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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

JANUARY 17, 2005 VOLUME 36 NO. 2

Celebrating 60 years of water fluoridation

BY STACIE CROZIER

On Jan. 25, 1945, at 4 p.m., Grand Rapids, Mich., became a pioneer in public health.

That's when it became the first city in the world to fluoridate its drinking water to levels optimal for preventing dental caries.

Since then, three generations of Americans nationwide who received water from fluoridated community water systems have enjoyed fewer caries, and lower dental care costs.

National Fluoridation Symposium 2005
Celebrating 60 Years of Water Fluoridation

Community water fluoridation's 60th anniversary will highlight the amazing benefits reaped by a seed planted in a small Michigan town as well as how fluoridation can continue to make a big impact toward overall better health for generations to come.

"Community water fluoridation is the most economical preventive method we have in dentistry," said Dr. Richard Haught, ADA president, "and for the underserved, we need to put special emphasis on providing fluoridation to those who aren't able to enjoy its benefits now."

Dr. Haught said that his more than 35 years of dental practice in Tulsa, Okla., have convinced him first hand of the benefits of community water fluoridation.

"There has been a graphic difference in the oral health of children in Tulsa before and after community water fluoridation was instituted here," he said. "It's dentistry's job to continue to work to bring fluoridation to those who don't have it, to reduce pain and suffering and save Medicaid dollars used to treat severe dental problems in the underserved."

The Centers for Disease Control and Prevention has called community water fluoridation one of 10 great

See CELEBRATE, page 23

AP Photo/Petros Karadjias

In need: Tsunami victims wait in line for aid at a camp in the eastern coastal village of Onthatchimadam, south of Batticaloa, Sri Lanka, Jan. 9. The disaster claimed the lives of 100,000 in Indonesia alone. The death toll for all countries is currently estimated at 150,000. See page 22 for the ADAF Tsunami Assistance Fund contribution form.

Double your tsunami donations

ADA/ADAF to match up to $100,000

BY STACIE CROZIER

ADA member dentists can show compassion and support for tsunami victims by contributing to a relief effort organized by the ADA and the ADA Foundation, and double their contribution at the same time.

The ADA and the Foundation have each donated $50,000 to be used as a challenge match fund, giving ADA member dentists, team members and

ADA | FOUNDATION
American Dental Association Foundation

others a chance not only to help, but to have their contributions make twice the impact. The ADAF will match—dollar for dollar—up to $100,000 donated for immediate relief needs.

The total raised for immediate assistance will be donated to the American Red Cross International Response Fund. The Red Cross is coordinating many of the donations given by American citizens at the urging of former presidents George Bush and Bill Clinton who are spearheading private fundraising efforts in the United States.

By the time this effort was barely a week old, the new relief fund already had collected more than $22,000 from

See TSUNAMI, page 22

Listerine ads halted

Judge issues "as effective as floss" injunction

BY MARK BERTHOLD

New York—A federal court issued an order Jan. 6 barring Listerine advertisements that claim the mouthwash is as effective as floss in reducing interproximal plaque and gingivitis.

U.S. District Judge Denny Chin of the Southern District of New York granted the preliminary injunction, which took effect Jan. 10, to plaintiff McNeil-PPC Inc., a subsidiary of Johnson & Johnson, in its suit against Listerine manufacturer Pfizer Inc.

In his written opinion, Judge Chin noted that dentists and hygienists have been telling their patients for decades to floss daily "for good reason."

The benefits of flossing "are real—they are not a myth," he

See RULING, page 15

BRIEFS

Lights, camera, action! In two weeks, dentists will donate their services to treat an estimated 475,000 children in more than 1,600 Give Kids A Smile programs in the United States and beyond. The profession is preparing for the Feb. 4 third annual national access-to-care day in a myriad of ways.

Olympic gold medal gymnast Carly Patterson serves as the 2005 Give Kids A Smile ambassador. Ms. Patterson is set to meet with members of Congress and their staff Jan. 26 to highlight the program, events in their districts and the need for better access to oral health care. She'll also appear at Columbia University dental school on Give Kids A Smile day with ADA and other dental officials and possibly representatives from the city health department.

In New Jersey, dentists and dental auxiliaries who participate in Give Kids A Smile will receive up to three hours of continuing education credit, according to a November 2004 announcement by the state dental board.

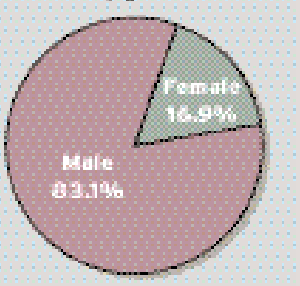
Supplies donated by GKAS sponsors Sullivan-Schein, Crest Healthy Smiles 2010, DEXIS Digital X-ray Systems and Ivoclar Vivadent Inc., will be

See BRIEFS, page 22

JUST THE FACTS

Dentists by gender

Percentage distribution of professionally active U.S. dentists by gender, 2002



Source: ADA Survey Center

Still time to apply

New grants to target older adult access programs

There's still time to apply for a new grant that encourages access to care for adults over age 65. But you need to act soon—the deadline for submitting a Request for Proposal is Jan. 31.

ADA | FOUNDATION
American Dental Association Foundation

The new Access to Oral Health Care for Older Adults Initiative, established in a cooperative effort between the ADA and the ADA Foundation and funded by a $250,000 grant from GlaxoSmithKline Consumer Healthcare, will award four or more pilot programs grants of up to $50,000 each.

Programs must be community-based, non-for-profit and designed to promote, improve and maintain older adults' oral health through education and treatment. Programs must be based in the United States and its territories.

Log on to "www.adafoundation.org" to download the RFP or view eligibility criteria, grant award criteria and more information. Or call Robert Czarnecki at the ADA Foundation toll free, Ext. 2544 or e-mail "czarneckir@ada.org". Proposals must be postmarked no later than Jan. 31. ■

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StatesWatch

Arizona reauthorizes dental board

Phoenix—Rebuking an anti-amalgamist bid to replace the state Board of Dental Examiners with more "holistic-centered" dentists, the state legislature's Joint Health Committee of Reference instead granted the dental board's renewal.

The committee's action concluded a sunset hearing for the board, during which the Arizona Dental Association presented testimony to support the board as well as to "contradict 'junk science' presented by anti-amalgamists," says AzDA Executive Director Rick Murray.

"So convincing was testimony by Dr. Rodway Mackert—that dental amalgam is a safe and effective restorative material—the committee granted the board a 10-year renewal and two-year budget cycle, instead of a five-year renewal and one-year budget as the committee has done in the past.

"Moreover," adds Mr. Murray, "AzDA will be able to utilize the research cited by Dr. Mackert for years to come to counter any legislation claiming amalgam is harmful or attempts to eliminate its use."

Michigan boy holds world record

Midland, Mich.—Dr. Larry Skoczylas' 12-year-old patient Matt Adams is the youngest person on record to have his wisdom teeth extracted, according to Guinness World Records.

Matt's family received the letter of confirmation from Guinness Dec. 12, 2004, for the procedure that occurred when Matt was 9 years and 339 days old.

Dr. Skoczylas had discovered the boy had two bottom wisdom teeth that were impacted and were not allowing the adult second molars to erupt.

Dr. Skoczylas told Matt's mother his teeth were more developed than in the average 9-year-old, and he suggested the wisdom teeth come out to decrease the possibility the second molars would not erupt.

Illinois awards dental grants for children

Hinsdale, Ill.—The Illinois Children's Healthcare Foundation awarded Dec. 6 grants to 32 organizations to improve the quality of and access to health care for children.

Among the organizations dedicated to improving the oral health of Illinois children are:

• Milestone, which will use its $262,090 grant to help expand a pediatric dental clinic that delivers care exclusively to developmentally disabled children; and

• Community Health Partnership of Illinois, which will use its $377,759 grant to help provide oral health care services and education to the children of migrant farmworkers living in northern Illinois.

"During the past two years [since ILCHF's inception], we have worked diligently in seeking to understand the scope of the health care needs of the children of Illinois," said ILCHF Chair C. William Pollard. "We look forward to continuing our efforts to provide a meaningful response to those needs." ■

—Reported by Mark Berthold

U.S. Dental Tennis group wins Davis cup

Palm Springs, Calif.—The U.S. Dental Tennis Association took the Medical-Dental Davis Cup Nov. 10, 2004, defeating the American Medical Tennis Association at the Smoke Tree Ranch Resort.

Dentists and their spouses won 15 matches to eight in competitions that included men's and women's singles, doubles and mixed doubles.

The USDTA followed up the match with a week of continuing education and tennis at the Shadow Mountain Racket Resort in Palm Desert, including an awards dinner and dancing.

The USDTA, with more than 300 member dentists from the U.S. and Canada, was founded in 1969 to encourage all dentists to play tennis to enhance their physical and mental well being, regardless of their level of skill and to promote continuing education. The organization is planning events for March in Florida and November in Hawaii. For more information or to join, log on to "www.dentaltennis.org". ■

Champions: Dr. Jerry Laffer (left), former U.S. Dental Tennis Association president, and Dr. Mark Sweeney, tennis chairman, pose with the Medical-Dental Davis Cup Nov. 10, 2004.

ViewPoint

MyView

Retirement uncertainties

Richard Mielke, D.M.D.

The best laid schemes o' mice and men
Gang aft a-gley

-Robert Burns

I think we have all used at least the first line of this quote from "To a Mouse" by the 18th century Scottish poet. American author John Steinbeck even used part of it as the title of one of his novels. We understand that it means the best made plans can go awry, even if we aren't sure about that "gang aft a-gley" business. When I think of this line, I think of retirement planning.

Lately, patients are asking me if I'm going to retire in the near future. I just assumed they were joking and have responded by asking them if I look old enough to be at retirement age. That always ends the discussion, usually with an awkward silence. I started to get an eerie feeling something about me was changing, though, when I went to my high school class reunion a few months ago. There were many people in attendance who appeared to be nearing senior citizen status, and I didn't recognize them at first. Most of my classmates must have been much older than I when we started our freshman year, I decided. Many of them were now beyond retirement planning. They were retired.

I have been avoiding doing any retirement planning for myself, preferring to wait until I'm older. Humor writer for the Seattle-King County Dental Society, Dr. Al Munk, wrote an editorial for the SKCDS News a while back advising that we should all keep working and thus make retirement planning unnecessary. As he explained it, retirement means first quitting work, then getting by for the next 20 or 30 years on what I have saved up during my working years. I don't need a plan to tell me that this is a frightening proposition.

