg grant

Funds will help increase minority faculty numbers

By Karen Fox

Washington—The American Dental Education Association has received a $2,408,127 six-year grant from the W.K. Kellogg Foundation to increase the number of underrepresented minority dental faculty members.

ADEA plans to use the funds to:

- create formal mentoring programs, academic partnerships and community-based practices and projects to attract, nurture and support the development of underrepresented minorities to become dental school faculty members;
- utilize training opportunities offered by the federal government;
- create a system of acquiring data to review and evaluate efforts to develop minority faculty.

ADEA will award eight grants to dental schools that can demonstrate they are able to invest in the strategic points of the program. All U.S. dental schools are eligible to apply for the grants.

The latest Kellogg grant complements a separate ADEA effort with the Robert Wood Johnson Foundation and Columbia University to implement programs at dental schools and develop minority leadership in academic dentistry.

"ADEA recognizes that the shortage of underrepresented minority dental faculty represents a crisis in our profession," said Dr. Paula Friedman, ADEA president. "We are going to respond to this crisis with a multi-pronged national effort that will be supported by the W.K. Kellogg grant."

For more information on the grant, contact Sonja Harrison at the ADEA Center for Equity and Diversity, 1-202-667-9433 or "harrisons@adea.org". ■

Acromegaly treatment approved

Rockville, Md.—The Food and Drug Administration has approved "pegvisomant" to treat acromegaly, an excessive growth disorder that can potentially lead to jaw growth and malocclusion.

"Somavert," its tradename by Pharmacia Corp., is the first in a new class of drugs called "growth hormone receptor antagonists that can help normalize concentrations of insulin-like growth factor-l, a hormone produced in excess due to a pituitary tumor."

Acromegaly causes joint disorders, changes in facial features and an enlarged jaw, among other things. Patients may have a shortened life span due to heart and respiratory diseases, diabetes mellitus and cancer. ■

Reaching

Continued from page eight

Materials developed to support the campaign—united under the theme "Something to Smile About: Careers in the Dental Profession"—are sensitive to the recruitment of underrepresented minorities. A mentoring initiative that pairs practicing dentists with students (K-16) who have an interest in dental careers is also in the works.

"As a committee, we looked at some of the traditional ways we've promoted dental careers, and explored new opportunities by collaborating with groups like ADEA and the National Association of Advisors for the Health Professions," said Dr. Sanders.

"A situation like this calls for nontraditional ways of doing things, and that requires some imagination and time to think the process through," he continued. "I think we will be able to make a significant improvement in developing strategies to expand the pool of those considering careers in dentistry."

The group's response to the challenge was to develop short- and long-term strategies that the CDEL can use to enhance the campaign to encourage qualified students to pursue dental careers.

Among the short-term strategies are:

- develop partnerships with the National Dental Association, Hispanic Dental Association, the Society of American Indian Dentists and other appropriate agencies to mobilize and train member dentists to be mentors, and develop resources for dental organizations to use to augment these efforts;
- build coalitions with the American Student Dental Association, the American Association of Women Dentists, the National Institute of Dental and Craniofacial Research and others;
- strengthen relationships with pre-health advisors;
- reach out to non-dental groups, such as church groups, the Boys and Girls Clubs of America and Head Start.

Some of the committee's long-term strategies include:

- portray dentistry in a more positive light and use initiatives like Give Kids a Smile to improve the public perception of dentistry;
- continue working to reduce student debt;
- review accreditation standards related to cultural competency.

For more information on the campaign, contact Beverly Skoog at Ext. 2390 or "skoogb@ada.org". ■

Anesthesia color codes

New system helps recognition, increases safety

By Mark Berthold

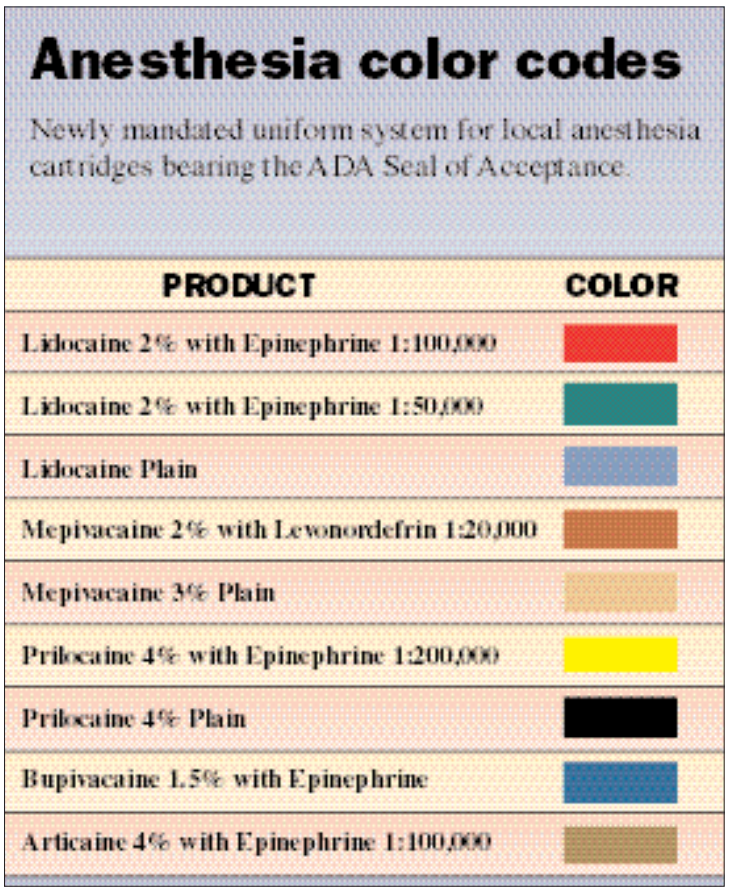
Local anesthesia dental products that participate in the ADA Seal of Acceptance Program have undergone a subtle change in appearance over the past year.

