6-6-2005

ADA News - 06/06/2005

American Dental Association, Publishing Division

Dr. Richard Mascola dies, page eight ◆ Soda bill in Connecticut, page 23

AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

JUNE 6, 2005 VOLUME 36 NO. 11

Doctor, who are you?

National Provider Identifiers key to e-transactions

BY CRAIG PALMER

An ADA information campaign encourages dentists to apply for the new National Provider Identifier intended for use in electronic transactions no later than May 23, 2007.

"Early application for and receipt of an NPI mean your practice will be ready to use an NPI when requested by a patient's health plan," says a National Provider Identifier Dental

See NPI, page 25

■ Grand Rapids celebrates fluoridation, page 24

Learning about patients' cultures from experts

BY KAREN FOX

Working in collaboration with the Hispanic Dental Association, the Indian Dental Association U.S.A. and the National Dental Association, the ADA has developed a series of Multicultural Regional Workshops to help dentists and staff teams care for their diverse patient populations.

"Diversity in Dentistry: Techniques for Managing Your Changing Patient Base" take place in three metropolitan

See CULTURES, page 20

It gets better: Dr. Denise Habjan leans in to comfort an unhappy 5-year-old Valentin Ramirez for dental treatment in one of Tomorrow's Dental Office Today's two operatories. Dr. Habjan said Valentin "probably will need all of his teeth restored." Turn to page 22 for a happier Valentin and more on TDOT's charitable efforts in San Juan Capistrano, Calif., last month.

Illustration by Peter Solarz

■ First in a series

E-claims boon for dentists

BY ARLENE FURLONG

Would any dentist in his or her right mind say "no" to lower claims processing costs, less paperwork, better cash flow and faster reimbursements?

You bet they would. In fact, more than 50 percent of dentists say "no," by not filing electronic dental claims.

"The Integrated Dental Office," a new and

See E-CLAIMS, page 14

BRIEFS

Executive update: For 28 dentists (as of press time), July 23 marks their first day of "The Executive Management Program" offered by the ADA and the Kellogg School of Management at Northwestern University.

Enrollments are being accepted until the maximum of 45 students is reached. The program features 72 business class sessions (all with tenured Kellogg professors) meeting for three five-day sessions on Northwestern's Chicago campus (near ADA Headquarters). This is an advanced business program; not dental practice management.

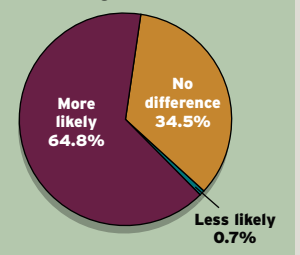
For more information, contact Tom Prince, Ph.D., at Kellogg ("t-prince@kellogg.northwestern.edu") or Joe Martin, director, ADA Dental Society Services ("martinj@ada.org"), Ext. 2597, or go to "www.ada.org/goto/kellogg".

New dentists: "Practice Options for the New Dentist: A How to Guide" has been updated and now includes sample associate agreements, partnership and sales agreements and model contracts. The publication is available through the ADA Catalog, Item #J088, at the member price of $49.95. To order, contact ADA Salable Materials at 1-800-947-4746 or go to "www.adacatalog.org". ■

JUST THE FACTS

Choosing a dentist

Likelihood that ADA membership makes a difference in choosing a new dentist.



Source: ADA Survey Center "survey@ada.org", Ext. 2568

No-interest payment plans can grow your practice.

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- Less effort spent on collections saves you time
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American College of Dentists honors ADA

The American College of Dentists has named the ADA the first recipient of its newly established Ethics and Professionalism Award, recognizing the Association's "significant and long-standing" contributions to dentistry's high ethical standards.

Dr. Richard Haught, ADA president, will accept the award on the Association's behalf at the ACD's Convocation Ceremony Oct. 6 in Philadelphia, during the ADA's annual session.

Expected at that event is U.S. Surgeon General Richard H. Carmona, M.D., who has agreed to deliver this year's convocation address.

Dr. Stephen A. Ralls, ACD executive director, informed the ADA of the award in a May 16 letter to Dr. Haught citing the "important and tangible" efforts of the ADA Council on Ethics, Bylaws and Judicial Affairs as an integral part of the ADA's overall contribution to professional ethics.

"Ethics and professionalism are extremely important to the long-term integrity and well-being of our profession, as well as [to] oral health care in general," wrote Dr. Ralls. "We are proud to recognize the ADA's leadership in this area."

Founded in 1920, the college has about 7,300 members. Its mission is "to promote excellence, ethics and professionalism in dentistry."

Said ADA President Haught, "We in dentistry must never lose sight of our ethical and professional responsibilities to the people of this country as we debate the merits of new ideas and initiatives before us. This award recommits us to that responsibility." Dr. Haught said the U.S. surgeon general's attendance at the award ceremony was an added bonus that would "send a positive message of dentistry's high standards" to other health professions.

Dr. James B. Bramson, ADA executive director, cited the work of the council and the ADA's Principle of Ethics and Code of Professional Conduct as "the foundations of dentistry's professionalism."

The award, he said, "shows the public that we dentists take our responsibilities very seriously and that we are determined to maintain the highest standards of care. This is not simply an honor for the ADA; it is an honor for the entire dental profession." ■

ViewPoint

MyView

A change of course


Gerald S. Phipps, D.M.D.

The condition of people's teeth remains the most visible separation between the haves and have-nots," wrote Rebecca Nappi, associate editor for Spokane's Spokesman-Review daily newspaper. After volunteering at Spokane's Christmas Bureau, where toys and food vouchers were given to over 30,000 adults and children, Ms. Nappi wrote:

"The volunteers, mostly middle- to upper-middle-class folks, had all their teeth and those teeth were white. This reflects dental insurance and/or the ability to pay for regular check-ups, cleaning and replacing of pulled teeth.

"Many of the clients, however, lacked several of their teeth. In others, their teeth had rotted completely away …

"When these clients are job-hunting or house-hunting, the terrible condition of their teeth is surely a handicap. A wish, floating around the bureau the past several years, is that community dentists will donate toothbrushes, toothpaste and dental floss to be handed out to the adults and children who come to the bureau. Perhaps dentists could staff a table and make referrals to those dentists in our community who already do pro bono work or are willing to start.

"Something is out of balance in a first-world country where baby-boomer adults pay thousands of dollars for multicolored braces—for themselves—while other adults walk around toothless."

Aside from being a plea for health care reform, this commentary represents a lay perspective of the disparities that exist with dental health and clarifies the lack of understanding that we, in the dental profession, face in our attempt to address the need. Granted, the gap between the haves and have-nots is growing in every material way. But the dental access issue is more complex than most people understand and demands far more than free toothbrushes and pro bono dentistry.

For years the Spokane District Dental Society was present at community events distributing toothbrushes, floss, mouthguards, dental education and dental advice, including information about the availability of low-cost and no-cost dental care. More recently, Spokane dentists have volunteered at community clinics, treated low-income patients at a reduced or no fee, participated with Give Kids A Smile and in local television question and answer sessions.

Most of these activities, as much as they may elevate our image, are feel-good activities. They make no appreciable impact on the incidence of dental disease, and the "wish" of those who think they will is naïve. Dentists donating dental hygiene materials to prevent dental disease is as effective as physicians donating washcloths and soap to prevent infection.

More important, even though dentists in Washington state write off $100 million annually to treat Medicaid patients and donate millions more in charitable care, the impact is below the radar. There is too much need and dental services are too costly to routinely give away.