Other dentists are apparently more decisive than I am. A study commissioned by the Washington State Dental Association three years ago found that half of our state's practicing dentists planned to retire in 13 years. At the present time, new dentists are being produced at a rate lower than the retirement rate of practicing dentists. In time, a shortage of dentists will result in our profession being unable to meet the demands for our services by the people of this state.

Last September, at our WSDA house of delegates, a decision was made to work for changes in our profession to help it meet its obligations to the public in the future. Most parts of it will require legislative action as well. The program involves making dental practices more productive by allowing other appropriately trained people to do more of the treatment directly and by freeing access to licensure for dentists and dental hygienists.

It was important for our association to take the initiative on this issue because some members of the legislature are watching the access situation closely and could develop their own solutions to an access "crisis." This has happened in other states, where licensure has been opened up. California is

See MY VIEW, page five

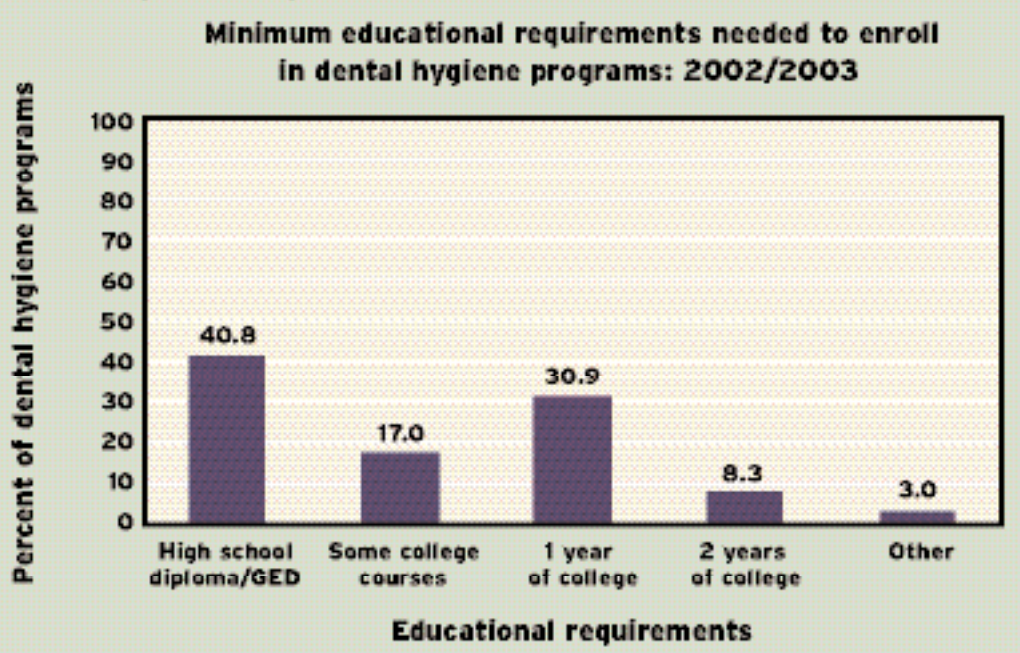
LettersPolicy

ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views on topics of interest in dentistry. Brevity is appreciated. For those wishing to fax their letters, the number is 1-312-440-3538; e-mail to "ADANews@ada.org".

SNAPSHOTS OF AMERICAN DENTISTRY

Dental hygiene

The minimum educational requirement needed to enter into a dental hygiene program varies from having a high school diploma or GED to as much as two years of college.



Source: American Dental Association, Survey Center, 2002/03 *Survey of Allied Dental Education*

Letters

Listerine

In the Jan. 8 New York Daily News (also New York Times, Bloomberg News and ADA News Today on ADA.org), there was a news story that describes how Judge Chin, a federal judge from Manhattan, ruled against Pfizer and will issue an injunction against them for advertising that Listerine is as effective as floss (which the judge ruled is false).

Judge Chin said that the mouthrinse was only as effective as improperly used floss. The New York State Dental Journal published my article (a survey of 622 people) in the May/June 2004 issue that shows that 40 percent of people who do floss are not doing so correctly (technique of flossing around the tooth).

The Listerine studies (two of which were paid for by Pfizer, but done quite well) show how Listerine decreases plaque and gingivitis better than flossing in people who also are brushing their teeth. The authors of the Listerine study themselves mentioned that one reason for such a discrepancy in plaque scores might have been the failure to wrap the floss around the line angles of the tooth, where the remaining plaque was measured.

My survey confirms that almost half the people who are flossing are not practicing the proper technique of wrapping the floss around the tooth, which was the area where the Listerine studies are measuring. So the Listerine commercials should actually be advertising, "Listerine is as effective as improper flossing."

People should be made aware that they should still floss everyday (or use other interproximal cleaners) and go to their dentist for proper oral hygiene instruction.

Stuart Segelnick, D.D.S.
Fresh Meadows, N.Y.

Access white paper

The front page article of the Nov. 1, 2004, ADA News, "Access For Those in Need," talks about a white paper named "State and Community Models for Improving Access to Dental Care for the Underserved."

This white paper, produced by the ADA, is purported to present "innovative" state and community models, which have made "significant gains" in delivering dental care to Medicaid-eligible children.

I am always eager to read ADA-published news items and articles on our nation's pressing problem of delivering oral health care and preventive health education to the underserved, especially at-risk children. I was disappointed, however, when I saw no mention of the "Kids Smiles" program in any of the five models reviewed.

My letter to the editor describing Kids Smiles was published in the March 19, 2001, ADA News. We now have over 13,000 Medicaid-eligible children as patients of record. If I read the white paper article correctly, that's more than all five presented models combined.

What will it take for my ADA to recognize Kids Smiles? Last spring I wrote to then-President Eugene Sekiguchi and he replied that he forwarded my information to the ADA Council on Access, Prevention and Interprofessional Relations. Kids Smiles invites the ADA to examine us

See LETTERS, page five

Letters

Continued from page four

and tell the membership about our model. We will sincerely extend ourselves to help anyone in any worthy community to build a Kids Smiles. We are soon to open a second site in Philadelphia and we hope to expand into other states.

Our model works! And on-site health empowerment education and outreach screening and education in local schools and community centers is more important to us than the incredible numbers of clinical care patients we have served. We have halved the decay rate at our local elementary school in just two years. We invite your dialogue.

Joseph R. Greenberg, D.M.D.
Founder, Kids Smiles
Bryn Mawr, Penn.

Editor's note: The ADA Division of Government Affairs responds: "The Nov. 1 article was not a comprehensive listing of all worthy access programs. There are several out there, and Dr. Greenberg deserves kudos for Kids Smiles, an access program that provides oral health care for disadvantaged children in the Philadelphia area.

"The recent article highlighted programs that take a comprehensive approach to addressing access-to-care systems for those covered by Medicaid, the State Children's Health Insurance Program and others. 'State and Community Models for Improving Access to Dental Care for the Undeserved,' the ADA's white paper, states up front that these programs were selected based on their approach to addressing four core areas—financing, administration, public education/awareness and workforce.

"To view the white paper, go to 'www.ADA.org/prof/resources/topics/access.asp'. "

Dental labs

Wow, what a great "My View" from Dr. James Robson ("The Future of a Dentist's Lab Support," Oct. 18, 2004, ADA News).

I could not agree more.

Partnering with another part of our profession (dental lab technology) just makes good sense. Using certified dental technicians and ADA-approved materials supports the quality of care that our patients have come to expect from a profession such as ours.

Only four states require a certified dental technician to be on site to license a dental lab, and the rest have no operational guidelines or licensure standards. As the repository and oversight body for dental lab technology, we should insist that all labs have a certified dental technician.

We should require all labs to be certified by the National Association of Dental Laboratories. It is sad that only 484 of the more than 15,000 dental labs in the United States are certified. If our patients knew that, they would demand the government step in and mandate safe operating standards for this custom manufacturer of dental prostheses.

I would rather that we heed the call. It is up to us to require the use of nationally certified dental labs. I am proud to use a DTI certified dental lab and will continue to do so. My peace of mind, and my patients' expectations, are that I will act professionally and in their best interest. This may be one small step, but I cannot compromise. I will hold out for what is best for my patients.

Mark T. Murphy, D.D.S.
Director, Continuing Education
Dental Technologies Inc.
Visiting Faculty, The Pankey Institute
Rochester Hills, Mich.

Cosmetic dentistry meeting in April

Nashville, Tenn.—The American Academy of Cosmetic Dentistry will hold its 21st annual scientific session April 19-23.

"Significant Science: Magnificent Art" will feature hands-on clinical courses, clinical workshops, new product seminars and other continuing education opportunities.

For more information, contact Eric Nelson by phone at 1-800-543-9220, fax 1-608-222-9540, e-mail "pr@aacd.com" or visit "www.aacd.com". ■

MyView

Continued from page four

offering some foreign-trained dentists direct access to its board exam.

There are uncertainties, however. For one, no one knows if our legislature will work with us on this issue. For another, no one knows for sure when dentists will actually stop practicing. It seems reasonable to assume the survey of dentists' planned retirement dates is out of date, following the stock market's long tumble. Double-digit returns on investment of retirement nest eggs, common in the '90s, are not expected to return in the foreseeable future.

It may be that the future of dentistry is not as much in the hands of the new dentists just coming in as it is in the hands of "seasoned" dentists like me who can't decide when to leave. Sitting on the fence, I can feel the power.

Maybe our association will be able to put off implementing its best-laid scheme for dealing with a shortage of dentists for a few extra years. That is uncertain. Ironically, Robert Burns probably never gave retirement planning much thought. He died at age 37, and he never explained what that "Gang aft a-gley" thing was all about.

Dr. Mielke is the editor of WSDA News, the publication of the Washington State Dental Association. His comments, reprinted here with permission, originally appeared in the July 2003 issue of that publication.

Anesthesia policy revisions proposed

BY KAREN FOX

In keeping with revisions to the ADA anesthesia guidelines documents adopted in 2002, the Council on Dental Education and Licensure has proposed changes to the "ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry."

The proposed revisions have been distributed to the communities of interested for comment. Comments—due no later than March 1—are also welcome from individual dentists.

"The 'ADA Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (Guidelines for Teaching)' and 'Guidelines for Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (Guidelines for Dentists)' were revised in 2002 and the policy statement was last updated in 1999," said Dr. Paul G. Sims, chair of the CDEL Committee on Anesthesiology. "We're now updating the statement to make it consistent with the guidelines."

The proposed revisions to the policy statement appear in two areas of the document—Risk Management and State Regulation:

Risk management

The council proposed amending the first bullet by adding language that addresses drug pharmacology, including absorption, distribution and metab-

"We review policy statements and guidelines as needed, and this is an example of the council keeping policies up-to-date."

olism. CDEL believes that this new language would assist dentists to further understand their responsibility in minimizing risk to patients when providing dental anesthesia. Additionally, a new bullet was added that is consistent with the definition of titration that appears in the Guidelines for Teaching and the Guidelines for Dentists.