You guessed it, the labeling on the anesthetic cartridge is now consistent with a new color-code system designed by the ADA Council on Scientific Affairs.

"This uniform color coding will bring needed standardization to the dental anesthetic cartridge—the outcome of which will be easier recognition for the practitioner and increased safety for the patient," says Dr. Michael A. Siegel, council chair.

The new look consists of a 3-millimeter band of color on the anesthetic cartridge, placed 15 mm from the stopper end, with durable black lettering that follows the labeling guidelines of the U.S. Food and Drug Administration.

The coding applies to all injectable local anesthetics and local anesthetic/vasoconstrictor combinations that participate in the Seal program. The council also encourages dental manufacturers of non-accepted anesthetics to adopt the system.



The council created the uniform color coding to fulfill Res. 2H-2001 of the ADA House of Delegates, which decided it would be "a useful adjunct" for dentists to identify which specific anesthetic/vasoconstrictor is needed. Delegates' concern was that some products, such as epinephrine and non-epinephrine, had labels very similar in appearance, which could lead to an error in anesthetic selection.

The council sent a letter dated June 21, 2002, to manufacturers of Seal anesthetics to notify them of the color coding system and give them one year to implement it. As of this June 21, manufacturers may ship only those Accepted products that comply with the ADA color code, the letter read.

Where possible, the council chose Pantone colors that reflected the colors used in long-established products; manufacturers were involved in developing the code and were eager to comply.

"We are proud to be part of the new color coding initiative," says Susan Crawford of Dentsply Pharmaceutical. "We feel this program is a step forward in eliminating confusion among the various anesthetic products."

Adds Jim Flood, manager, Cook-Waite anesthetics, "Eastman Kodak was happy to work with the ADA Council on Scientific Affairs for our common goals of patient safety and helping dentists identify the appropriate product in the operatory. We're happy our involvement has helped result in a much-improved system for local anesthetics." ■

New York fights human subjects in clinical exams

By Mark Berthold

Albany, N.Y.—A bill introduced at the New York State Dental Association's request would prohibit the use of human subjects in clinical dental examinations.

Allowing unlicensed persons to test live patients poses a health risk, says the NYSDA, and it uses a population drawn overwhelmingly from poor and minority communities. The practice is also unfair to the dental applicant, who is failed if the patient fails to keep the appointment.

"The association feels the time has come to replace live subjects in clinical examinations with other methods that we feel more accurately reflect a candidate's level of competency," says Dr. William Calnon, NYSDA president.

"A new state law, which allows the successful completion of a Commission on Dental Accreditation-approved residency to be used as an alternative to a clinical exam, is a perfect example." ■

Anesthesia code doesn't replace label directions

The uniform color coding system for local anesthesia dental products is a new convenience and safety measure.

However, "It's also important that dentists not rely on the cartridge's color as a substitute for carefully reading the label," says Dr. Michael Siegel, chair of the ADA Council on Scientific Affairs.

"Some products on the market don't participate in the Seal program and could use another color system—even some Seal products that were shipped before the deadline might still display the company's prior color-coding system," he notes.

Adds Dr. Daniel Meyer, associate executive director of the ADA Division of Science, "The new color coding system is intended only as an adjunct for timely and accurate identification of the anesthetic cartridge, to help ensure that the dental provider delivers the appropriate anesthetic and dose to the patient."

He adds, "Dentists should not consider the color coding as a substitute for reading the cartridge label."

When selecting a specific local anesthetic/vasoconstrictor during the changeover, dentists should take extra precautions to read the product labeling and not rely on the cartridge's color. ■

Starting Out

Taking chances?

Insure your practice, income

By Karen Fox

Dr. Robert Kochenderfer was diagnosed with an arthritic back condition 10 years ago while still a dental student at the University of Minnesota.

As a result, he has the tendency to suffer stiffness in his back that can lead to fatigue. And going on an amusement park ride? Don't even think about it.

Right now, Dr. Kochenderfer's condition doesn't interfere with his ability to practice dentistry. But for the 35-year-old general practitioner, it's a constant reminder of the need to protect his investment in his dental education and training by maintaining the right level of disability insurance coverage.

"It's just one of those things you have to have," he said. "Just like malpractice insurance to protect your practice, you buy disability insurance to protect yourself in case you have an injury."

Dr. Kochenderfer has never had to file a claim on his disability coverage, and he may never need to. But he stands out among new dentists in that he has maintained disability insurance since day one of practice.

Disability insurance provides dentists with benefits that replace the net income they earn from their practice when they are unable to practice due to illness or injury. Depending on the policy, benefits can be paid during periods of partial disability as well as total disability.

Dentists can insure up to 60 percent of their net income before taxes with disability insurance. In most cases, disability benefits are not subject to income taxes.

For many, disability coverage can be the difference between making ends meet and bankruptcy. This is particularly true for young dentists who usually have limited financial assets and large debts.

Yet statistics show that many dentists in practice 10 years or less have no disability insurance. According to the 2000 ADA Membership Needs and Opinions Survey, 17.7 percent of ADA member new dentists and 31.9 percent of nonmember new dentists stated they had no coverage.