As stated by ADA Executive Director James Bramson, "Through Give Kids A Smile and many other voluntary events, dentists demonstrate their creativity and

See MY VIEW, page five

LettersPolicy

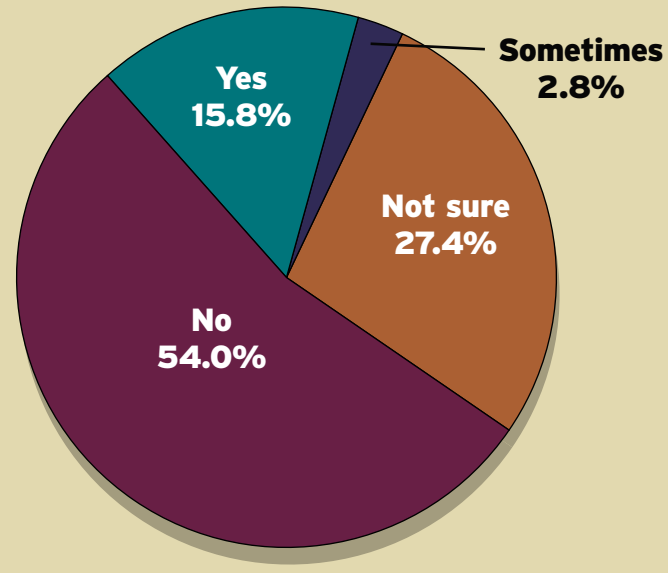
ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views 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

Bottled water

Most people who drink bottled water report that their brand does not contain fluoride. Nearly 28 percent aren't sure if it contains fluoride.

Percentage of respondents who drink bottled water containing fluoride, 2003



Source: American Dental Association, 2003 *Public Opinion Survey.*

Letters

Disability claims

The article "Disability Claims For Dentists" (May 16 issue) is one of the most valuable articles ever published by the ADA News.

As a dentist forced to retire due to deterioration of the fifth, sixth and seventh cervical vertebrae, I can attest to everything that Arthur Fries presented in his article. He is right on the money.

The article should be cut out, saved and re-read by every dentist who may find him-/herself unfortunate enough to have to submit a claim for disability.

Jay S. Orlikoff, D.D.S.
Stony Brook, N.Y.

Treatment denied?

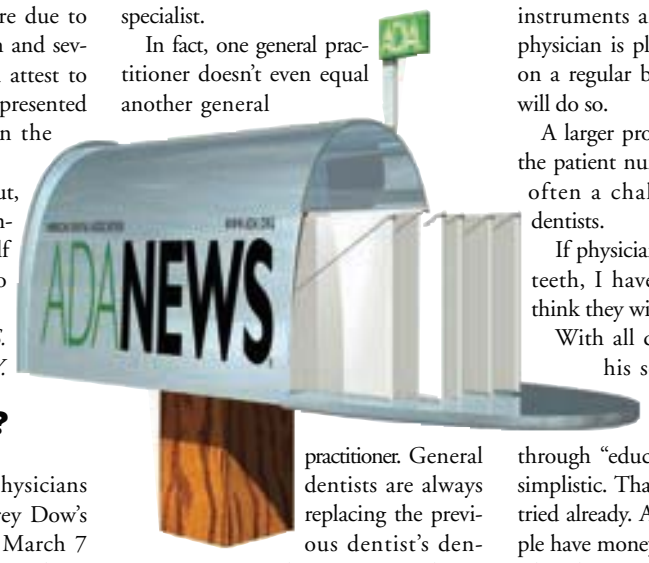
This is in reference to "Physicians Removing Teeth?"—Dr. Jeffrey Dow's "My View" editorial in the March 7 ADA News. A few things crossed my mind as I read the column.

First was his statement that "our medical colleagues are frustrated about seeing patients with dental needs who they feel are being denied dental treatment by dentists."

How many dentists you know are turning patients away? The dentists I know are looking for patients. Some send out advertisements.

Regarding the "standard of care" that seems to be a yardstick devised by lawyers to use against dentists—that the standard is to be the same for general practitioners and specialists is nonsense.

No intelligent person believes that a general practitioner is equivalent to a specialist.



In fact, one general practitioner doesn't even equal another general practitioner. General dentists are always replacing the previous dentist's dentistry, sometimes when it was "just done." The standard seems to be all over the lot.

Oral surgeons who have a medical degree along with their specialty degree scare me. Would you want an oral surgeon who also happens to be an M.D. treating you for diabetes or a heart condition? Would their standard of care equal that of an internist, cardiologist or endocrinologist?

As for being concerned about Veterans Affairs, teaching medical residents to extract teeth seems like a waste of taxpayer money. Wouldn't that be practicing dentistry without a license?

Removing teeth requires a degree of experience that needs to be practiced fairly frequently. The forceps and related instruments are expensive. Unless the physician is planning to take out teeth on a regular basis, I don't think many will do so.

A larger problem they face is getting the patient numb on the lower. That is often a challenge for experienced dentists.

If physicians want to take out a few teeth, I have no problem with it. I think they will have the problem.

With all due respect to Dr. Dow, his solution to patients not getting the dental care "they need or desire" through "education and prevention" is simplistic. That has been suggested and tried already. As one clinician said, people have money for what they want, not what they need. We are in competition with Madison Avenue, and big business has more money than dentistry will ever have for advertising to induce people to spend their money.

Finally, I have no idea what Dr. Dow is talking about when he stated "that the dental office may or may not be the best place for patients to access this treatment/education." Where then? Governments are not bending over backward to

See LETTERS, page five

MyView

Continued from page four

willingness to reach out to underserved children. But altruism is not a health care delivery system. Dentistry alone cannot be expected to solve the problem of providing sustained access to oral health care for the millions in need."

So where do we go from here? In Spokane and other communities around the state and country, the first and foremost step toward closing the dental health gap is community water fluoridation. Only half the state's population currently benefits from this highly safe and effective way to prevent the single most common chronic childhood disease—tooth decay.

As noted in the May 2000 report, "Oral Health in America: A Report of the Surgeon General": "Water fluoridation is a powerful strategy in our efforts to eliminate health disparities among populations. … Fluoridation is the single most effective public health measure to prevent tooth decay and improve oral health over a lifetime, for both children and adults."

Organized dentistry supports water fluoridation and for several years the Washington State Dental Association has provided fluoridation assistance to local dentists and their communities. But we have encountered staunch resistance because a very persistent and vocal gang of antifluoridationists believe that fluoride is responsible for everything from acid rain to cancer. And their ignorance is making a difference. In Spokane, the emotional and irresponsible babble of the antifluoridationists is the primary cause of "the most visible separation between the haves and have-nots."

It's time for a change of course. It's time to put a face on the damage done by failing to fluoridate and to herald this failure as nothing less than child neglect. It's time to make community water fluoridation the priority, and it appears that leadership is ready.

During recent meetings of its board of directors, WSDA leadership agreed to take an aggressive and proactive position toward achieving statewide fluoridation. The WSDA has engaged a consultant to execute a successful fluoridation campaign in Bellingham and to begin the groundwork for future campaigns in Olympia, Richland and Kennewick. The goal is to develop a winning strategy and progressively apply it to communities around the state—eventually including Spokane.

We must stop rationalizing that we are somehow containing the growing dental health disparity with feel-good projects. It's time to make a difference—a solid difference. Fluoridation is not the entire solution, but it will have a greater impact than anything else we can do. And that would be a great start!

Dr. Phipps is the news editor of the Washington State Dental Association News. His comments, reprinted here with permission, originally appeared in the March issue of WSDA News.

Editor's note: In conjunction with the Centers for Disease Control and Prevention, the ADA is hosting the National Fluoridation Symposium 2005, July 13-16. For more information, see page 24.

Letters

Continued from page four

provide dental care. Dentistry is basically elective. Teeth are not a life-and-death issue.

W. Braden Speer, D.D.S.
Dallas

NYU dental-nursing

Regarding "NYU Dental School Absorbs Nursing College" (April 4 ADA News), Roy Lasky, New York State Dental Association executive director, states that "doctors of dentistry are educated at a higher level than undergraduate nurses," and that "dentists are not auxiliaries." What can the dental community as a whole make of NYU's decision to merge the College of Nursing with the College of Dentistry?