State regulation

Several proposed revisions appear under this section. The council recommends deletion of the sentence that urges state boards to regulate dentists' use of conscious sedation, deep sedation and general anesthesia. It's unnecessary since all state boards regulate dentists' use of these modalities.

The council also recommends replacing the

Hillenbrand deadline is Jan. 31

The application deadline for the ADA Foundation Hillenbrand Fellowship is Jan. 31. Dentists interested in applying for the program should submit their application materials to the ADA Foundation, postmarked by the deadline.

The ADA Foundation Hillenbrand Fellowship is an opportunity for dentists who aspire to make a career transition from dental practice, education or research to management and leadership in a health related organization. The fellowship is a 12-month internship at ADA Headquarters that provides intensive orientation to all ADA agencies and other organizations serving oral health, academic courses through the Kellogg School of Management at Northwestern University and project management experience.

The Fellow will reside in the Chicago metro area for a year beginning in September 2005 and receive a stipend to help offset living expenses. ADA member dentists are encouraged to apply.

Detailed information about the fellowship is available at "www.ada.org/goto/hillenbrand" or by contacting the ADA at Ext. 4699 or "starsiaks@ada.org". ■

Council meeting: Dr. Paul Sims (left), anesthesiology committee chair, speaks with Dr. Roger Wood, CDEL chair, at the Nov. 11, 2004, meeting.

word "certify" with "issue permits to" because the term "certify" could be misleading.

Finally, the council recommends the addition of "route of administration" and "level of sedation" to encourage state boards to give consideration to these elements in the safe and appropriate delivery of dental anesthesia.

"We review policy statements and guidelines as needed, and this is an example of the council keeping policies up-to-date," said Dr. Roger Wood, CDEL chair. "Now that they are in circulation, we're looking for affirmation from the dental community for the revisions."

Go to ADA News Today ("www.ada.org/goto/adanews") to download a PDF file of the policy statement with proposed changes.

Comments can be sent by mail to Dr. Roger Wood, chair, Council on Dental Education and Licensure, 211 E. Chicago Ave., Chicago 60611; by fax to 1-312-440-2915; or by e-mail to "haglundl@ada.org". CDEL will consider only those written comments submitted by March 1. If you have questions, call Ext. 2694. ■

Scholarships, grants now available from PFA Foundation

Fairport, N.Y.—More than $350,000 in grants and scholarships is available in 2005 from the Foundation of the Pierre Fauchard Academy.

The foundation awards grants to programs and projects that emphasize increasing dental care access to underserved people in the U.S. and around the world as well as dental student education scholarships. This year, the foundation will offer a $1,500 grant to each United States dental school and to 28 international dental schools.

Since 1996, the foundation has awarded more than $3 million in grants and scholarships—including more than 800 scholarships to dental students and more than 270 grants to dental programs for the underserved.

Grant applications must be submitted by June 1.

For more information or an application, log on to the PFA Web site: "www.fauchard.org" or contact Dr. Fred Halik, 30 Spruce Ridge, Fairport, N.Y. 14450-4278; phone 1-585-218-9393; fax 1-583-387-9134; e-mail "fpfa@rochester.it.com". ■

TDOT coming to Denver

Denver—Tomorrow's Dental Office Today will roll into Denver in time for dentists to tour the mobile dental office exhibit during the Rocky Mountain Dental Convention Jan. 20-22 at the Colorado Convention Center.

The meeting's exhibit hall will be open Jan. 20 and 21, from 10 a.m.-5:30 p.m., and Jan. 22, 10 a.m.-2 p.m.

The TDOT exhibit, billed as an "ADA educational experience" sponsored by dental products distributor Sullivan-Schein, is part of a multifaceted three-year campaign focused on dental technology and software for managing all aspects of a dental practices.

TDOT was featured at the Greater New York Dental Meeting in November 2004 and is set to visit other dental meetings in 2005, including:

- The Chicago Dental Society Midwinter Meeting, Feb. 25-27
- The California Dental Association Spring Session in Anaheim, May 12-15
- The ADA's 146th annual session in Philadelphia, Oct. 7-9. ■

Electronic claims filing made easy

New ADA tool shows dental community how

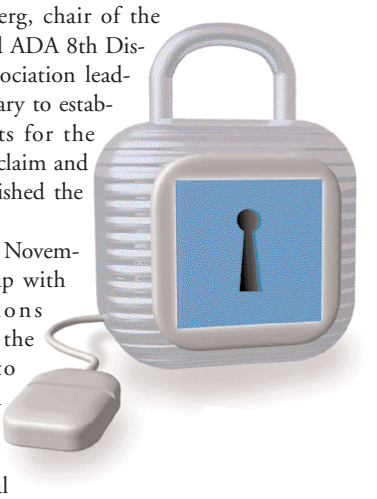
BY ARLENE FURLONG

A new online resource is one of the benefits of ADA efforts to simplify the electronic dental claims filing process.

Filing electronic claims got more complicated when the HIPAA rule on electronic transactions and code sets went into effect Oct. 16, 2002. The ADA is now working to put the simplification back into this federal administrative simplification provision through the Dental Content Committee.

The rule's inherent flexibility actually worked against simplification because payers developed unique requirements for filling out claims. It turned out to be a disincentive to filing electronically because clearinghouses have to spend more time adapting claims for individual payers and then pass more of that expense to providers.

"Moving from a single ADA paper claim to many variations of the electronic dental claim was clearly contrary to the goals of HIPAA," said Dr. Perry Tuneberg, chair of the ADA's DeCC and ADA 8th District trustee. "Association leadership was necessary to establish requirements for the electronic dental claim and we have accomplished the first step."



The DeCC in November 2004 came up with recommendations that standardize the data required to adjudicate and process 70 percent to 90 percent of all dental claims.

"This is really exciting to us because it's the first time anyone has set down specifications that say this is all you should need," said Fred L. Horowitz, chief operating officer of Affiliated Network Services, a claims clearinghouse that translates dental provider claims for some 200 payers. "Someone has got to make an effort to achieve uniformity in dental claims data requirements and the DeCC is well positioned to do it."

Dr. Horowitz says his greatest hope is that dentists will start filing electronically. "Uniformity means a cost savings for clearinghouses that translates into a cost savings for providers," explains Dr. Horowitz. He estimates that only about 30 percent of claims now come in electronically.

The online resource gives payers the opportunity to compare the data elements they require with the rest of the industry. The goal is that payers will see where they deviate from each other, identify what information they really need to process claims and thereby voluntarily achieve uniformity in requirements.

See, CLAIMS, page 10

Does HIPAA apply to you?

HIPAA regulations only apply to dental practices that submit or receive electronic transactions for which a standard has been established by the U.S. Department of Health and Human Services, either directly or through a vendor or clearinghouse. ■

Claims

Continued from page eight

Claredi Corporation develops electronic data management tools and is providing free access to the HIPAA transaction requirement lists at "www.claredi.com/convergence". Access is open to the entire industry and there is no charge for viewing or providing data.

"This resource is one way for the entire dental payer community to join us in converting to a single set of information requirements for dental claims," explained Dr. Tuneberg.

Delta Dental Plans Association's representative Michael McGinley believes uniformity would increase electronic transactions. "Anything that will increase electronic commerce is beneficial because payers can be far more efficient with electronic claims data," commented Mr. McGinley. Like Dr. Horowitz, Mr. McGinley serves on the DeCC subcommittee that helped determine the ADA recommendations for dental claims requirements.

"This new resource will allow payers to see what other payers require and reassess their own requirements," said Mr. McGinley. "The more payers list their requirements, the more useful the tool will be."

Claredi's president, Kepa Zubeldia, Ph.D., ran a claims clearinghouse for many years. When he realized claims transactions were diverging rather than converging, he wanted to do something about it. "This effort will help streamline the process," Dr. Zebeldia said.

Claredi is making such tools available for the entire health care industry because the company believes it's the right thing to do.

The DeCC is named one of the six Designated Standards Maintenance Organizations by the U.S. Secretary of Health and Human Services to review and approve changes to Health Insurance Portability and Accountability Act of 1996 standard transactions.

Sponsored by the ADA, the group addresses standard transaction content on behalf of the dental sector of the health care community.

Current member organizations include the ADA, America's Health Insurance Plans, Blue Cross and Blue Shield Association, Centers for Medicare and Medicaid Services, Delta Dental Plans Association, National Uniform Claim Committee, State Medicaid Agency and the Workgroup for Electronic Data Interchange. ■

Your ADA, your HIPAA resource

The ADA Council on Dental Practice encourages members to seek clarification from the ADA for questions on any regulations under the Health Insurance Portability and Accountability Act of 1996. Go online at "wwwada.org/goto/HIPAA", e-mail the ADA at "HIPAA@ADA.org" or call Robert Lapp, Ph.D., director of the ADA Department of Dental Informatics, toll-free at Ext. 2750. Dr. Lapp frequently speaks on HIPAA issues and participated in the development of ADA comments and consultations on all proposed and final regulations.

The ADA Seminar Series offers "HIPAA: The Current Issues," to help dentists prepare for compliance with HIPAA regulations. E-mail Tina Martinez at "martinezt@ada.org", or Susan Barthel at "barthels@ada.org" or call toll-free, Ext. 2908. ■

DR talks: Dr. Glen D. Hall presides over the Council on Dental Benefit Program's review of the direct reimbursement campaign. The council planned a DR report to the Board of Trustees in 2005, during its Nov. 5-7 meeting at ADA Headquarters in Chicago.

New report from ADA Survey Center

Periodontists in private practice had an average net income of $216,430 in 2001, according to a new report published by the ADA Survey Center.

"Periodontists in Private Practice "includes data on periodontists' net income, gross billings and expenses. Using data collected during the ADA's 2002 Survey of Dental Practice, the report also provides data on patient visits, hours worked per week and employment of dental staff. The report is part of a series of reports on individual specialties recently published by the ADA Survey Center.

Dentists interested in purchasing a copy of Periodontists in Private Practice should call the ADA Survey Center toll-free, Ext. 2568, or go to "www.adacatalog.org". The cost of the report (catalog number 5PER) is $40 for ADA members, $60 for nonmembers and $120 for commercial firms, plus shipping and handling. ■

ATTN: USERS OF SELF-ETCH BONDING AGENTS

If your bonding agent refuses to bond self- or dual-cure composite ...
If your bonding agent creates a thick film ...
If your bonding agent requires mixing ... or multiple coats ...
or rubbing ... or blotting ... or more than 35-seconds start-to-finish ...

you can do better.