"My perception is that dentists are cash-strapped when they enter practice, and whether they purchase disability insurance or not depends on whether they think they can afford it," said David Dwyer, director of the ADA Council on Members' Insurance and Retirement Programs.

"Dental careers depend on a combination of intellectual capabilities and a high level of physical capabilities," Mr. Dwyer added. "Dentists are artisans. If they can't control their fingers or hands, they are out of business. Or if their backs go, they're out of business. That same level of physical vulnerability is not present in other professions."

To put it more bluntly: "A lacerated thumb wouldn't take out a lawyer."

With Great-West Life & Annuity Insurance Co. as its exclusive carrier, the ADA offers members two disability insurance products: the ADA Income Protection Plan (disability income coverage) and the ADA Office Overhead Expense Plan (business overhead disability coverage). (See story, page 21.)

Examining current claims data from Great-West shows a number of revealing trends for dentists under age 45:

- 15 percent of all current disability claimants are dentists under age 45.
- Of that 15 percent, about one-third became disabled under age 40 and two-thirds became disabled between ages 40 and 44.
- 33 percent of the claims are due to back/cervical injuries, including degenerative disorders.
- 10 percent of claims are due to wrist injuries.
- 10 percent are due to nervous system disorders (60 percent of these claims list essential tremors, multiple sclerosis or amyotrophic lateral sclerosis, or Lou Gehrig's disease, as the cause for disability).
- Other causes for disability include stroke/hypertension, cancer, vision impair-

See DISABILITY, page 21

Oral cancer awareness

ADA survey shows more than one-quarter of respondents pay more attention to lesions

By Arlene Furlong

Most people don't even know dentists look for oral cancer during a routine dental exam.

That's just one of the findings from the 2002 Oral Cancer Campaign report published by the ADA Survey Center.

The 2001 oral cancer public service campaign was promoted in outdoor billboards, on taxi-tops and bus shelters in 11 major cities and through direct mail and ADA publications. It targeted dentists and consumers throughout the country.

A girl with a lesion on her tongue and a tongue with a lesion illustrated the message: "It's tiny now [referring to the lesion]. Don't let it grow up to be oral cancer."

In 2002, the ADA Survey Center conducted surveys of dentists and consumers to gauge pre-campaign and post-campaign awareness of both oral cancer and the ADA campaign.

"When you conduct a campaign like this one, you're bringing the issue forward for renewal of discussion, re-opening the dialogue."

The results show that nearly three-quarters of surveyed dentists knew about the campaign. And one-quarter of them report paying more attention to lesions since the campaign than before.

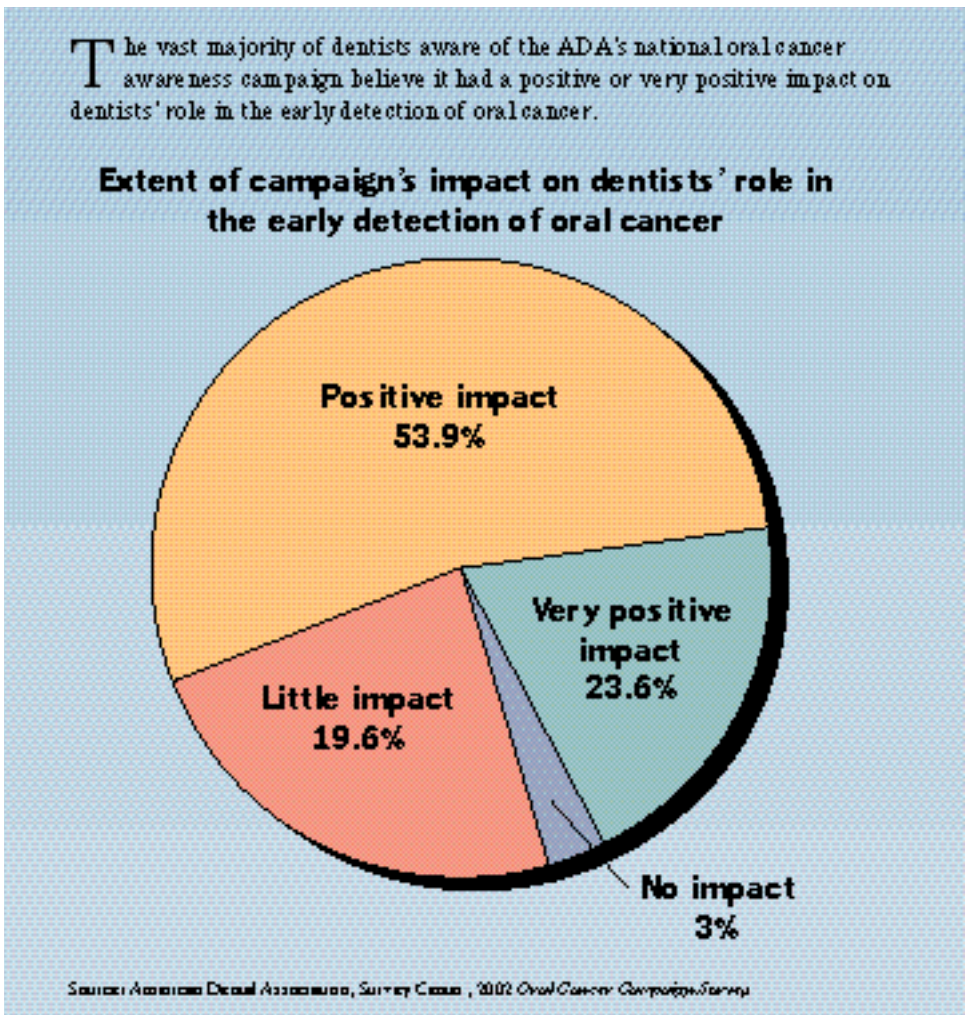
"Overall, it was a great use of ADA resources," says Dr. Jay H. Garlitz, vice-chair of the ADA Council on Communications. "When you conduct a campaign like this one, you're bringing the issue forward for renewal of discussion, re-opening the dialogue."