Admittance into any college of dentistry requires an undergraduate college degree, as compared to a nursing program that requires a high school diploma or equivalency. With no disrespect intended to the wonderful nurses who serve society, I simply don't get the arguments put forth in favor of this merger.

A merger between dental and medical schools on a level involving basic science classes has traditionally been seen as the standard. This seems to be a cost-effective means of education as departments can be shared with a common curriculum. So the question at hand is to what advantage would the College of Dentistry have to merge a doctoral program with an undergraduate program?

NYU's decision was stated to be driven by the "Institute of Medicine's report that addressed the nation's future health needs by identifying key competencies essential for health professionals."

The IOM study reads as follows: "Dental schools must move closer to the academic, research and patient care missions of medical schools specifically and academic health centers in general." Reading through the Future of Dentistry Report, which quotes the IOM report, I am remiss to find mention of a need to fuse dentistry and nursing. It appears instead that the major need being addressed is the financial need of New York University.

As an educator and a former assistant clinical professor at NYU during Dean Edward G. Kaufman's tenure, I just don't see the logic. If "nursing will continue to be an independent program that meets its requirements for accreditation, and dentistry will run as an independent program," just what kind of merger is happening? If this merger answers a call for interdisciplinary health research and education, why is the School of Medicine—a more logical partner to either dentistry or nursing—excluded?

Dean Michael Alfano and New York University were given an opportunity to answer these questions at a public meeting with alumni. The original

See LETTERS, page six

CareCredit offers financing solutions

New ways to increase elective treatment acceptance with no-interest, low-interest plans

ADA MEMBER ADVANTAGE℠

The number of patients desiring cosmetic or other elective treatments is on the rise.

CareCredit reports that studies from the American Academy of Cosmetic Dentistry show that aesthetic services grew an average of 12.5 percent in the past five years—with some doctors experiencing close to a 40 percent increase.

Doctors also indicated that when evaluating the acceptance of cosmetic procedures, patients' No. 1 concern is cost. As a result, more and more dentists are seeking ways to ease the financial burden on their patients.

CareCredit, one of the industry leaders in patient payment programs, has announced new enhancements designed to give patients the most complete financing solution, especially for comprehensive and elective dental treatment.

CareCredit now offers a new 18-month no-interest payment plan (in addition to existing three-, six- and 12-month no-interest plans), which is ideal for patients with higher treatment fees.

The company has also introduced a new, lower 9.9 percent patient interest rate on their 24-, 36- and 48-month extended payment plans, which is lower than the interest rate on the average consumer credit card. (The average interest for existing card accounts has climbed from 15.62 percent a year ago to 16.75 percent, according to "www.carddata.com".)

The enhancements to CareCredit's plans were designed to make it easier and more comfortable for patients to agree to treatment plans over $1,000.

CareCredit is at work in more than 45,000 health care practices and has been used by over 3.5 million patients. With innovations like instant online applications, CareCredit is continuing its commitment to helping patients to get the dentistry they need and want.

A division of General Electric Co., CareCredit is the only patient payment program endorsed by ADA Member Advantage. For more information, call 1-800-300-3046, Ext. 4519. ■

Letters

Continued from page five

proposal presented would have involved a name change to the "NYU College of Dentistry and Nursing," a name that I believe did not suit the many exemplary dental leaders in our profession who are NYU alumni. A meeting scheduled to discuss the merger and name change was abruptly canceled. Instead, Dr. Alfano and NYU neglected to hear and answer the concerns of its alumni community.

Louis F. DeSantis, D.D.S.
Chief of Prosthodontics
New York Methodist Hospital
NYU College of Dentistry, Class of 1984
Brooklyn, N.Y.

More than auxiliaries

In response to "NYU Dental School Absorbs Nursing College," I would like to comment.

In this day and age, it is saddening to see the words of Roy Lasky, NYSDA executive director. Mr. Lasky states, "This is not to show disrespect to the nursing profession, but dentists are not auxiliaries. They (dentists) perform surgical procedures and have more in common with physicians than they do with nurses."

Mr. Lasky, nurses are not auxiliaries by any means. A nurse is a highly trained professional with a body of knowledge based in theory with the performance of complex technical skills. Nurses must complete board examinations and licensure through a state board, the same as a dentist or physician.

An auxiliary implies a hierarchy of health professional who bolsters the more rigorous care of the dentist or physician. Nursing care is not that. Nursing is a set of skills that requires thought and careful application to the patient, some of which a dentist or physician cannot or will not perform for the patient.

When nursing is trying to recruit young people to care for us aging baby boomers, such an attitude is counterproductive in that effort. I invite you to come and spend a day with a bedside floor nurse or an intensive care nurse and watch the mechanism that keeps the wheels of medicine moving toward a common goal: professional care of patients.

Allan J. Schwartz, D.D.S.
Certified Registered Nurse Anesthetist
Columbia, Mo.

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Dr. Mascola, past ADA president, dies at 68

Staunch defender of private dental practice

Dr. Richard F. Mascola: 1936-2005

BY JAMES BERRY

Palm Beach Gardens, Fla.—Dr. Richard F. Mascola, a past ADA president who fought for the rights of dentists to practice without third-party intrusions, died May 28 after a six-month bout with cancer. Dr. Mascola would have been 69 years old in July.

"He was a wonderful person, a great motivator, a true mentor and a strong advocate for the private practice of dentistry," said Dr. Robert Uchin, dean of the College of Dental Medicine at Nova Southeastern University in Ft. Lauderdale, Fla., where Dr. Mascola was an associate professor and director of the dental clinic and faculty practice.

A service for Dr. Mascola was held May 31 in Ft. Lauderdale. A second service and burial will be held June 11 at 10 a.m. at St. Charles Cemetery, Conklin Street, Farmingdale, N.Y.

After earning his bachelor's degree from College of the Holy Cross (Worcester, Mass.) in 1958, Dr. Mascola served as a U.S. Navy pilot until 1963, having learned to fly when he was just 16. (In the mid-1980s, be built his own World War I-style Christian Eagle biplane. And it flew.)

He received his dental degree in 1968 from New York University's College of Dentistry, where he went on to complete graduate studies in prosthodontics. He later opened a private practice in Jericho, N.Y., and was attending prosthodontist at Nassau County Medical Center in Mineola and the Catholic Medical Center in Jamaica.

Dr. Mascola and his wife, Betsy, were married for 38 years and had three children: Richard, Michael and Elizabeth, known to all as Lizzie. Both Michael and Lizzie spoke at the May 31 service for their father.

"My father may not be physically with us right now," said Lizzie, "but the love for his family, for his friends and for his profession will remain alive in our hearts forever."

She continued, "He was strong, caring, generous and determined. He was hard working. He was dedicated to his wife, to his children, to his family, to his friends and, of course, to dentistry."

Michael read an open letter to his father. "To others, you leave behind an impressive legacy of achievement that's hard to repeat," he wrote. "But for me, your legacy is simple: You were my dad. That's all that mattered to me."

Dr. Mascola got involved in organized dentistry early in his career, serving as president and later executive director of the Queens County Dental Society. He held a number of posts with the New York State Dental Association, including membership on its Board of Governors in the late 1980s.

Dr. Sanford Klein, a member of the Queens County Dental Society Board of Trustees, has written a tribute to Dr. Mascola for the dental society's newsletter.

"People flocked to him, particularly young dentists," wrote Dr. Klein, friends with Dr. Mascola since the 1960s. "He knew how to connect with them. He had a natural flair and openness that our younger professional colleagues responded to."

On the national level, Dr. Mascola chaired the ADA Council on Communications in 1994 and represented the 2nd District (New York) on the Board of Trustees from 1994-98.

But for many ADA members, Richard Mascola burst onto dentistry's national stage with a stunning, firebrand speech to the 1998 House of Delegates, delivered shortly after he was nominated as

See DR. MASCOLA, page 21

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Health&Science

Influenza pandemic?

Dentists urged to read reliable sources

BY MARK BERTHOLD

The American Dental Association has issued a report on the potential worldwide spread of severe influenza, and how dentists can be responsive to such an event in the United States.