CONVENTIONAL SELF-ETCH BONDING AGENTS DON'T BOND TO SELF- OR DUAL-CURE COMPOSITES.

Most self-etch bonding agents do not reliably bond dual-cure or self-cure resins. (Just check the instructions!) This means you have to switch to another adhesive when you're bonding self-cure core material or a dual-cure resin cement.

Brush&Bond™ is different.

Right out of the bottle it's great for dual-cure and self-cure resins. So you can use it for all your dentin bonding needs.[1] One surprised testing organization described Brush&Bond's ability to bond a wide variety of self-cure and dual-cure resins as *"amazing."*[2] (Perhaps they hadn't read our advertising.)

MOST SELF-ETCH BONDING AGENTS ARE VERY THICK

Self-etch bonding agents can be extremely viscous. Some have adhesive films as thick as 90 microns, and the puddles they form at the line angles can be as deep as 300 microns.

A thick bonding agent leaves a band of unfilled adhesive at the margin, where it's exposed to the oral cavity. If you look very carefully, you can sometimes see the bonding agent as a line around a Class 5 restoration.

And, of course, 80 microns is far too thick to allow accurate seating of indirect restorations like inlays, onlays and crowns.

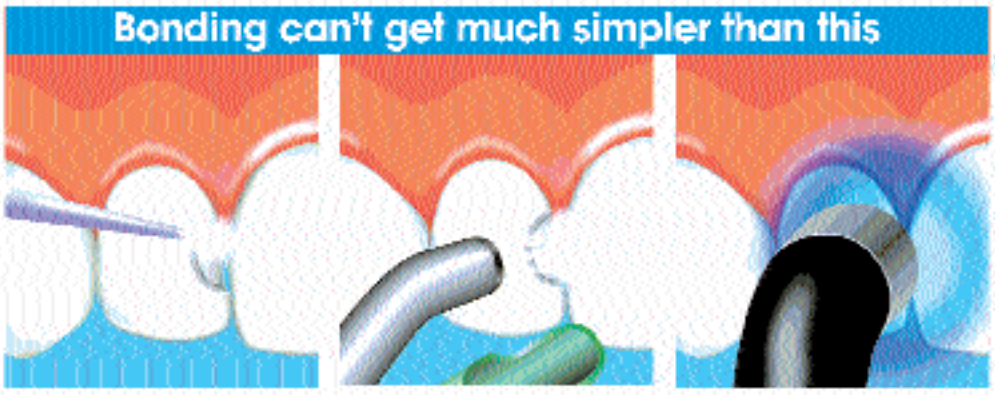
Brush&Bond is different. It produces a thin, 9-micron film (about one tenth the thickness of some self-etchers!) So unless you slop it on like a barbarian, Brush&Bond will let your most precise gold inlay seat comfortably.

MANY SELF-ETCHERS ARE A LOT MORE COMPLICATED THAN THEY SOUND.

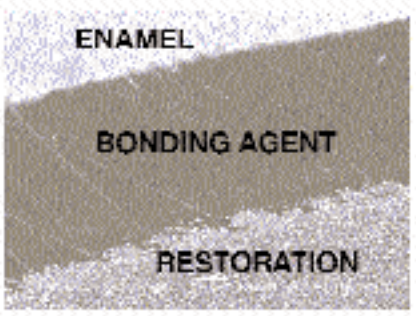
Most self-etch bonding agents require mixing. Some require that the tooth surface be damp - or conversely - dry. Many require two or even three coats. Some require scrubbing the prep with the adhesive, or restrict you to a halogen curing light.

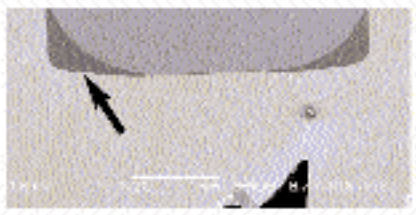
Brush&Bond is different.

There's no mixing. Using the special MicroBrush supplied with the kit, apply a single coat to both dentin and cut enamel. Let it sit on the tooth for 20 seconds. (Don't "rub" it. Don't "agitate" it. Just let it sit there while you day-dream about something pleasant.) Then blow lightly to evaporate the remainder and cure a few seconds with any curing light.



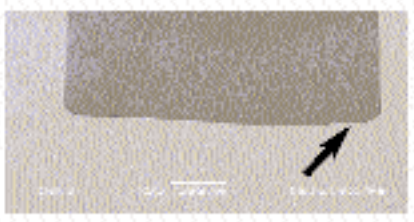
THICK-FILM SELF ETCHER





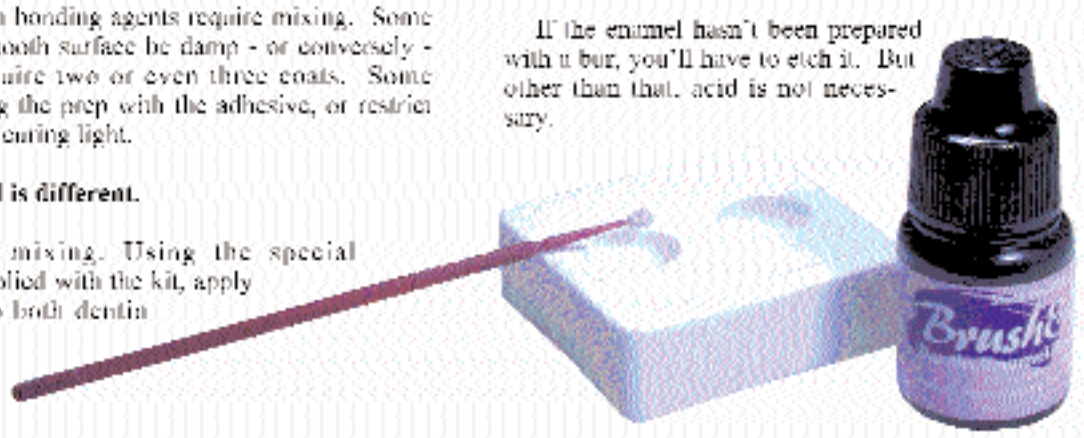
Viscous self etchers can cause a halo of unfilled bonding agent at the margins of direct restorations (left) and severe puddling that poses sealing problems for indirect restorations (above).

THIN-FILM BRUSH&BOND™



Brush&Bond's thin 9 micron film (left) seals the tooth and retains the resin without leaving a thick unfilled margin or interfering with subsequent seating.

If the enamel hasn't been prepared with a bur, you'll have to etch it. But other than that, acid is not necessary.



A different kind of no-etch bonding

SOME SELF-ETCHERS AREN'T AS FREE OF POST-OP SENSITIVITY AS THEY CLAIM.[3]

Brush&Bond is different.

In fact, it wasn't originally created as a bonding agent. It grew out of polymer research into dentin desensitizers.

And it may just be the most effective desensitizer ever developed. Research suggests that it occludes patent tubules more effectively and resists toothbrush abrasion better than other agents tested.[4,5]

Hygienists simply apply Brush&Bond to sensitive roots and light cure it for immediate resolution of sensitivity. It creates a thin but robust polymer film, so there's no need to cover it with flowable composite to prevent wear.[6]

If you currently "desensitize" your preps before bonding, Brush&Bond eliminates that step. And unlike conventional desensitizers, Brush&Bond's acid-resistant hybrid layer protects the tooth as it desensitizes it.[7]

In a survey of dentists with at least 6 months experience bonding restorations with Brush&Bond, 98.3% reported no post-op sensitivity problems at all. None. That's the lowest incidence of post-op sensitivity of any bonding agent we've ever studied. Lower than Amalgambond. Lower than Touch&Bond.

By the way if you thought all self-etchers were equally desensitizing, consider this:

When asked to compare Brush&Bond to their prior bonding agent, 71% of dentists who reported switching from another self-etch bonding agent reported that B&B was "better" or even "wonderful" in preventing sensitivity.

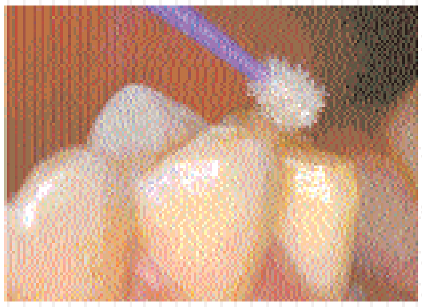
At a recent presentation, one respected clinician said that the incidence of endo after placing restorations has dropped dramatically in his practice since he switched to Brush&Bond. Of course, that's purely anecdotal, but it makes you think.[8]

RELIABLE BONDS

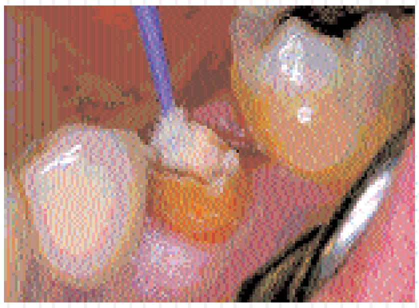
Funny. Researchers have never shown that high bond strength has any relationship to clinical success. Yet bond strength is the one property dentists ask about when they select a bonding agent.

So if you're into numbers, you'll be happy to know that Brush&Bond shows excellent bond strength. (MicroTensile bond strength generally runs about 30MPa[9,10])

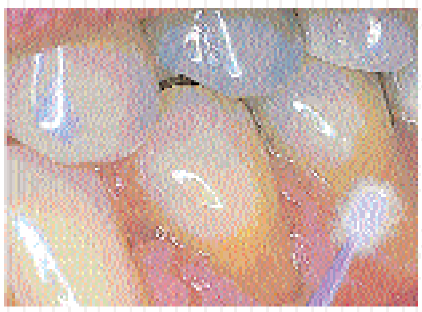
Visit Parkell at major dental meetings:



INDIRECT RESTORATIONS



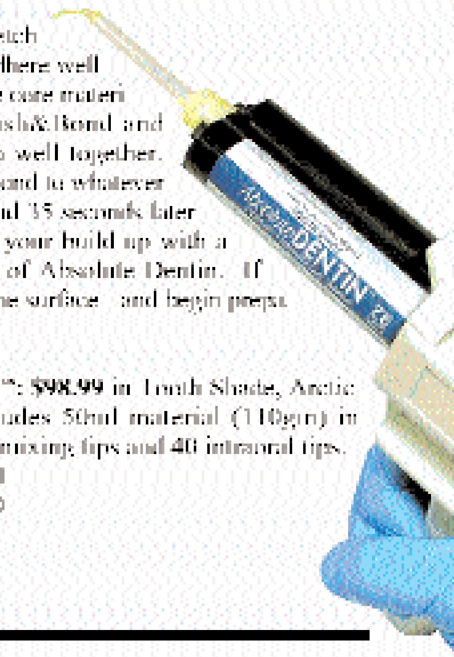
CORE BUILD-UPS



TREATING DENTIN HYPERSENSITIVITY

DIRECT COMPOSITE RESTORATIONS

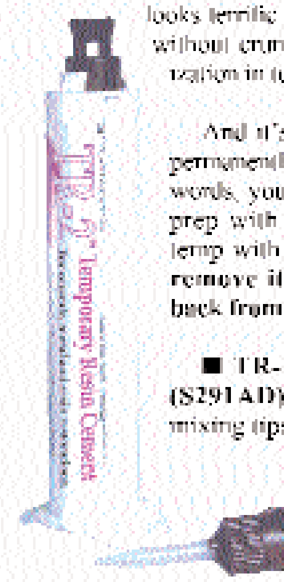
A dual-cure core composite that bonds like crazy to Brush&Bond. (at about half the price of other core materials)



Conventional self etch bonding agents don't adhere well to self cure or dual cure core materials. That's why Brush&Bond and Absolute Dentin go so well together. Simply apply Brush&Bond to whatever remains of the tooth, and 35 seconds later you're ready to create your build up with a single bulk placement of Absolute Dentin. If you're in a hurry zap the surface and begin preparation.