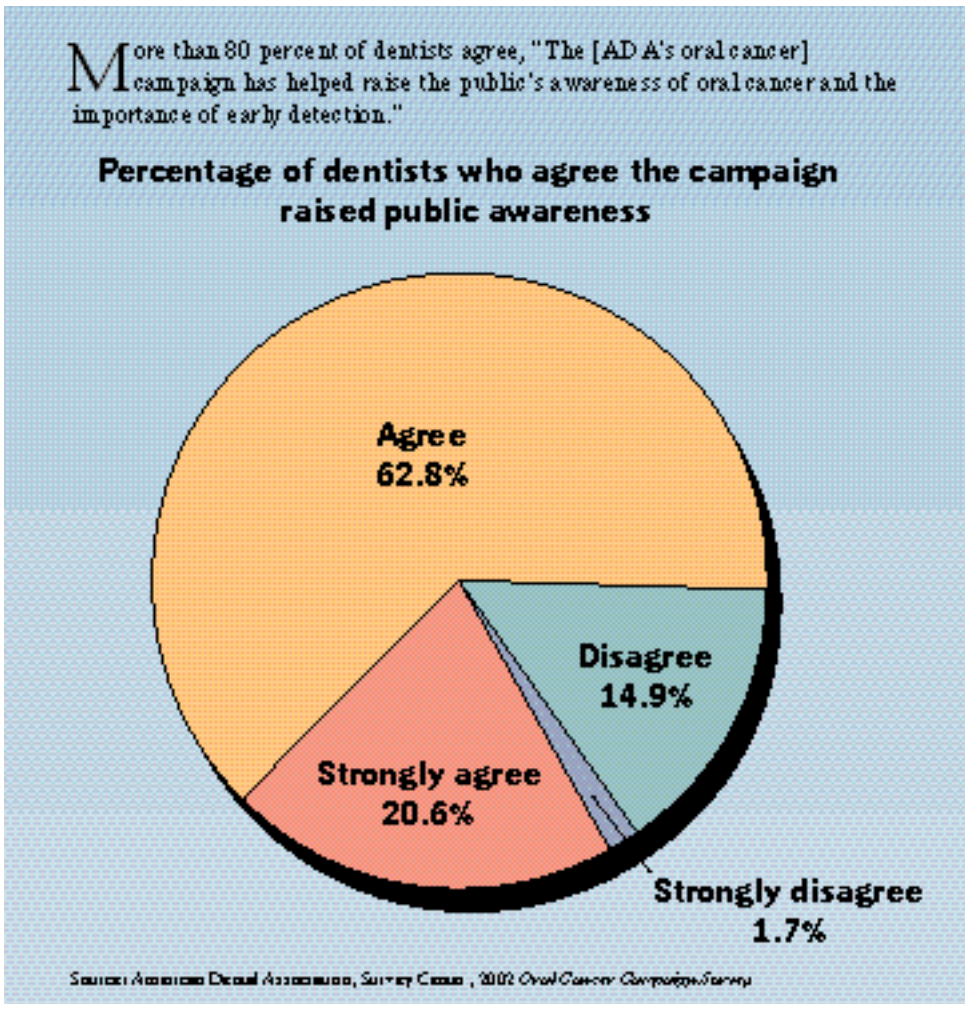
Dr. Thomas Sullivan, council chair, said the survey results show how the campaign put early "With the survival rate the same now as it was 20 years ago, the campaign was the kick in the behind we all needed," says Dr. Sullivan.

Some 28,900 new cases of oral cancer emerged in 2000, according to the American Cancer Society's Facts and Figures 2002. The five-year survival rate of oral cancer at all stages is 56 percent.

Results from both the dentist and the consumer surveys are reported in the 2002 Oral Cancer Campaign: Dentist and Consumer Surveys.

The report costs $20 for members; $30 for nonmembers and $60 for commercial firms, plus shipping and handling. Call the Survey Center toll-free, Ext. 2568, or e-mail "survey@ada.org". ■





Cancer

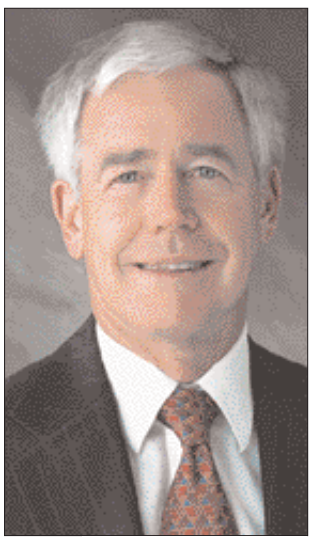
Continued from page one

Oral cancers among men are also on the rise. Though the cause is uncertain, tongue cancer in males under age 40 has increased, according to the National Cancer Institute.

The stakes are high in detecting oral cancer. About 30,000 new cases are diagnosed each year in the United States, and the American Cancer Society states that oral cancer occurs almost as frequently as leukemia and claims almost as many lives as melanoma cancer.

Although tobacco users and those who consume alcohol are at higher risk for developing the disease, more than 25 percent of oral cancer patients do not fall into these risk categories.