The new report, "Influenza Pandemic," by Dr. Albert H. Guay, ADA chief policy advisor, is available from the Association online at ADA.org or by calling Ext. 2844.

"The threat of an influenza pandemic is real, and prediction of a pandemic's onset or immediate containment remain impossible," says Dr. Guay.

"Yet, this is not a reason for hysterics or panic," he adds. "Instead, I urge dentists to pay attention to health reports from around the world, and to look for balanced information from reliable sources—not from alarmist opinions."

In his report, Dr. Guay outlines the historical characteristics and typical progression of an influenza pandemic. In discussing our federal government's strategies to handle a future event, he makes clear that no predetermined plan will be absolutely the best for whatever situation may occur—since information about the exact nature of a pandemic must await its emergence. Nonetheless, he says, a well-developed plan will allow a mechanism to establish for the most rapid response.

"How badly a potential pandemic might affect the United States is anybody's guess," he notes, "but we do know that our public health infrastructure in the United States is vastly different than in the past, when devastating influenza pandemics hit with little warning."

Surveillance and early detection are key steps to containing the initial outbreak of a new and potentially severe strain of influenza. Sick patients would likely go first to the medical community with flu-like symptoms, rather than go to the dentist for treatment.

"The dentists' role would be ancillary," says Dr. Guay, "but their vigilance concerning patient behaviors could still aid in the early detection of an influenza outbreak."

However, in the event of a full-scale pandemic, the medical community would not be able to control or monitor the situation on its own. Local medical resources could be overwhelmed.

Dr. Guay

"The surge capacity would be over the top," he says, "and dentists may need to play a hands-on and vital role to counteract the spread of disease and safeguard the public health."

Infection control procedures, for example, would likely need to increase, as well as apply beyond the operatory and dental treatment into the waiting room. Dental offices may be required to close down, except for emergency treatment. Two ADA councils, he notes, are considering which expanded infection control practices may be appropriate for dental offices to employ in the event of a severe influenza situation.

Dentists might also be mobilized in ways similar to a response to bioterrorism, such as administering medications and immunizations or using their dental offices as temporary medical centers.

"Which is why the ADA is urging dentists to be familiar with their state dental society's emergency response plan," says Dr. Guay, "to keep themselves up-to-date with mass-disaster training programs and above all, to pay attention and keep informed by monitoring world health events from reliable sources.

"The ADA will help," he adds, "by providing information to dentists in a timely manner." ■

CORRECTION

ADA News wishes to revise a disclaimer that appeared with an article published in the March 19, 2001, issue of ADA News, "How Do Your Patients Pay," by Dr. Roger Levin. At the time, the News was not aware that CareCredit (a patient financing company that is an ADA Member Advantage partner) was an educational sponsor of The Levin Institute. The disclaimer was drafted by the ADA. The Levin Group did not know of the disclaimer, approve it or have any responsibility for its publication. The ADA News regrets this error. ■

Third molar study inconclusive

Cochrane findings are based on three studies

BY MARK BERTHOLD

Nijmegen, Netherlands—The results of a recent Cochrane review on third molar extraction and late incisor crowding are inconclusive, and should not be misinterpreted to mean that asymptomatic dental patients should not have their third molars removed, says Dr. Domenick T. Zero, chair of the ADA Council on Scientific Affairs.

"Clinicians should make it clear to adult patients with asymptomatic third molars that there is no evidence, one way or another, about the effect on incisor crowding of otherwise removing these molars," says Dr. Zero. "Same to adolescents and parents regarding the impact of surgical removal on the late lower incisor crowding."

The systematic review, "Interventions for Treating Asymptomatic Impacted Wisdom Teeth in Adolescents and Adults," was published April 18 by The Cochrane Collaboration.

The review was intended to analyze the effect of removing wisdom teeth—compared to retaining them—on multiple outcomes, including pericoronitis and infection of bone and surrounding tissues.

However, only three studies were included in the review, and these studies addressed only one outcome: crowding. This led the study's chief author, Dr. Dirk Mettes of Radboud University Medical Centre, to conclude that "no evidence was found to support or refute the routine prophylactic removal of asymptomatic impacted wisdom teeth in adults."

"There is some reliable evidence," Dr. Mettes added, which "suggests that the prophylactic removal of asymptomatic impacted wisdom teeth in adolescents neither reduces nor prevents late incisor crowding."

Many reasons other than late incisor crowding may lead a dentist to recommend extracting the third molars, says Dr. Zero. In the decision-making process, dentists and oral surgeons can use this review, along with other related information and their own clinical expertise. "It's also prudent," he says, "that dentists include the preferences of the individual patient."

Further information can be found online at ADA.org at "www.ada.org/goto/ebd". ■

Recall study finds no data for frequency

BY MARK BERTHOLD

Cork, Ireland—A Cochrane review, conducted to evaluate recall intervals between dental check-ups, doesn't make any conclusion on the optimal frequency for periodic recalls.

"There is insufficient evidence from randomized controlled trials to draw any conclusions regarding the potential beneficial and harmful effects of altering the recall interval between dental check-ups," wrote lead author Dr. Paul Beirne of the University Dental School and Hospital, Cork.

He added, "There is insufficient evidence to support or refute the practice of encouraging patients to attend for dental check-ups at 6-month intervals."

The systematic review, "Recall Intervals For Oral Health in Primary Care Patients," was published April 18 by the Cochrane Collaboration and sought to evaluate the beneficial and harmful effects of different recall intervals. However, only one study met the review's inclusion criteria—and this study was judged by the authors as likely to be biased.

"The reviewers' inability to come to a conclusion does not indicate that periodic recalls are ineffective," notes Dr. Domenick T. Zero, chair of the ADA Council on Scientific Affairs.

Rather, dentists can use this review, along with many other studies that address the effectiveness of periodic recalls, in their decision-making process. This also includes their clinical expertise, the preferences of the individual patient and an assessment of each patient's oral health and risks for oral disease.

Further information can be found online at ADA.org at "www.ada.org/goto/ebd". ■

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.

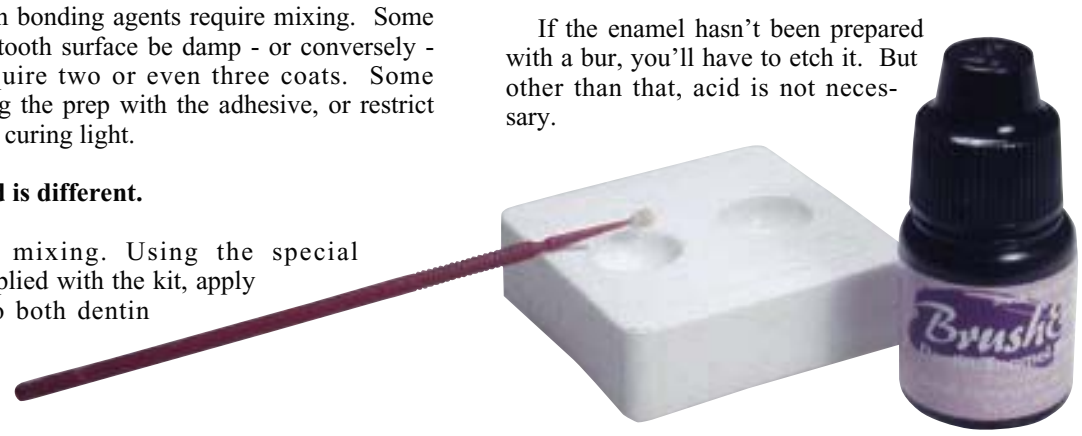
Most self-etch bonding agents require mixing. Some require that the tooth surface be damp - or conversely - dry. Many require two or even three coats. Some require scrubbing the prep with the adhesive, or restrict you to a halogen curing light.

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.