■ **Absolute Dentin™: $98.99** in Tooth Shade, Arctic White, or Blue. Includes 50ml material (110gm) in split cartridge with 40 mixing tips and 40 intraoral tips.
Tooth Shade S301
Arctic White S300
Blue S307

Prevent provisional sensitivity with Brush&Bond - then cement the temp with TR-2



Tooth-shade TR-2 temporary resin cement looks terrific and strips cleanly from the tooth without crumbling. It's great for provisionalization in today's cosmetic practices.

And it's specifically formulated NOT to permanently bond to Brush&Bond. In other words, you can protect and desensitized the prep with Brush&Bond, then cement the temp with TR-2 ... **and you'll be able to remove it when the final crown comes back from the lab.**

■ **TR-2™ Temporary Resin Cement (S291AD): $29.95** 10ml syringe plus 10 mixing tips.

But here's something we consider much more significant ...

In a survey of dentists who'd bonded a total of 50,000 restorations with Brush&Bond, 63% said that clinically the bond seemed better than their prior bonding agent's. 37% said it seemed about the same. 0% said it seemed weaker.

AND THREE FULL MONTHS TO PROVE IT TO YOURSELF

Of course, what researchers, or newsletters, or even current users say doesn't matter. It's what you think that's important.

That's why we let you try it in your practice for three full months risk-free. If you don't find it everything we promise, just call us toll-free. We'll have whatever remains of the kit picked up at our expense - and we'll give you all your money back - including the original shipping charges.

1 Farah JW, Powers JM. Brush&Bond. The Dental Advisor. Vol 20 03
2 Reality Now #199 Mar 04
3 Ritsco R. Self-etch adhesives spark discussion. Dent Prod Report, p61A-62, Apr 03
4 (Yamamoto T, et al. Evaluation of Sealing ability of self-etching bonding systems. IADR-HA. Abstr #1737 Mar 04)
5 Suzuki S. et al. In vitro wear evaluation of desensitizers for dentin hypersensitivity. IADR-San Antonio Abstr 40958, 2003
6 Schoenreck GA. Brush&Bond. Interface: 15 89, Oct 04 Suzuki wear study
7 Fukegawa Y, et al. Prevention of secondary caries by self-etch bonding system (Hybrid Bond). Inter Symp on Dntl Hygiene. Madrid July 04
8 Mackow RH. Rapid-fired prosthesis resins. Interview with Martin B Goldstein DMD. Richards Report Tape Series July 04
9 Nikaido T, et al. The resin-coating technique. Effect of single-step bonding system on dentin bonding strengths. Jour Adhes Dent. Vol 5, No 4. p293-300, 2003
10 Brown PL, Microtensile strength of adhesives utilizing indirect and direct composites. IADR. Mar 2004
11 Ott L, et al. Bond strength of cement-affected dentin using five-liter bonding agent(s). IADR. Hawaii Mar 04

	FILM THICKNESS	BOND SELF-CURE	BOND INDIRECT RESTORATIONS	TIME REQUIRED	COATS	REPORTED PROBLEMS*
BRUSH&BOND™	THIN 9 microns	YES	YES	35 sec	1	VERY FEW
CLEARFIL™ SE	THICK 70 microns	NO	NO	46 sec	2	VERY FEW
iBOND™	THIN 5 microns	NO	YES	1 min 9 sec	3	MARGINAL DISCOLORATION
PROMPT™ L-POP	THIN 5 microns	NO	NO	54 sec	2	EARLY FORMULA LEAKED, DEBONDED
ONE UP™ F	VERY THICK 90 microns	NO	NO	41 sec	1	--
PROTECT BOND™	THICK 70 microns	NO	NO	45 sec	2	--

*Certain bonding agents require meticulous technique to avoid problems. Others are much more forgiving.

New radiograph guidelines

Joint ADA, FDA update

BY MARK BERTHOLD

The American Dental Association, working with the federal Food and Drug Administration and dental specialty groups, has updated the FDA's guidelines on dental radiographs.

Available on ADA.org at "www.ada.org/prof/resources/topics/radiography.asp" and on the FDA's Web site at "www.fda.gov", the newly updated guidelines will assist dentists in the selection of patients for dental radiographic examinations.

But they're not meant to be rules, notes Dr. Charles Greenblatt Jr., chair of the ADA Panel on Radiographs Guidelines Review.

Rather, the guidelines are an adjunct to the dentist's professional judgment of how to best use diagnostic imaging for each individual patient, weighing the benefits of taking dental radiographs against the risk of exposing a patient to X-rays.

"The recommendations are broad," he says, "so the clinician decides—after reviewing the patient's health history and completing a thorough clinical examination—what imaging is needed."

The ADA-FDA joint effort includes new information on key subjects:

• the clinical use of radiographs to assess patients with implants, monitor enamel remineralization and evaluate restorative and endodontic needs and other pathology;

Dr. Greenblatt

• monitoring of edentulous patients;

• panoramic examinations, their expanded use and technological improvements;

• "bitewings" to mean either or both horizontal and vertical bitewings;

• an updated bibliography to reference.

The impetus for updating the guidelines began in 2002, when the ADA recommended the FDA review its original 1987 document, "The Selection of Patients for X-Ray Examination" to reflect changes in technology and practice.

The FDA welcomed the ADA to undertake the review, which formed a collaborative workgroup represented by the ADA, FDA, Academy of General Dentistry and interested dental specialty organizations.

The ADA-led workgroup's final draft for updated radiograph guidelines was accepted in November 2004. "The FDA didn't require any further adjustments to our deliberations and proceedings," Dr. Greenblatt is pleased to note.

"And it was a pleasure working with the FDA and every other dental group that served on the panel," he adds. "All representatives were very well informed; they came with great ideas and no personal agendas—except to get the best document out there for dentists and their patients." ■

Key updates

The ADA/FDA "Selection of Patients for Dental Radiographic Examination" makes recommendations for different patient categories (age and stage of dental development), clinical circumstances and oral diseases. The following are applicable to all categories of patient:

• intraoral radiography is useful to evaluate dentoalveolar trauma; extraoral imaging may be indicated beyond the dentoalveolar complex.

• all radiographs should be examined for any evidence of caries, bone loss from periodontal disease, developmental anomalies and occult disease.

• clinical examination should precede any radiograph and consider patient history, prior radiographs, caries risk assessment and both the dental and general health needs of the patient.

In addition, when a radiograph is indicated, the dentist is responsible for following the "As Low As Reasonably Achievable" (ALARA) principle to minimize the patient's exposure to radiation. This includes using the fastest compatible image receptor, collimated size of beam and proper film exposure and processing techniques.

In adhering to the ALARA principle, patients should wear protective thyroid collars and aprons whenever possible. This practice is strongly recommended for children, women of childbearing age and pregnant women. ■

Ruling

Continued from page one

wrote, adding that "substantial evidence also demonstrates, overwhelmingly, that flossing is important in reducing tooth decay and periodontitis and that it cannot be replaced by rinsing with a mouthwash."

Judge Chin concluded that the Listerine claims represent "false and misleading advertising" and pose a public health risk, as they "present a danger of undermining the efforts of dental professionals—and the ADA—to convince consumers to floss on a daily basis."

McNeil-PPC's complaint, originally filed Sept. 28, 2004, alleged that Pfizer violated the state's Lanham Act on unfair competition, in that the Listerine ads are false and misleading in two respects.

First, McNeil-PPC alleged, the explicit claim that clinical studies prove Listerine is as effective as floss against plaque and gingivitis is false. Second, it alleged, the implicit claim that Listerine is a replacement for floss and all benefits of flossing may be obtained by rinsing with the mouthwash is false.

Judge Chin ordered the preliminary injunction because, according to his written opinion, plaintiff McNeil-PPC sufficiently demonstrated a likelihood it would suffer irreparable injury to its share in the dental products market, and because McNeil-PPC demonstrated a likelihood of success on the merits of its complaints.

"We are pleased with the court's ruling, and the finding that there is no substitute for daily flossing as a preventive step in the reduction of tooth decay and gum disease," said Caitlin Pappas, vice president, professional sales and marketing, Johnson & Johnson Consumer Companies Inc.

Pfizer is considering an appeal of the decision ordering the company to discontinue the advertising and promotion of a claim comparing Listerine mouthwash to dental floss, according to Tom Sanford, global director, communications, Pfizer Consumer Healthcare.

"Pfizer based this claim on the results of two six-month, well-controlled clinical studies, both of which followed ADA guidelines and were reviewed and accepted by the ADA's Council on Scientific Affairs," Mr. Sanford noted.

"The court, however, did not accept these studies as they relate to flossing," he continued. "Because the flossing arm of both studies, like the rinsing arm, was conducted under unsupervised, 'real-world' conditions, the judge concluded that the flossing arm of the study was not done properly. The court's decision does not in any way challenge the proven safety and effectiveness of Listerine. In fact, the court affirmed that Pfizer may continue to use the studies in question to support the claim that Listerine fights plaque and gingivitis."

Mr. Sanford added that Pfizer is taking steps to remove the "as effective as floss" claim from Listerine products. About 4,000 workers, he said, will be deployed around the country to place stickers on bottles and to remove it from bottlenecks—the action will encompass several million bottles. Pfizer also will stop television, print and medical-journal advertisements that use the claim, he said, as well as remove it from the Listerine Web site. Mr. Sanford estimates the all-inclusive cost to be about $2 million.