From a dental perspective, the message is simple: Routine, careful examinations of patients and testing of suspect areas can be achieved during a regular dental visit. When detected at its earliest stage, oral cancer is more easily treated and cured.



Dr. Jones

"Testing is painless, and there is no question that early detection saves lives," said Dr. Jones.

"The ADA has been very aggressive in educating our members about oral cancer control and the importance of tobacco cessation," he added. "We now need to expand professional and consumer awareness about the fact that patients should be screened for oral cancer."

The early phases of the ADA's oral cancer awareness campaign showed promising results. Findings from the 2002 Oral Cancer Awareness Campaign survey revealed that responding dentists were aware of the campaign, a number made changes in their practice since the campaign, and many believed that the campaign shed a positive light on the role of dentists in the detection of oral cancer. (For more on the oral cancer awareness surveys, see page 16.)

CDx Laboratories—providers of OralCDx, the computer-assisted, painless brush biopsy oral cancer detection test—support the campaign through an unrestricted educational grant.

"Since the introduction of OralCDx three years ago, we have talked to thousands of dentists who tell us how much their patients appreciate receiving regular early oral cancer screening and appropriate testing," said Mark Rutenberg, CEO, CDx Laboratories.

"Our partnership with the ADA on this new national campaign will bring important information—such as the rise in oral cancer incidence among traditionally low-risk populations, including people under age 40 and women—to the profession," continued Mr. Rutenberg, "and will help make early oral cancer detection part of practice routine."

Sullivan-Schein Dental has been the exclusive distributor of OralCDx since 1999.

"We recognize the important role that the dental team plays in identifying oral cancer, and fully support their efforts to enhance patient health," said James Breslawski, president, Sullivan-Schein Dental.

The current phase of the oral cancer awareness campaign will run through January 2004, and will be highlighted by a special lecture at the ADA annual session.

"Oral Cancer: How Risky Is It?"—featuring speakers Drs. Anthony DiAngelis and James Sciubba and moderator Dr. Lawrence Meskin—will be held Sunday, Oct. 26, from 9:45 a.m. to 12:15 p.m. For information on registering for annual session workshops, go to "www.ada.org/goto/session".

The Association is working with state and local dental societies to promote education and awareness among members, featuring a series of activities targeted to dentists, dental schools, patients and consumers.

Go to "www.ada.org/public/topics/cancer/cancer.html" for more information on oral cancer. ■

New theme: the Oral Cancer Campaign image dons a new theme as it enters its third phase.

Tooth prints: a unique ID tool

Massachusetts dentists volunteer in CHIP program to protect kids

By Stacie Crozier

Milton, Mass.—When television personality John Walsh spoke at a pediatric dental meeting some two decades ago, Dr. David Tesini was touched.

"After his son Adam was abducted and murdered, John Walsh said he wanted to thank the dental profession for giving some closure to his ordeal, since Adam was identified through dental forensics," says Dr. Tesini.

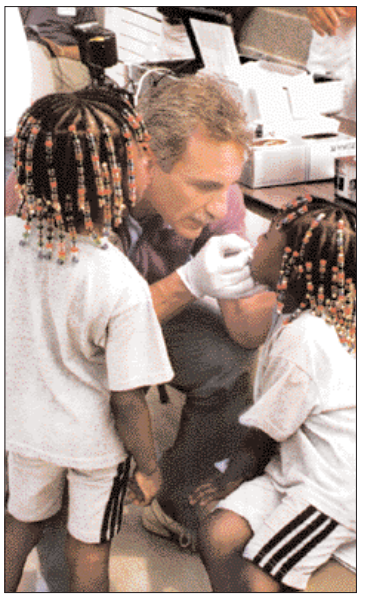
Mr. Walsh's speech got Dr. Tesini wondering how children's dentition—often caries-free thanks to fluorides and good oral care—could be identified without markers like restorations or other dental work. And, with a young son of his own, he wondered as a parent how the process could help find lost or abducted children.

Since every child's teeth have distinctive sizes, shapes, positions and relationship in the bite, he says, he developed a way to make "tooth prints" by having the child bite into wax wafers.

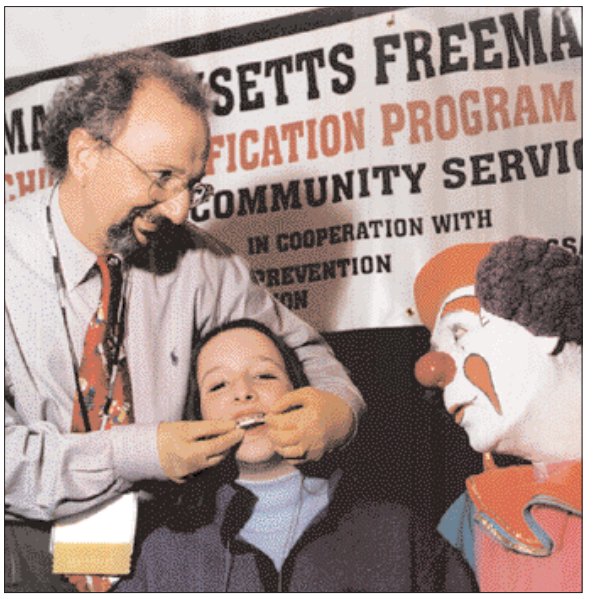
"Every child's tooth print is unique, kind of like a dental fingerprint," he says. "And by recording them, we can make a reliable, long-term record that can be used to identify them."

The original tooth prints, he notes, were too sensitive to temperature, so he modified them by using thermal plastic wafers. A wafer is warmed until pliable and then tooth printed by a child. The wafer then hardens into a reliable long-term record of the child's unique dentition.