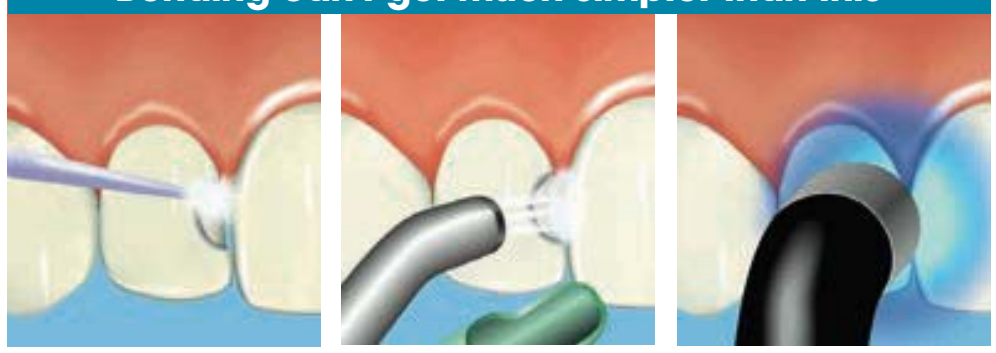
From start to finish, the Brush&Bond procedure takes about 35 seconds. (In the interest of full disclosure, researchers at one independent organization reported it took them 37 seconds - not 35. So your personal time may vary somewhat.)

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



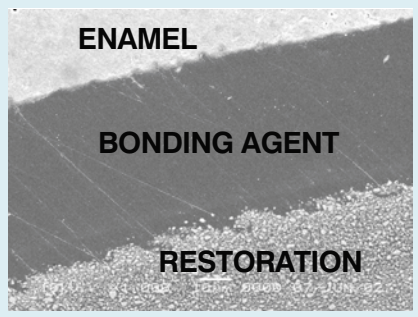
A different kind of no-etch bonding

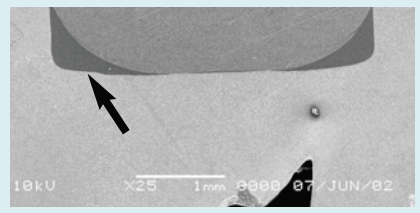
Bonding can't get much simpler than this



1. APPLY (Let sit for 20 sec) *2. BLOW* *3. CURE*

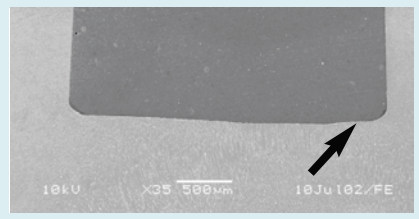
THICK-FILM SELF ETCHER





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

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]

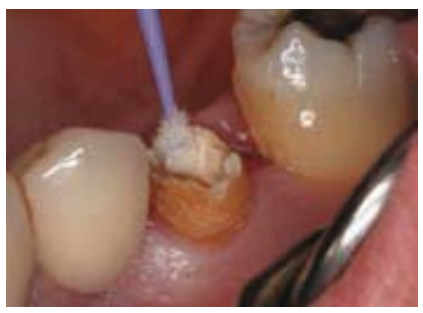
RELIABLE BONDS

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[9,10,11])

Visit Parkell at major dental meetings: San Francisco CDA (Sep 9–1

INDIRECT RESTORATIONS



CORE BUILD-UPS

TREATING DENTIN HYPERSENSITIVITY

DIRECT COMPOSITE RESTORATIONS

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. #159, Mar 04

3 Ritsco R. Self-etch adhesives spark discussion. Dent Prod Reprt, p61A-62, Apr 03

4 (Yamamoto T, et al. Evaluation of Sealing ability of self- etching bonding systems. IADR-HA. Abstr #1752, Mar 04)

5 Suzuki S, et al. In vitro wear evaluation of desensitizers for dentin hypersensitivity. IADR-San Antonio, Abstr #0953, 2003

6 Schoenrock GA. Brush&Bond. Interface 15:89, Oct 03 Suzuki wear study

7 Fukagawa Y, et al. Prevention of secondary caries by self-etch bonding system (Hybrid Bond). Inter Symp on Dntl Hygiene, Madrid Jly 04

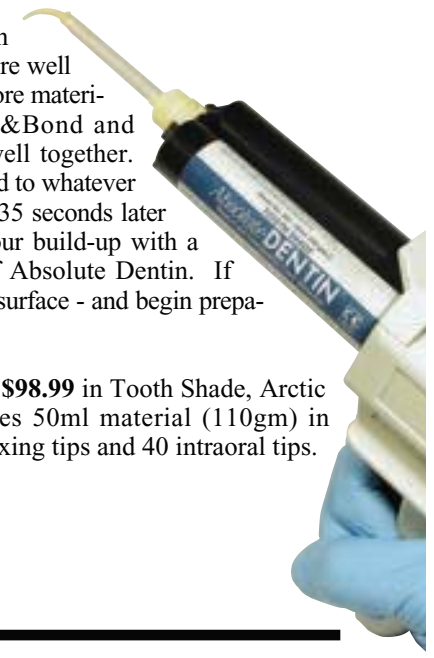
8 Madow RH. Rapid-fired posterior resins: Inteview with Martin B. Goldstein, DMD. Richards Report Tape Series. July 04

9 Nikaido T, et al. The resin-coating technique. Effect of single-step bonding system on dentin bonding strengths. Jour Adhsv Dent. Vol 5, No 4. p293-300, 2003

10 Brown PL, Microtensile strength of adhesives utilizing indirect and direct composites. IADR. Mar 2004

11 Ori T, et al. Bond strength of caries-affected dentin using tin-film bonding agent(s), IADR, Hawaii Mar 04.

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

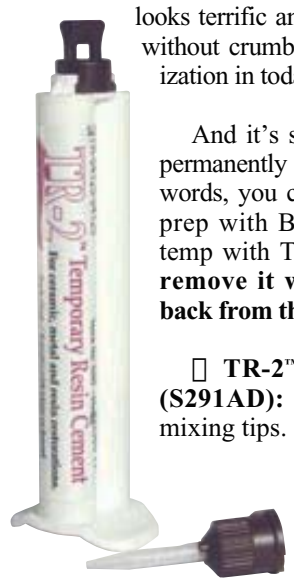


Conventional self-etch bonding agents don't adhere well to self-cure or dual-cure core materials. That's why Brush&Bond and Absolute Dentin go so well together. Simply apply Brush&Bond to whatever remains of the tooth, and 35 seconds later you're ready to create your build-up with a single bulk placement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

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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	46 sec	2	--

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

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1),PhiladelphiaADA(Oct6-9),GreaterNY(Nov27-30,Booth2303)

E-claims

Continued from page one

continuing ADA News series, will show you how technology in equipment, processes and dental informatics can serve you in your practice today and in the future.

The series will include articles on the advantages of filing electronic claims—just one of the many benefits of electronic commerce in dental practice.

The ADA is working with payers, software developers and clearinghouses to make electronic claims processing the most cost-effective method for dentists to manage claims. Already, dentists filing electronically report their electronic claims are processed in less than half the time of their paper claims—just one of electronic commerce's potential advantages for dentists, according to the Council on Dental Practice.

"The more dentists who file electronically, the better positioned the ADA is in negotiations with payers," explained Dr. Michael L. Stuart, council chair. "We have more clout in the industry as a profession if we come together as a profession."

Dr. Gordon Isbell III, vice-chair of the council, said it's all about the numbers.

"With enough dentists participating in electronic claims submission, we can secure a win-win situation for dentistry and patients," he said.

The ADA 2002 Member Advantage Survey reports that 44.6 percent of practices submit some claims electronically. Dental claims clearinghouses and payers report that 35 to 40 percent of all dental claims are filed electronically.

Dr. Isbell

Dr. Kyger

Dr. Stuart

Mr. Hardin

Among its advantages, electronic commerce between dentists, payers and clearinghouses not only speeds up dentists' revenue cycle but can also help the patient by establishing what the service will cost before treatment, according to CDP members.