On May 19, 2004, the Council on Scientific Affairs approved a request by Pfizer Inc. to use the "as effective as flossing" claim in advertising Listerine to consumers. In granting this approval, the ADA instructed Pfizer to inform consumers they should ask their dentist and floss daily.

When Pfizer began its "as effective as floss" advertising campaign the following month, the ADA posted a statement on its Web site, ADA.org, which is printed on this page.

In support of the claim, Pfizer submitted to the ADA two independent, well-designed, six-

See RULING, page 18

ADA statement on flossing posted online

The ADA has a statement on flossing posted online at "www.ada.org/public/topics/cleaning.asp#flossing". The text follows here.

Flossing recommended for good oral health care

The American Dental Association is aware of the recent preliminary injunction against a mouthwash manufacturer's advertising claim that its mouth rinse is as effective as flossing. The ADA continues to recommend flossing as part of a good oral hygiene regimen. The following updated, flossing information was posted on the ADA's Web site in June 2004.

While some study results indicate the use of a mouth rinse can be as effective as flossing for reducing plaque between the teeth, the American Dental Association recommends to brush twice a day and clean between the teeth with floss or interdental cleaners once each day to remove plaque from all tooth surfaces. Plaque is responsible for both tooth decay and periodontal (gum) disease.

Regarding the studies, the authors concluded that in patients with mild to moderate gingivitis (early periodontal (gum) disease), rinsing twice a day with the antiseptic mouth rinse was as effective as flossing for reducing plaque and gingivitis between the teeth. The studies did not examine whether the mouth rinse had the same effect as floss on reducing tooth decay or periodontitis (advanced periodontal (gum) disease). Flossing and interdental cleaners also help remove food debris caught between teeth that may not be rinsed away.

The ADA recommends following the above overview information ["overview information" refers to flossing instructions at this link: "www.ada.org/public/topics/cleaning.asp#overview"] to help keep your teeth and gums in good health. ■

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The HealthFirst emergent-ez "e-cart" system is a mobile oxygen supply unit complete with a demand and resuscitation valve. The "e-cart" system, when combined with a basic emergency kit, prepares your office for common emergencies.

The oxygen supply, on a wheeled cart, can be quickly moved to an emergency.

The demand and resuscitation valve will provide either positive pressure or demand oxygen applications (pictured lower left.)

The basic color-coded emergency kit, either model SM10 or model HM1010 (pictured above) is accessible in the easy-to-reach bracket on the cart.

PROTECT YOURSELF... BE PREPARED!

DEMAND VALVE (LEFT) Patient activates valve with breathing. RESUSCITATOR (rt.) The non-rebreathing valve permits it to be used as a resuscitator in combination with a manually operated button easily located on top of the valve.

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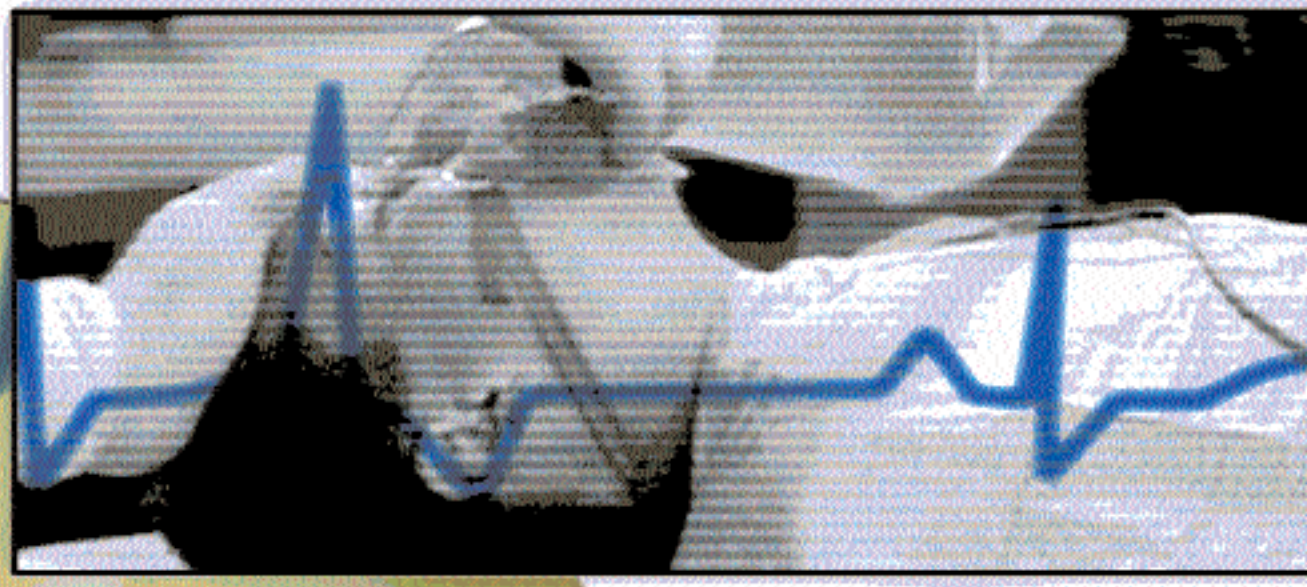
WARNINGS *Dental practitioners who employ local anesthetics should be well versed in diagnosis and management of emergencies that may arise from their use. Resuscitative equipment, oxygen and other resuscitative drugs should be available for immediate use.*



You and your staff should be familiar with the latest protocols associated with managing medical emergencies in the dental office.

- **This two DVD set provides updated protocols you and your staff need to know for the safe practice of dentistry.**
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- **Great for in-office training sessions, or individual take-home training.**
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This interactive DVD is written, directed, and narrated by Dr. Stanley Malamed, dentistry's leading expert in the management of medical emergencies.

Dr. Stanley Malamed

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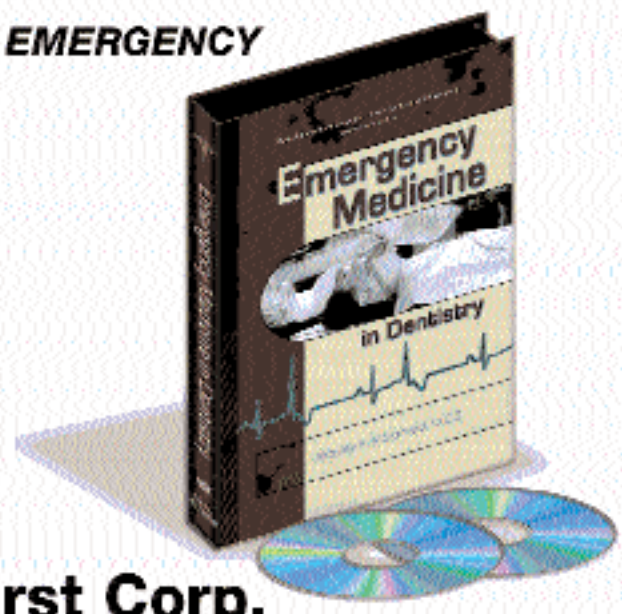

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TMJ pain genetic?

BY STACIE CROZIER

Chapel Hill, N.C.—Some patients really do feel pain more keenly than others and their sensitivity—or lack of it—can probably be traced to their genes, according to a study published in the January issue of Human Molecular Genetics.

Researchers studying pain perception and predisposition to chronic tempormandibular joint pain at at the University of North Carolina at Chapel Hill have discovered a genetic explanation for why individuals feel pain differently and why some are more prone to chronic pain conditions.

A person's level of the enzyme catecholamine-O-methytransferase, or COMT—the enzyme that controls levels of adrenaline, noadrenalin and dopamine—is an indicator of how sensitive he or she is to painful stimulation, they theorize. Humans' genetic variants of COMT fall into one of three variations that give them either high, average or low pain sensitivity.

Researchers from a variety of disciplines, including medicine, dentistry, physiology, epidemiology, molecular biology and genetics, studied 202 healthy, pain-free women ages 18-34 for up to three years. All participants provided a blood sample for genotyping and had regular pressure and thermal pain perception assessments and head and neck examinations.

Study results showed that those with lower levels of COMT were more sensitive to pain and more likely to develop temporomandibular joint disorder. Researchers theorize that individuals with low levels of COMT may also be at greater risk for developing other chronic pain conditions like fibromyalgia, irritable bowl syndrome and other chronic sensory disorders. They also note that testing for genetic variants can help tailor treatments for patients with chronic pain. ■

ADA seeks volunteers for amalgam waste, laser groups

BY MARK BERTHOLD

The Standards Committee of the American Dental Association is seeking volunteers for workgroups on amalgam waste and lasers.

The amalgam waste group will assist in the development of a uniform procedure for collecting, storing and shipping amalgam waste.

Although the vast majority of mercury in surface water is from coal-fired utility plant exhaust, the ADA nevertheless encourages recycling in dental offices, based on its comprehensive Best Management Practices.

However, there currently is no uniform, national standard on how to prepare the material for recycling; guidelines often vary from one recycling company to another.

The ADA believes a uniform standard will simplify the procedure for dental office staff, and anticipates recycling companies across the country will widely adopt the standard.

The laser workgroup will issue a technical report on dental lasers toward development of a scientifically based technical reference on lasers and their interaction with biological tissues for use by dentists. Currently, a broad range of laser wavelengths and designs are available, each with markedly different effects on oral soft and hard tissues.

The technical report will provide information on the safety and effectiveness of dental laser technology, and answer questions on penetration, scattering and absorption of laser energy as it relates to wavelength, intensity, waveform and overall energy deposited.

For more information on participating in the amalgam waste or dental laser work group, contact Janet Hagen at Ext. 2506 or e-mail "hagenj@ada.org". ■

Ruling

Continued from page 15

month clinical studies that comply with the ADA Guidelines for Acceptance of Chemotherapeutic Products for the Control of Gingivitis, explained Dr. Daniel Meyer, associate executive director, ADA Division of Science.

The Council on Scientific Affairs concluded these studies show that in patients with mild to moderate gingivitis, rinsing twice a day with Listerine is as effective as flossing for reducing interproximal plaque and gingivitis. Both studies were performed by independent labs under contract with Pfizer, and both are published.

"The council has not changed its conclusion about the scientific merit of these studies," said Dr. Meyer. "Nor has the council or the ADA changed its position that individuals should clean between teeth daily with floss or other interdental cleaners to remove interproximal plaque."