Another plus for tooth prints is that when they are sealed in a zippered plastic baggie, the child's DNA from his or her saliva as well as the scent of saliva remains on the wafers, facilitating use of DNA evidence in identifications and scents for scent dogs searching for missing children.



Tooth printing in action: Dr. Michael Swartz takes a young girl's tooth prints during a CHIP program.



Fun with a purpose: Dr. David Tesini demonstrates his unique identification tool on a participant as a Massachusetts Freemasons CHIP fair entertainer looks on.

Tooth printing was embraced in the state of Massachusetts in 1999 as part of a unique community-based child identification program called CHIP for short. So far, more than 161,000 children in the state have participated in the program.

Volunteers take three types of vital records at school-, community- and health fair-based CHIP programs: tooth prints, fingerprints and a video that records children's appearance, mannerisms and voice.

The state program is funded by the Massachusetts Freemasons and more than 1,500 Massachusetts Dental Society member dentists have volunteered in their communities for the program. The Freemasons administrate CHIP programs in 20 states, and tooth printing is a component of the programs in Connecticut, Massachusetts, Nevada and Rhode Island.

"Massachusetts dentists have donated about $4.8 million in time to protect kids in their communities in the last five years," says Dr. David Harte, state Masonic CHIP program director. "To date, 37 school systems participate in the program and at least a third of MDS member dentists have volunteered their time and talents.

"This program is a good thing for dentistry and I encourage state societies to seek similar collaborations," says Dr. Michael Swartz, a member of the ADA Council on Access, Prevention and Interprofessional Relations. "CHIP is also an excellent way to enhance public relations for the profession, for participating community organizations and for each volunteer dentist's own practice. Not only is it a great public service, it's something that makes you feel good about doing it—that's what volunteering is all about."

Former MDS president, Dr. Swartz helped set up the tooth printing portion of the state CHIP program with the Freemasons and the dental society during his term in office.

"Tragedies like plane crashes, 9-11 and high-profile cases like the Elizabeth Smart abduction have shown us how important a good identification system can be," adds Dr. Harte. "Dentists can play a significant role in helping protect children and bringing families peace of mind."

For more information on the Massachusetts program, e-mail "chip@glmasons-mass.org" or log on to "www.mychip.org". ■

SARS: update for dentists

To date, there has been no reported transmission of severe acute respiratory syndrome (SARS) to dental health care workers, nor is there any evidence that SARS can be transmitted by aerosol-generating dental procedures, reports the ADA Council on Scientific Affairs.

However, dental health care workers should take routine precautions to reduce aerosol-generating procedures and use personal protective equipment in any patient contact area, says Dr. Michael A. Siegel, chair of the Council on Scientific Affairs.

"Though SARS transmission to health care workers has occurred following unprotected direct contact with symptomatic SARS patients, it appears unlikely, given the quick course of the disease, that dentists will encounter SARS patients in the dental office," explains Dr. Siegel.

At this time, there has been no indication of community transmission in the United States.

To avoid unprotected exposure to SARS:

- Do not treat a suspected SARS patient in the dental office.
- Educate dental personnel about SARS. The learning protocol should include the use of personal protective equipment, hand hygiene, case identification and asking screening questions of all dental patients.
- Enforce infection control measures and the use of personal protective equipment at all times. (See infection control table.) Personal protective equipment should be used with all patient contacts.
- Wear N-95 respirators if you work in a hospital and care for patients with suspected SARS. Follow the hospital infection control protocol.
- Ask screening questions of all patients when they call for appointments, when staff calls to confirm appointments and at every office visit.
- Place visual signs in the reception area and operatories advising patients to notify the dentist or dental personnel if they have fever or respiratory symptoms.

Three tables, based on information that CSA has compiled from the Centers for Disease Control and Prevention and the World Health Organization are included on this page for quick reference. For more information, go on the Web at "www.ada.org/goto/sars" or call the Department of Scientific Information, ADA Division of Science, via the ADA toll-free number, Ext. 2648. ■

Severe Acute Respiratory Syndrome (SARS) in brief

Cause of SARS

SARS is caused by SARS-associated coronavirus (SARS-CoV).

Incubation period

The incubation period for SARS is two to seven days and may be as long as 10 days.

How SARS spreads

- The transmission is predominantly by direct contact with infectious material or respiratory secretions and possibly through the airborne route.
- Transmission appears to occur after close unprotected contact with symptomatic SARS patients.

Who is at risk

- Travelers returning to the United States from parts of the world with SARS.
- People who have had direct close contact with an infected person, such as those sharing a household with a SARS patient and health care workers who did not use infection control procedures while caring for a symptomatic SARS patient.

Identifying SARS

The CDC criteria for identifying the SARS patient:

- The probable SARS patient will meet the clinical criteria for severe respiratory illness of unknown etiology and epidemiological criteria for exposure.
- The suspected SARS patient will meet the clinical criteria for moderate respiratory illness of unknown etiology and epidemiological criteria for exposure.
- The clinical criteria include respiratory illness and temperature of >100.4° F (>38° C). Epidemiological criteria include:
- Travel (including transit in an airport) within 10 days of onset of symptoms to an area with current or suspected community transmission of SARS. Those areas currently include China, Hong Kong, Singapore, Taiwan and Toronto.
- Close contact within 10 days of onset of symptoms with a person known or suspected to have SARS. The CDC has defined close contact as having cared for or lived with a person known to have SARS.