"The goal here is to achieve best practices for patients," commented Dr. Billie Sue Kyger, another CDP member. "If the ADA drives the transition to electronic claims filing, we can help develop a standard mechanism to obtain service data in a consistent manner without being dependent on our payers."

Uniformity was one among potential advantages for dentists filing electronic claims the council discussed last month with Philip Hardin, WebMD Dental, during his presentation to the council at ADA Headquarters in Chicago. WebMD is an ADA Member Advantage partner and the largest dental claims clearinghouse in the United States.

Being able to determine a patient's financial responsibility for an extensive treatment plan during the initial visit, rather than after, is a realistic goal, according to the council. The ADA Dental Content Committee has established a working group to address a minimum claims data set acceptable to all payers for various types of dental claims. The DeCC was created by the ADA Board of Trustees and is named one of the six Designated Standards Maintenance Organizations by the Secretary of Health and Human Services to review and approve changes to HIPAA (Health Insurance Portability and Accountability Act of 1996) standard transactions. Sponsored and chaired by the ADA, the group addresses standard transaction content on behalf of the dental sector of the health care community.

Dr. Isbell said there are too many advantages for dentistry to pass up participating in the electronic claims submission world.

"Dentists have to take a leap of faith," commented Dr. Isbell. "And the first thing they should know is that filing electronically will turn their dollar around very quickly. The next thing they need to understand is that making the transition from paper to electronic claims filing can be easy and doesn't have to be expensive."

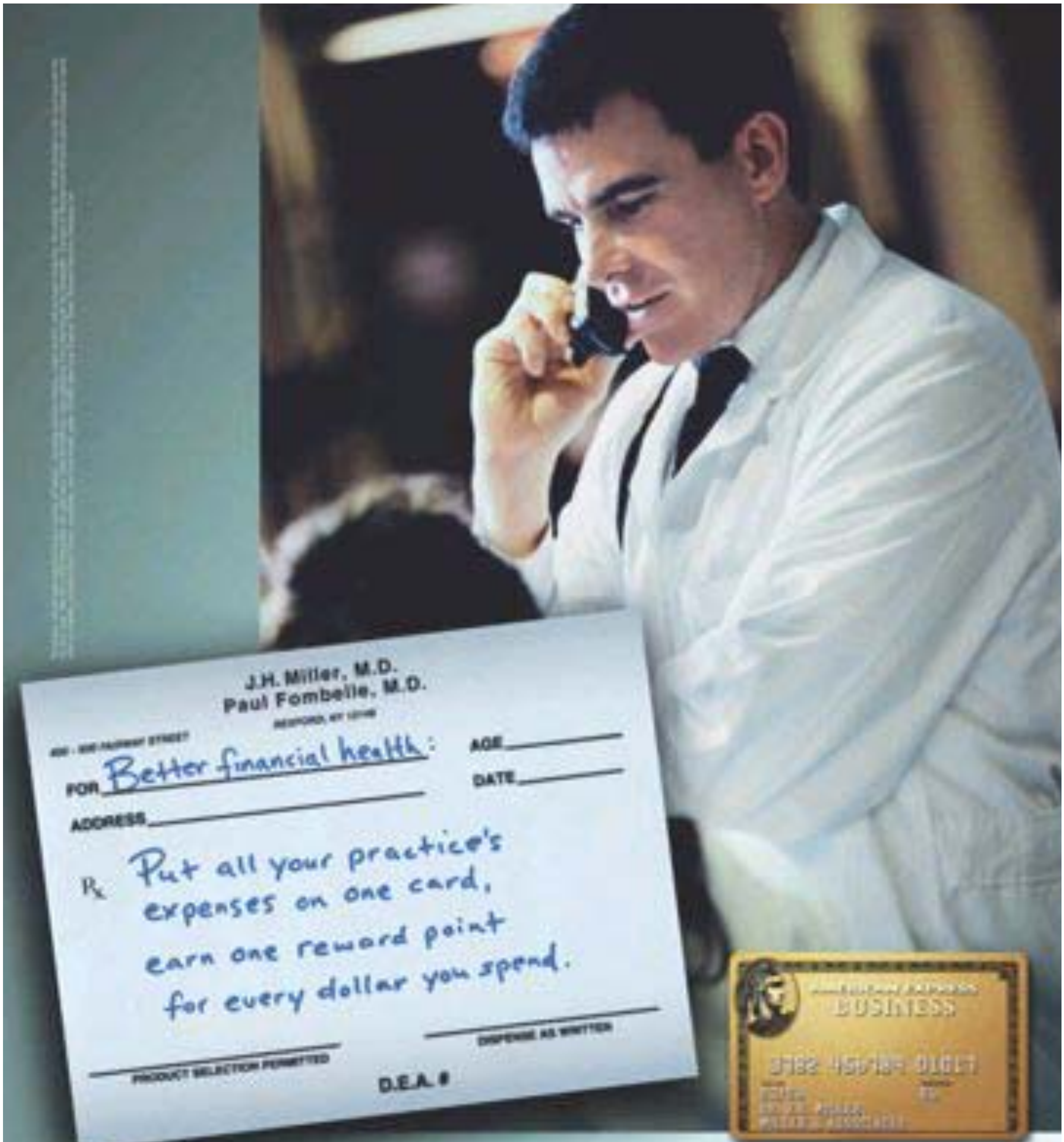
Many dentists haven't made the transition from paper to electronic filing for the simple reason that the cost of the technology seems higher than its potential worth—a mistake, according to those who have already made the change.

"We hear about the cost of a stamp being less than the cost to file an electronic claim, additional costs of mailing attachments and increased complexity and cost when attachments are required, in general," said Dr. Stuart. "The council is aware of members' concerns about claims requiring attachments and is working to address them. But none of these are valid reasons to avoid taking steps toward filing electronically."

Dr. Stuart said that since taking the paperless path, he's never looked back.

"I only wish I'd done it sooner," he commented. "It's natural to feel a little apprehensive about going to a computer-based records system. But I've never known a dentist to regret it."

Look to future issues of the ADA News to begin educating yourself about electronic claims processing, and to learn the realities and the myths. Read case studies from dentists who have already made the transition about how easy it can be, how much it can help your practice's efficiency and profitability. If you're currently transacting electronically, learn to use this tool to its greatest potential. ■



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OPEN
FOR BUSINESS

ADA Pavilion: one-stop guide to ADA resources

AnnualSession

Member services spotlight: Lerone Fong assists Dr. Steven Able and dental hygienist Lisa Weber of Mount Kisco, N.Y., as the full-service ADA Pavilion debuts at annual session 2004 in Orlando.

Philadelphia—Learn more about "ADA Resources for Your Practice and Your Life," talk to the ADA and meet special guest speakers at the ADA Pavilion at annual session.

Members who visit the ADA Pavilion will receive a commemorative New Yorker cartoon poster, courtesy of ADA Catalog (while quantities last).

During the Oct. 6-9 meeting, the ADA Pavilion will host a variety of special events, including "meet and greets" with ADA President Richard Haught, President-Elect Bob M. Brandjord and Executive Director James B. Bramson; a chance to meet Olympic gold medalists Carly Patterson, 2004 gymnastics champion, and Dr. William H. Baker, member of the U.S. "Miracle on Ice" 1980 hockey team, and sign up for the 2006 Give Kids A Smile program; and much more.

The Pavilion will feature a variety of programs at its theater and offer a special presentation on annual session 2006 in Las Vegas.

The ADA Pavilion will also launch a new program, "Talk to the ADA," which will allow dentists to videotape a question to be posted on ADA.org. Videotaped replies by ADA leaders and staff also will be posted on ADA.org approximately two weeks after annual session.

ADA staff members will be on hand to answer your questions and provide information on the ADA's array of member services and resources, including:

- Dental practice;
- Standards and informatics;
- ADA Library;
- Career resources;
- Survey research on dental topics;
- Membership;
- ADA Seal program and new product report;
- ADA Catalog;
- Journal of the American Dental Association and ADA News;
- American Dental Political Action Committee;
- ADA Foundation;
- Tripartite Grassroots Membership Initiative.