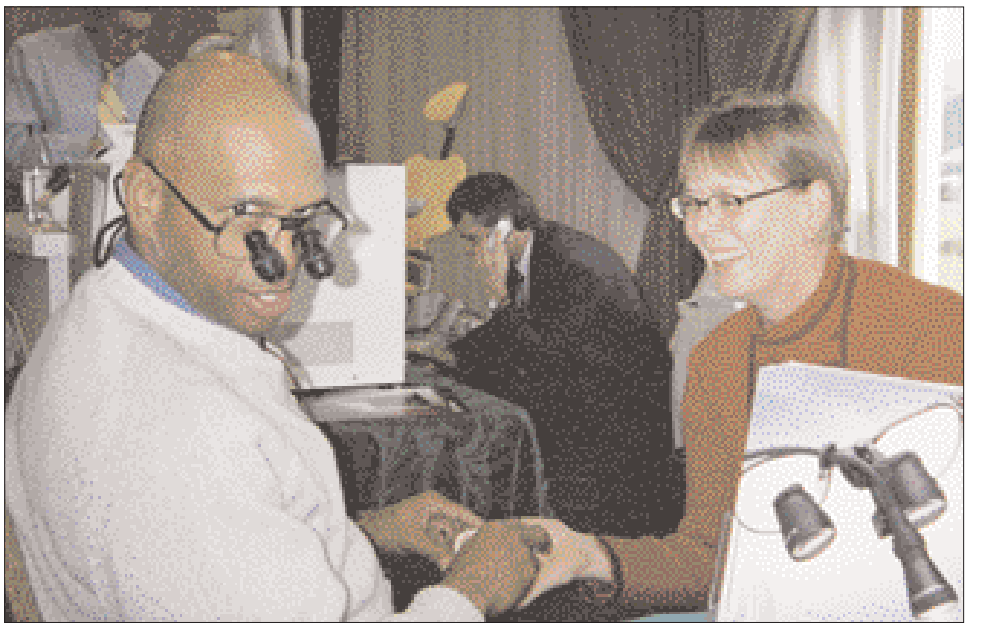
Added Dr. James Bramson, ADA executive director, "The ADA's first concern is the oral health of the public. We continue to recommend that patients brush and floss or use interdental cleaners to remove plaque from all tooth surfaces."

Plaque produces mild to moderate gingivitis as well as advanced gingivitis, periodontitis and interproximal caries. The Pfizer studies did not examine the effects of Listerine and flossing on advanced gingivitis, periodontitis or interproximal caries. ■

Membership

In the Army

Military dentists in Germany learn about ADA legislative issues, Association gratitude



Fix: Col. Sidney A. Brooks (left), commander, U.S. Army Dental Command, receives an adjustment from Orascoptic representatives during the conference in November.

Garmisch: Edelweiss Lodge and Resort in Garmisch, Germany, site of the U.S. Army Europe Regional Dental Command's 48th Annual Dental Training Conference. In a secure location, the four-month-old resort replaced two hotels that the Army previously owned and used for rest and relaxation and conferences for active duty military personnel.

BY KAREN FOX

Garmisch, Germany—Like their civilian counterparts, military dentists are required to obtain continuing education credits on an annual basis.

But their opportunities for CE and professional interaction are hard to come by, especially for those deployed overseas. That's one reason the U.S. Army Europe Regional Dental Command's Annual Dental Training Conference is becoming the hottest ticket around.

The ERDC held its 48th Annual Dental Training Conference Nov. 1-5, 2004, with more than 200 dentists from the Army, Air Force and Navy in attendance.

"Our dentists are sometimes geographically isolated due to assignments around the world, and may not have time, access or funding required to attend any of the ADA-recognized CE meetings," said Col. John W. Davis, former chief of staff, Europe Regional Dental Command and director of the annual training conference. Educational topics at the meeting focused on clinical issues such as prosthodontics, oral pathology and oral surgery.

For the first time, the ADA dispatched a representative to Germany to deliver an update on legislative and other issues of importance to military dentists and extend the Association's gratitude for the unique role that military dentists play in the profession.

"We weighed this trip carefully because overseas travel is expensive, tiring and time consuming," said Dr. James Bramson, ADA executive director. "When we learned that over 200 deployed dentist troops would be at the meeting, we decided it was a wonderful opportunity to say thank you for their service to our country and to recruit."

ADA updates covered funding for military dental research, scholarships, special pay for dentists in advanced training and progress toward greater freedom of movement through recent changes in the licensure process.

The meeting gave the ADA access to a variety of military dentists at all levels for exchanging information on organized dentistry and membership benefits. That direct communication had results, with 13 military dentists joining the ADA as new members during the meeting.

As Col. Davis explained, military dentists rely on alternative CE like online courses or video teleconferencing, which makes it difficult for the ADA to reach out to members who are accomplishing their military requirements in their home stations.

"The ADA being there demonstrates that the organization is concerned about all of their diverse members and makes it clear that membership is important," said Col. Davis. "The ADA's presence at these meetings ensures the message gets to the membership and also provides the opportunity to join the ADA."

One member who didn't travel far was Lt. Col. George Holzer, the officer in charge of the Garmisch Dental Clinic.

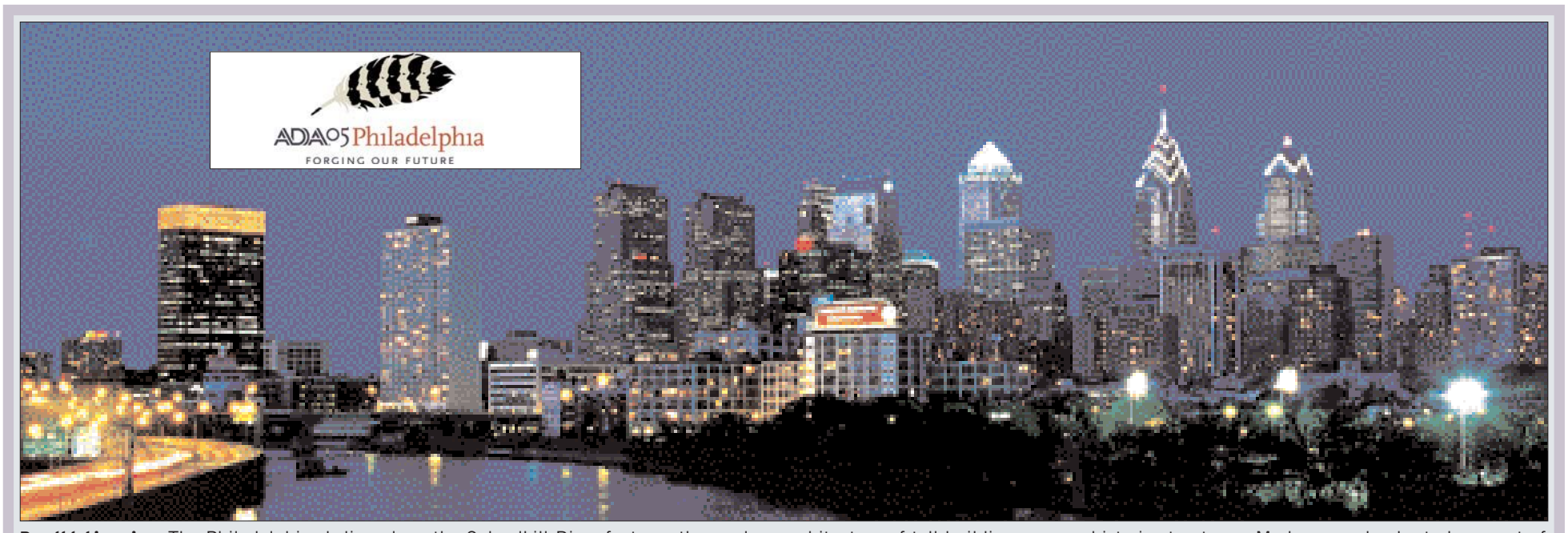
Lt. Col. Holzer's patients include active duty Army, Navy, Air Force and Marines and their family members stationed in the German communities of Garmisch and Oberammergau.

"The nearest military clinic to me is three hours away," he said. "This meeting saves the government and taxpayers a lot of money because we're able to bring in world class speakers to draw dentists here and accomplish a lot in one location."

More than half of those attending the Dental Training Conference were U.S. military dentists. "We have a few dentists stationed in Kuwait who came up this year, and several at the meeting were in Iraq last year supporting Operation Iraqi Freedom," said Lt. Col. Holzer.

For him, the benefits of membership are clear.

"The ADA does a better job demonstrating its effectiveness as a lobby force on behalf of U.S. military members, such as fighting to increase our pay packages. We cannot do that on our own," said Lt. Col. Holzer. "The more of us who are members of the ADA, the more reason for the ADA to say, 'Let's work to take care of these people.' " ■



Breathtaking view: The Philadelphia skyline along the Schuylkill River features the modern architecture of tall buildings among historic structures. Mark your calendar to be a part of history on Oct. 6-9, at ADA05Philadelphia. For more information on annual session, log on to "www.ada.org/goto/session" or call 1-800-232-1432.

Photo courtesy Bob Krist by Greater Philadelphia Tourism Marketing Corp.

Dental dispatch from Afghanistan

BY CRAIG PALMER

Bagram Air Base, Afghanistan—Dr. John J. Caulfield considers himself lucky to be pulling duty here "because I don't have an active practice with employees, overhead and competition to worry about as so many reservists do.

"I asked a group of these reserve physicians and dentists what keeps them in the reserves at a time like this when they face multiple deployments interfering with lives, practices, families and careers. After some discussion one of the ER (emergency room) physicians offered that they probably inherited a dominant form of the 'patriot gene,' which is probably as good an answer as any."

In his first communication with the Association after reporting here in late October 2004, Dr. Caulfield wrote, "The military notified the last group of reservist general surgeons to arrive that they can expect to spend three months of every year for the foreseeable future in Iraq or Afghanistan, and I assume that also applies to the dental personnel."

Dr. Caulfield, a 70-year-old oral surgeon, is on what he and the military describe as "voluntary deployment" with the 325th Combat Support Hospital in Bagram. He agreed to share his experiences with the profession through continuing e-mail exchanges with the ADA News.

"Our units are U.S. Army contemporary field, which are pretty primitive but adequate for basic things," he said. "I split my time between the hospital and the small two-person field dental clinic, which is still located in a tent. I am told we should be moving to a plywood building shortly. Our patient load is whatever and whoever comes in the door, from GIs with toothaches to POWs (persons under control or PUCs) to New Zealand, Turk, Slovakian or whatever troops to embassy personnel to KBR (construction/engineering) employees.

"We work six days a week, do 'sick call' in the morning and appointed patients in the afternoon. I treat casualties when they come in and can bring back local nationals for reconstruction. My first OR (operating room) case ended up being a gunshot wound I treated while wearing a gun myself."

Sure, he wears a gun to work, said Dr. Caulfield. "Everyone is required to carry their weapons all the time with a clip loaded, but on safety, and without having a round chambered. The major surprise is how long it is taking me to adapt to wearing boots and a gun all the time. They are heavy and my poor old joints object to the weight."