For example, a patient with severe respiratory illness of unknown origin, who recently traveled to China or came in close contact with a SARS patient in the past 10 days should be considered a probable case of SARS. Therefore, not every respiratory illness or common cold symptoms should be feared as SARS-related.

Source for all tables: ADA Council on Scientific Affairs, CDC and WHO.

Management of exposure to SARS

The asymptomatic dental health care worker

No exclusion from duty is recommended for dental personnel after unprotected exposure if they do not have fever or respiratory symptoms.

Referral to a physician is important as the exposed person should be monitored for symptoms, including measurement of body temperature at least twice daily for 10 days following the exposure.
The same rule applies to dental personnel or dental students who have traveled to an area with documented or suspected community transmission of SARS.

The symptomatic dental health care worker

Exclusion from duty is recommended for dental personnel if fever or respiratory symptoms develop during the 10 days following unprotected exposure to SARS patients.
If symptoms do not progress to resemble the case definition (described under title Identifying SARS), the person may be allowed to return to work after consultation with a health care provider.
If symptoms progress to resemble the case definition, then the person should be excluded from work until 10 days after the resolution of fever, provided respiratory symptoms are absent or improving.

Recommendations for infection control procedures to prevent the spread of SARS in the dental office

Administrative measures

Enforce infection control measures at all times.
Ask screening questions of all patients* at every office visit.
Questions may include:

- Do you have a recent onset of a respiratory problem like cough or difficulty breathing?
- Have you traveled internationally in the past 10 days?
- Have you come in contact with a SARS patient in the past 10 days?

If a patient answered "yes" to the clinical question and any of the exposure questions, put on a surgical mask, discuss the potential concerns with the patient, call a medical facility and notify it that you are sending a patient so that arrangements can be made for care and transport of the patient.

Engineering measures

- Make sure the dental office has good ventilation.

Dental personnel protection

- **Disposable gloves** (latex or vinyl) which must be changed after every patient.
- **Surgical masks** which should resist fluid penetration and fit tightly around the mouth and nose when properly applied to the face.
- **Protective eyewear.**
- **Gowns:** reusable or disposable.

Hand hygiene

Wash hands with soap and water between patients. An alcohol-based hand rub may be used if the hands are not soiled.

Disinfection

- **Wear** appropriate personal protective equipment (goggles, mask and gloves) when cleaning and disinfecting treatment rooms. A face shield is not enough.
- **Use** any EPA-registered hospital disinfectant currently used by the dental office (e.g. glutaraldehyde). Manufacturer's recommendations for use-dilution (i.e., concentration), contact time and care in handling should be followed.

What to do with a suspected SARS patient

- Put on a surgical mask immediately.
- Ask the patient to put on a surgical mask.
- Discuss the potential concerns with the patient.
- Notify a health care facility that you are sending a patient so that arrangements can be made for the patient's transport and care.
- Report the case to state or local health departments.

What to do with a patient who just returned from Asia

- Advise the patient to consult with a health care professional as he/she will need to be monitored (for fever and respiratory symptoms) on daily basis for 10 days.

*Limiting screening questions to only select patient populations can undermine early detection efforts and, depending on the specific facts involved, might be misconstrued as pretext for discrimination.

Disability

Continued from page 14

ment, HIV/AIDS and other infectious diseases, general trauma, arthritis, diabetes, dermatitis, mental illness and substance abuse.

A young dentist who just graduated dental school or completed a residency has no reason to expect accidents, injury or degenerative illness, yet the statistics show they occur with frequency.

"There is some sense of invulnerability, that 'Nothing will happen to me, so I'll save some money and put off buying insurance until later,' " said Mr. Dwyer.

But what many new dentists don't realize is that if you develop health problems, disability insurance can be impossible to obtain.

"Once you have anything wrong with you, it's unlikely you will obtain coverage," said Mr. Dwyer. "If you wait until you have a back problem, for example, no insurance company will insure you for future disabilities resulting from back problems."

New ADA members are notified of a one-time opportunity to enroll in the ADA Income Protection Plan and the ADA Office Overhead Expense Plan on a guaranteed basis, and they have a limited time to act on the offer.

Dentists who don't take advantage of the open enrollment opportunity and choose to apply later will have to meet underwriting guidelines—which means they could be declined or offered coverage with elimination riders for disabilities resulting from preexisting medical problems.

Despite the fact that many young dentists overlook disability insurance as integral to protecting their practice investment, there is some good news to report.

Great-West sales and claims data show that young dentists who carry disability insurance are

Dr. Kochenderfer

maintaining a higher level of coverage than they have in the past.

In 2002, members under age 45 accounted for 79 percent of all new sales for the ADA Income Protection Plan, and those with existing coverage were responsible for 50 percent of increased sales. The growth reflects the value seen in the ADA plan, which can cost 20-30 percent less than other disability insurance products for dentists in all age brackets.

Mentors, financial advisors, attorneys and accountants tend to advise young dentists to carry as comprehensive disability insurance as possible, but for many young dentists, word-of-mouth is still one of the most effective tools.

Years ago, Dr. Kochenderfer met a dentist who had suffered a stroke that left him partially paralyzed. That was all he needed to hear before looking into disability insurance for himself.

"There are ways for professionals to protect their career investment, and that's the way I look at disability insurance," he said. "Dentists spend at least eight years becoming educated. How do you protect that investment? One way is to have disability insurance." ■

ADA products for members

The ADA has offered members affordable group disability insurance products customized for dentistry since 1952.

Great-West Life & Annuity Insurance Co. offers two products to ADA members: the ADA Income Protection Plan (disability income coverage) and the ADA Office Overhead Expense Plan (business overhead disability coverage).