Watch for details in your annual session registration packet and on ADA.org. ■

Plan, register for session with new preliminary program

Philadelphia—Hot off the presses: the new annual session preliminary program is now available.

The 112-page program has everything you need to plan your trip to annual session Oct. 6-9, including transportation information for getting to and around Philadelphia; a complete list of hotels offering special rates to ADA meeting attendees; details on special events and tours; descriptions of 260-some scientific programs; ADA Marketplace highlights and exhibitors; detailed day-by-day schedules; and registration forms and instructions to help you register in advance and save time and money.

ADA05 Philadelphia
FORGING OUR FUTURE

Request a copy by calling toll free, 1-800-232-1432, e-mailing "annualsession@ada.org", or downloading the program at "www.ada.org/prof/events/session/2005_general.asp". ■

NEW For the Treatment of Acute, Moderate to Severe Pain


COMBUNOX is contraindicated in patients with known hypersensitivity to oxycodone HCl, ibuprofen, or any of its components, and in situations where opioids are contraindicated. This includes patients with significant respiratory depression (in unmonitored settings or in the absence of resuscitative equipment) and patients with acute or severe bronchial asthma or hypercarbia. COMBUNOX is contraindicated in any patient who has or is suspected of having paralytic ileus. COMBUNOX should not be given to patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Severe anaphylactoid reactions to NSAIDs, some fatal, have been reported in such patients. COMBUNOX contains oxycodone, which has an abuse potential similar to other opioid agonists. The most common adverse events reported with COMBUNOX (≥1% and higher than with placebo) in single-dose studies were nausea, somnolence, vomiting, dizziness, sweat, and flatulence.
Please see Brief Summary of Prescribing Information on the accompanying page.

Introducing COMBUNOX

For acute, moderate to severe pain

Effective Short-Term Treatment* for Acute Pain with the First and Only Combination Product Containing Oxycodone and Ibuprofen

- **The strength of oxycodone and ibuprofen**[1]

  Increased analgesia along with the anti-inflammatory properties of ibuprofen—at 400 mg, the highest dose available in a combination opioid product

- **Significant pain relief**[1-4]

  COMBUNOX provided more pain relief over 6 hours than oxycodone, ibuprofen, or placebo ($P<0.05$)

- **Greater reduction in pain intensity**[1-4]

  Reduction in pain intensity scores was significantly greater than with oxycodone, ibuprofen, or placebo ($P<0.05$)

- **Long-lasting and rapid pain relief**[1-4]

- **Safety and tolerability demonstrated in both single- and multiple-dose studies**[1]

- **Simple dosing and administration**[1]

New **Combunox**
(Oxycodone HCl and Ibuprofen) Tablets
5 mg/400 mg
C II

Treats the components of pain

Forest Pharmaceuticals, Inc.

Cultures

Continued from page one

areas: Washington, D.C. (Oct. 26); Los Angeles (Nov. 6); and Orlando, Fla. (Feb. 10, 2006).

Aetna is the sole corporate sponsor of the workshops.

"Aetna's sponsorship continues our focus on reducing racial and ethnic disparities in health care," said Dr. Mary L. Conicella, Aetna's national director of clinical operations. "Aetna aims to improve access to quality care through integrated business and philanthropic efforts. Enhancement of cultural competency, voluntary data collection and collaboration with national experts to develop outreach programs are included among these efforts."

ADA Executive Director James Bramson said "we are very appreciative of Aetna's support" for this programming.

Expertise: From left, workshop advisory panel members Drs. Jon Tilton (ADA Council on Dental Practice), Chad Gehani (Indian Dental Association U.S.A.) and Edward Chappelle Jr. (National Dental Association) listen to commentary at the March 18 meeting.

"Helping the profession learn about cultural diversity is important to all of us," noted Dr. Bramson.

General dentists, specialists and dental team staff, dental school faculty and those involved in research who wish to enhance their communications and ability to provide culturally sensitive and appropriate care for diverse patient populations should plan to attend.

According to the 2002 U.S. Census, minorities now make up one-quarter of the U.S. population.

"The workshops will be a great benefit to every dentist and their staff to better understand the cultural differences in many of their patients," said ADA President Richard Haught. "Oral health literacy is one of the most important steps toward achieving optimal oral health. Every dental office team should have a thorough understanding of the cultural customs of their patients."

Added Dr. Haught: "Dentists understand that recommending preventive measures, nutritional ideas and home care are a must to achieving optimal oral health. Understanding cultural backgrounds will help to deliver this information in an acceptable, understandable and practical way."

An advisory panel representing the HDA, the IDA U.S.A. and NDA convened March 18 to plan the workshops, with input provided by dental societies in which the events take place: the Florida Dental Association, Central Florida District Dental Association, District of Columbia Dental Society, California Dental Association and Western Los Angeles Dental Society. All eight organizations serve as workshop cosponsors.

"The ADA is recognizing that the traditional patient base has changed," said advisory panel member Dr. Jorge Alvarez of the Hispanic Dental Association. "There are differences among patient populations and how these patients were treated in their own countries. Threshold of pain is one example. How do we as dentists know what some of these patients are used to? The workshops will help sensitize dentists and staff members to diverse patient populations and serve as a good source of information regarding the cultural diversity of these groups."

Advisory panel member Dr. Chad Gehani of the IDA U.S.A. added, "Many times the patients do not give us a complete medical history because some of the details are personal and they don't feel comfortable telling a dentist the whole story. The workshops will give dentists ways to address medical conditions and help them explain why a complete history is necessary."

"Oral health is integral to overall health," said Dr. Conicella from Aetna. "By improving access to and acceptance of dental care, the dental team can help to promote the overall health of multicultural populations."

The keynote speaker at all three workshops is William A. Guillory, Ph.D., a national authority on diversity, empowerment and leadership.

The workshops also feature two speakers on oral medicine topics. In Orlando and Washington, D.C., Dr. Michael Glick, editor of The Journal of the American Dental Association and faculty member at the University of Medicine and Dentistry of New Jersey, is the presenter. In Los Angeles, Dr. Linda Niessen, vice president of clinical education at Dentsply International and faculty member at Baylor College of Dentistry, will speak.

Dentists and team staff are eligible for six hours of continuing education hours for attending the workshops.

Registration fees are: $160 for dentists, $80 per team member if one or two team members attend, and $60 per member if a dentist brings three or more team members.

For more information, contact Ron Polaniecki (Ext. 2599) or Stephanie Starsiak (Ext. 4699) by phone, or e-mail "multicultural@ada.org". ■

ADAF scholarships available

ADA | FOUNDATION

American Dental Association Foundation

BY STACIE CROZIER

The ADA Foundation wants to mentor the best and brightest students in dental professional education programs through its annual scholarship program.

Dental students, minority dental students and students enrolled in dental hygiene, assisting and laboratory technology programs are eligible for scholarships from the ADAF.

Qualified applicants must obtain application forms from their schools. Deadlines for submission begin July 31. Supporters of scholarship programs include Colgate-Palmolive, Gillette, Procter & Gamble, Sunstar Butler Co., Harry J. Bosworth Co. and Handler Manufacturing Co.

• Second-year dental students demonstrating academic success and financial need are eligible to apply for a scholarship up to $2,500. Deadline for applications is July 31.

• Second-year dental students from groups underrepresented in dentistry who demonstrate academic success and financial need are eligible to apply for a scholarship up to $2,500. Deadline for applications is July 31.

• Final-year dental hygiene students are eligible to apply for a $1,000 scholarship. Deadline for applications is Aug. 15.

• First-year dental assisting students are eligible to apply for a $1,000 scholarship. Deadline for applications is Oct. 15.

• Final-year dental laboratory technology students are eligible to apply for a $1,000 scholarship. Deadline for applications is Aug. 15.