However, Dr. Caulfield concedes little to age or circumstance. "The professional skills you asked about all seem to be relatively intact, even though they may be a bit slower to bubble to the surface. I had a child with a massive maxillary bony lesion I was trying to identify and sat bolt upright at two o'clock in the morning two days later with the solution. Now I have to try to track the child down and get him back to see if I am right because if I am, he may be treatable, which I did not think he was originally."

When the military invited Dr. Caulfield's return to active duty, they told him age doesn't matter. Their computers, on the other hand, are having trouble computing that.

"My wife told me that since they stopped my military retirement pay when I returned to active duty, the active duty pay never kicked in as it was supposed to. It turns out that the Army finance computers rejected my information input because of an 'invalid birth date'." Dr. Caulfield turned 70 on Aug. 7, 2004. ■

Time to apply for ADA diversity leadership program

The ADA is now extending a call for applications to participate in its third ADA Institute for Diversity in Leadership.

The Institute is a three-part personal leadership training program designed to enhance the leadership skills of dentists who belong to racial, ethnic and/or gender backgrounds that have been traditionally underrepresented in leadership roles.

Each class will participate in leadership training sessions led by faculty from the Kellogg School of Management at Northwestern University, one of the nation's top-ranked business schools. Participants will also complete a self-selected personal leadership project that provides hands-on experience at identifying and taking action on a civic or professional issue.

The first two class sessions will take place at ADA Headquarters Sept. 8-9 and Dec. 12-13. The third session takes place Sept. 7-8, 2006. There is no tuition for the Institute, and dentists chosen to participate will receive a stipend to offset travel and related expenses. Interested dentists call contact the ADA at Ext. 4699 or "starsiaks@ada.org" to be added to a mailing list for application materials.

The ADA Institute for Diversity in Leadership is made possible by the ADA Foundation through generous corporate contributions from Colgate-Palmolive Co.; GlaxoSmithKline; Procter & Gamble and Sullivan-Schein. ■

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American Dental Association Foundation

TSUNAMI ASSISTANCE FUND

CONTRIBUTION FORM

____ Yes, I want to make a contribution of $_____ to the Tsunami Assistance Fund designated for immediate disaster relief efforts.

____ Yes, I am interested in learning more about the ADA/ADAF long-term relief effort to help reconstruct dental clinics through a Tsunami Dental Reconstruction Fund. I have completed sections 1-4 below for future contact. Thank you.

1. Name:_____

2. Address:_____

3. City:_____ State:_____ Zip:_____

4. Phone:_____ E-mail:_____

Enclosed is my gift by:___ Check ___ Visa ____MasterCard ____ American Express

For donations by credit card, please provide:

Credit Card #:_____ Expiration Date:___/_____

Card Holder Signature:_____

Please mail your contribution to: **ADA Foundation, Tsunami Assistance Fund, 211 E. Chicago Ave., Chicago, Ill. 60611. Credit card donations may be faxed to ADAF at 1-312-440-3526.**

The ADA Foundation is a 501(c)(3) organization. All contributions are tax-deductible to the extent permitted by law.

New York dentists respond: ADA President Richard Haught, center, accepts donations to the ADA Tsunami Assistance Fund from Dr. Jay Ledner, left, and Dr. Chad Gehani of the Queens County Dental Society as QCDS members gathered for Dr. Ledner's installation as president Jan. 8. QCDS members donated $3,300 to the fund within two days of its establishment and pledged to raise another $700 by the end of the week. Dr. Larry Volland, president of the New York State Dental Association, also pledged $5,000 for the cause.

Tsunami

Continued from page one

ADA members and staff. Watch for an update in future issues of ADA News and on the ADA's Web site.

"Dentistry is a caring and concerned profession and dentists pride themselves on providing a nimble response in emergency and disaster situations," said ADA President Richard Haught. "By offering a challenge match to dentists in America who may wish to give through the Association rather than directly to the charities themselves, we can give dentists a unique, value-added opportunity to make donations to the ADAF for tsunami assistance, provide them with the chance to double their donation and build on the sense of community that dentists feel for the ADA and the Foundation."

ADA/ADAF relief efforts will also focus on long-term assistance, enabling dentists, dental organizations and other interested parties to donate to another fundraising campaign to be launched after the immediate emergency phase. This campaign will focus on the next phase—disaster reconstruction—and will provide financial assistance and other resources to help cities and villages damaged by the tsunami rebuild dental clinics. The ADA and ADAF plan to coordinate the long-term rebuilding efforts with the FDI World Dental Federation and the national dental organizations of the countries affected by the disaster.

"With the horror of this disaster, the ADA and its Foundation want to help," said Dr. James B. Bramson, ADA executive director. "We organized two distinct fundraising efforts—one for the near term and one designed for the rebuilding phase. Funds we raise for immediate relief will go directly to the American Red Cross. Funds donated to the ADA/ADAF Tsunami Dental Reconstruction Fund will be used to work with the affected countries, relief organizations, affected national dental organizations and others to fund the rebuilding of dental clinics, dental hospitals or school environments. We hope dentists will want to donate to both the short-term relief effort and longer-term reconstruction.

"Obviously, we need to get past the immediate needs but want to be ready to help restore dental health delivery services," Dr. Bramson added. "We invite any and all dental organizations to join us in this effort."

"The ADA Foundation is pleased to have a role in helping dentists make a difference for the people affected by this disaster," said Arthur A. Dugoni, ADAF president. "Dentists will be able to help the millions of people who lack shelter and basic necessities now, and help devastated countries rebuild in the future by participating in this fundraising campaign. We hope they will feel secure in knowing that the ADA and the Foundation will make sure their caring and generosity will benefit those in need."

The deadly tsunami, triggered by a 9.0 earthquake in the Indian Ocean off the coast of Indonesia Dec. 26, 2004, killed more than 150,000 (at press time) and has left some 5 million people in southern Asia and east Africa without shelter, food, water and sanitation.

To make a donation, please complete the form found on this page or download and complete the Tsunami Assistance Fund form online at "www.ada.org/ada/prod/adaf/index.asp" and return it to the ADA Foundation, 211 E. Chicago Ave., Chicago, 60611. Make checks payable to the ADA Foundation, or use your Visa, MasterCard or American Express card. ■

BRIEFS

Continued from page one

distributed to GKAS programs by the end of this month.

GKAS participants are invited to submit photos and comments on events to the ADA News for publication, however space is limited. Send high-resolution digital images to "adanews@ada.org" starting Feb. 4. Please identify those pictured.

On Feb. 4, ADA News writers will fan out across the country to cover GKAS events. For the latest coverage and photos, be sure to log on to "www.ada.org/goto/adanews" starting Feb. 4. Complete coverage of Give Kids A Smile will appear in the Feb. 21 print edition of the ADA News. ■

Celebrate

Continued from page one

public health achievements in the United States from 1900-1999.

"Fluoridation is the single most effective public health measure to prevent tooth decay and improve oral health over a lifetime," said Dr. William R. Maas, director, CDC Division of Oral Health. "Since it reaches all people in a community regardless of education or income level, it also is a powerful strategy in our efforts to eliminate differences in oral health among our citizens. This year's anniversary provides the dental community with an opportunity to reaffirm its importance and work with other sectors of society to take action to continue to increase the number of people in our country who receive its benefits."

Grand Rapids became the initial site of a 15-year study by the U.S. Public Health Service (and later the National Institute of Dental Research) to track the safety and effectiveness of maintaining a fluoride level in public drinking water of 1 part per million.

Grand Rapids was selected because its water supply was consistently free of fluoride, it was home to a large school-age population (some 30,000 schoolchildren) and its citizens were willing to be a part of scientific history. Muskegon, Mich., with similar demographics and water, was selected as a control city for the study. Within months, several other cities and control cities were joining the historic study.

After the first decade, researchers reported a 60 percent decrease in the prevalence of dental caries in the primary teeth of its children and a 35 percent decrease in caries in adults in Grand Rapids without negative effects.

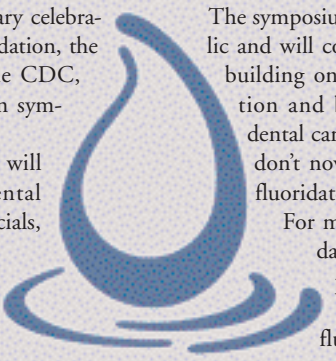
The ADA endorses fluoridation as the most efficient way to prevent one of the most common childhood diseases. The ADA, the CDC, the American Medical Association, the U.S. Surgeon General, the National Institute of Dental and Craniofacial Research and other groups concur: community water fluoridation benefits everyone, especially those without access to regular dental care. It is the most efficient way to prevent one of the most common childhood diseases—tooth decay (five times as common as asthma and seven times as common as hay fever in 5- to-17-year-olds). Without fluoridation, there would be many more than the estimated 51 million school hours lost per year in this country because of dental-related illness.

Today more than two-thirds of Americans (67.3 percent) who are served by public water systems receive optimally fluoridated water. Studies conducted throughout the past 60 years have consistently showed fluoridation to be safe and effective. The CDC estimates that access to optimally fluoridated water reduces incidence of decay from 18 to 40 percent even in an era with widespread availability of fluoride from other sources, such as fluoride toothpaste. And the cost of fluoridating community water supplies over the average lifetime costs less than treating one cavity. ■

ADA, CDC plan fluoridation symposium as part of 60th anniversary celebration

As part of the 60th anniversary celebration of community water fluoridation, the ADA, in conjunction with the CDC, will host a national fluoridation symposium in Chicago July 13-16.

A host of interested parties will gather—from researchers, dental professionals, public health officials, community leaders and legislators to anyone with an interest in improving public health in their community.



The symposium will be open to the public and will convene with an eye toward building on the successes of fluoridation and bringing protection from dental caries to the underserved who don't now have access to optimally fluoridated water.

For more information on fluoridation or the upcoming symposium, log on to "www.ada.org/goto/fluoride". ■

New: CDC posters for water facilities

Atlanta—In conjunction with the 60th anniversary of community water fluoridation, the Centers for Disease Control and Prevention has developed an operational resource poster for water facility operators.

The poster provides information for facility operators on the optimal fluoridation level for their state, how to monitor fluoridation levels at the plant to ensure optimal levels, operational and maintenance guidance, benefits to the community and key contacts at the CDC, ADA, and the American Water Works Association.

For more information on the posters, contact the CDC Division of Oral Health, 1-770-488-6054. More information on the CDC Division of Oral Health is available at "www.cdc.gov/oralhealth". ■

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Dentistry courtesy of Frank J. Milner, DDS.

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