For more information, go to "www.ada.org/prof/prac/insure/meminsure.html", or call 1-888-463-4545 (weekdays, 7:30 a.m. to 5 p.m., Mountain Time). ■

Save the date!

Baltimore—The deadline for reduced-rate registration for the 17th National Conference on the New Dentist is just around the corner.

Register by July 11 to receive the early bird discount for this year's conference at the Baltimore Marriott Waterfront Hotel Aug. 21-23. Registration will be accepted by the ADA office until noon on Aug. 1. On-site registration is available after that.

Boating in Baltimore

Specially designed for those less than 10 years out of dental school, the conference offers attendees CE credit hours through practice management, clinical and professional issues and leadership development workshops led by distinguished experts in dentistry, and many opportunities for new dentists, students and residents to network with ADA leaders and peers.

For information, call the ADA toll-free number, Ext. 2779, or register online at "www.ada.org/goto/newdentconf". ■

A happy homecoming

Loved ones, new and old, welcome dentist's return from Middle East

By Arlene Furlong

On May 2, for the first time ever, Dr. Gary Piorkowski met his 23-day-old son, Jake.

In the Middle East, providing what he describes as "high-tech dentistry in a tent while doing some high-end camping in the sand," to supporting Operation Iraqi Freedom, he missed his son's birth.

Friends told him going overseas would be the worst decision he could make in his life. But on Feb. 20, despite the warnings, the 15-year U.S. Air Force veteran said goodbye to his wife, then seven months pregnant, and his three daughters.

"As it turns out, it was the best decision I could've made," says 41-year-old Dr. Piorkowski. "God has been good to me."

The dental flight commander of a 27-person clinic at McConnell Air Force Base in Wichita, Kan., is senior among five dentists there. Typically, that kind of seniority saves him from deployment. "The low man on the totem pole is usually the first to go," he says. But the circumstances at McConnell weren't what Dr. Piorkowski calls typical.

One officer was waiting for the birth of his first child. Another was new to the Air Force with two young children. Another would have missed an opportunity to start an advanced general dentistry residency program and another had just finished a possible deployment period.

"We're so connected here at McConnell," says Dr. Piorkowski. "I just knew it would be easiest for me to go."

All together now: Dr. Piorkowski, his wife, son and daughters May 2.

Two and one-half months later, Dr. Piorkowski's wife, Karen, said, "It was all worth it—just to see the look on Gary's face when he met Jake."

Born on April 8, Jake was "just a small loaf of bread when I met him," describes Dr. Piorkowski, whose daughters are seven-, five- and four-years-old.

"I had to go," he says. "It's the reason I got in the military in the first place, to do this kind of thing—get out there, be in the field," he explains. "I never wanted to practice on Maple Street, Anywhere, U.S.A."

Serving 2nd in command of an entire Medical Unit in the Middle East, Dr. Piorkowski did everything from full rotary endodontics to moving equipment and loading airplanes.

"In a deployment situation, you do everything, " explains Dr. Piorkowski, whose main charge was treating Air Force, Army and Marine personnel. Recreation options were more limited.

"The airplane hangar was it," explains Dr. Piorkowski. "It was the gym, community center and dance floor."

"Most importantly, we were very busy making sure no pilot would end up with a toothache," says Dr. Piorkowski, who usually worked 12-hour shifts. "I'm glad I got the chance to do it." ■

Dental assistants overseas

Tours-of-duty go well beyond U.S. borders

Photo courtesy of U.S. Army Dental Command

On-duty: Specialist Monique Jones signs up patients in a dental services unit tent in Saudi Arabia.

By Arlene Furlong

"It's been a great assignment," said the 22-year-old dental assistant who after a six-month tour of duty in Saudi Arabia left June 9 to return to Fort Bragg, N.C.

"It was difficult because we worked long hours and went to a seven-day work week," she said on her departing day. "But it was well worth it. This was a Joint Services operation so I had the opportunity to interact with personnel from the Air Force, Navy and Marines. I saw all the services come together as one."

The American Dental Assistants Association provides continuing education to dental assistants all over the world. For more information, contact Jennifer Blake, CDA, ADAA director of education and professional relations, by fax at 1-312-541-1496 or e-mail "adaa1@aol.com". ■

RECOGNITION
DENTAL ASSISTANTS
WEEK

Apply to win!

More than 20 military bases sent in applications for the 2003 Dental Assistants Recognition Week promotion. Interested dental assistants can contact the ADAA, at "adaa1@aol.com" or Joan Block at the American Dental Association by e-mail at "blockj@ada.org" or by calling 1-312-440-2762 about the March 7-13, 2004 event. ■

Dentistry Overseas lanches new program in Nicaragua

By Stacie Crozier

Health Volunteers Overseas is seeking dental volunteers with an academic background or extensive clinical experience to provide undergraduate level clinical training and continuing education in dentistry in Nicaragua.

Volunteers are needed for one-week assignments to provide clinical supervision, demonstration and practical course presentation at the Universidad Americana in Managua as well as CE for practicing dentists. Housing is provided for volunteers.

Course topics can include endodontics, periodontics, infection control and orthodontics. All courses will be presented in English; the university will provide translation materials.

Dentistry Overseas, the dental division of Health Volunteers Overseas, is sponsored by the ADA. All Dentistry Overseas volunteers must be ADA members.

For more information on the new Nicaragua program, contact the HVO Program Department in Washington by calling 1-202-296-0928 or e-mailing "info@hvousa.org". ■