Applications, available at dental schools, need to be completed and returned directly to the schools.

For more information, visit the ADA Foundation Web site, "www.adafoundation.org/ada/prod/adaf/prog_scholarship_prog.asp" or contact the Foundation toll free, Ext. 2547 or e-mail "adaf@ada.org". ■

Dr. Mascola

Continued from page eight

one of four candidates that year for president-elect.

As dentistry enters the 21st century, he told the delegates, many things will change—technology, government, the demographics of the nation and the dental profession.

"But one principle must be forever carved in stone," he said, his voice rising sharply. "That is, practice decisions must be made by the dentist. If they are not, we lose our autonomy. Our patients will suffer, and the profession will be demeaned."

Later, he insisted that the 21st century would "not belong to the timid. It will belong to those who stand on principle, to those who fight the good fight and never—I say never, never—back down."

The delegates responded with thunderous applause and made Richard Mascola their president-elect; he served as president in 1999-2000.

"Richard was president during my freshman year on the ADA Board," said current ADA President Richard Haught. "I very much admired his ability to lead and his dedication to dentistry."

Dr. Al Guay, a former ADA trustee and now the Association's chief policy advisor, was a long-time friend of Dr. Mascola's.

"For me, he personified the ADA presidency," said Dr. Guay. "He had a presence, he spoke well and he was highly respected in all communities of dentistry."

Shortly after his presidency, Dr. Mascola sold his dental practice and worked briefly for the ADA. He and his family then headed to Florida where Dr. Mascola took a part-time teaching position with Nova Southeastern.

"He wasn't part-time for long," says Nova's Dr. Uchin.

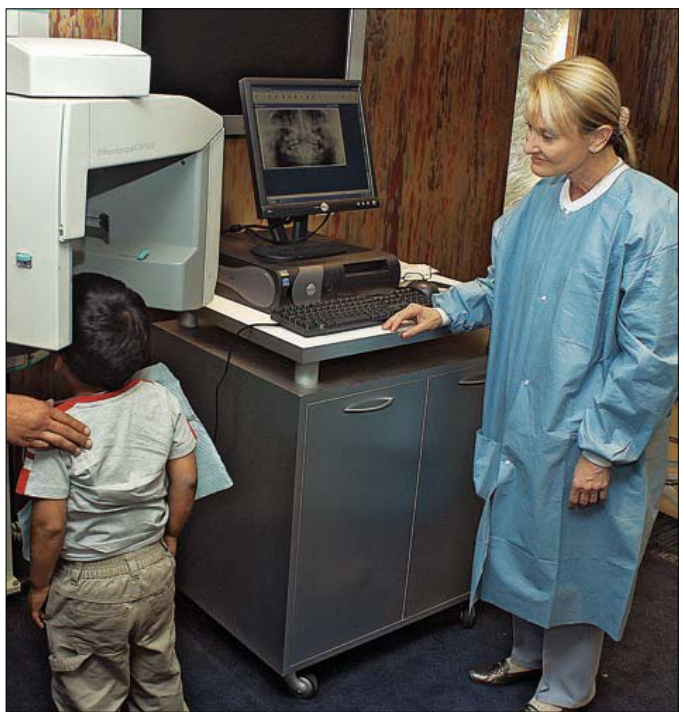
This year, students honored Dr. Mascola with their Golden Apple Award, given each year to their favorite faculty member. They also dedicated the yearbook to him.

The award was presented at a graduation banquet held on the night of Friday, May 27. Dr. Uchin accepted the award for Dr. Mascola who was at home with his family.

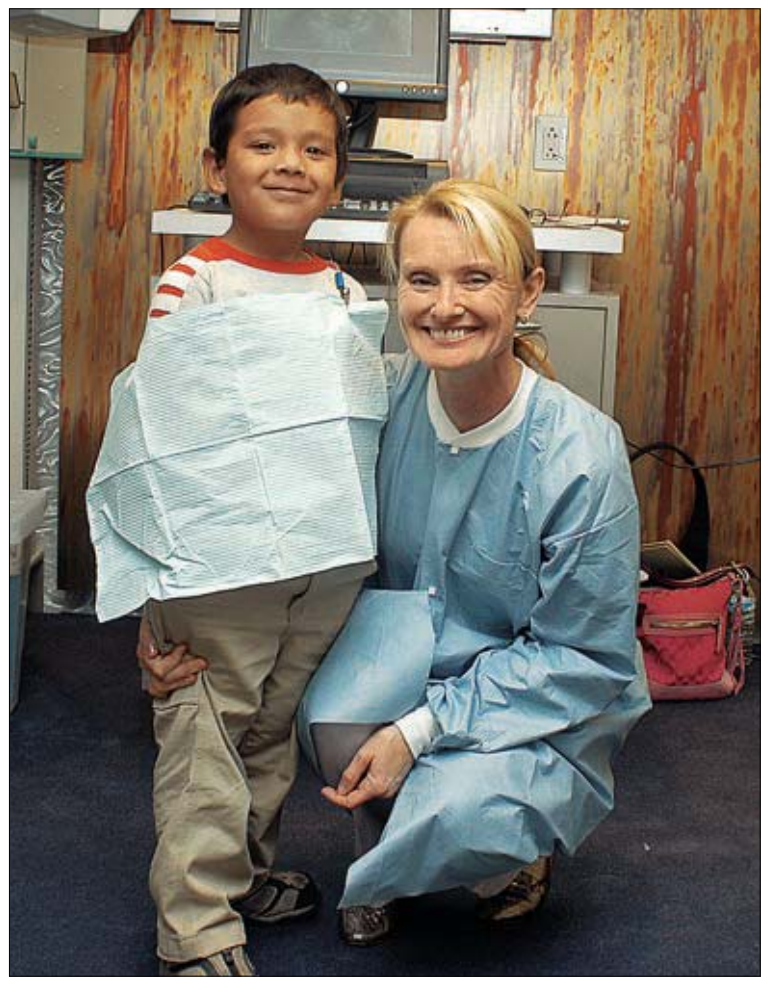
That night, Richard became too weak to walk and was taken by ambulance to the Palm Beach Gardens Medical Center. He died at about 4 a.m. Saturday, May 28.

Dr. Uchin presented the Golden Apple Award to Richard's wife, Betsy, at the memorial service for her husband three days later.

At press time, officials at Nova Southeastern were considering naming the clinic in the College of Dental Medicine for Dr. Mascola. Contributions can be sent to: The Richard Mascola Clinic Fund, Nova Southeastern University College of Dental Medicine, 3200 S.W. University Drive, Ft. Lauderdale, Fla. 33328-2018. ■



Hello TDOT: 5-year-old Valentin Ramirez prepares for digital panoramic X-rays May 18 (left), and Dr. Habjan explains the results (right). Like many children at San Juan Elementary, Valentin needs significant restorative work.



Goodbye TDOT: Valentin says goodbye to Dr. Habjan at the end of his appointment.

Have wheels, will travel

TDOT goes on the road for kids

BY KAREN FOX

San Juan Capistrano, Calif.—Proving that its futuristic mobile dental office is more than bells and whistles, Sullivan-Schein donated the Tomorrow's Dental Office Today unit for use in an access program here May 18-19.

Just steps from the playground of San Juan Elementary School—and a stone's throw from the historic Mission San Juan Capistrano—a group of Orange County Dental Society volunteers performed comprehensive dental care in the TDOT exhibit for elementary school students who were prescreened for visits based on need. The California Dental Association coordinated the event.

In the end, the seven dentists, one dental assistant, two hygienists and two society staff members who volunteered donated care estimated at $4,425. There were 16 patient visits that included 10 posterior amalgam restorations and one pulpotomy.

"This is quite nice," Santa Ana dentist Dr. Denise Habjan said of the TDOT exhibit. "For once we have room to move around. With the chairs and the latest equipment on hand, it makes it a lot easier to do dentistry."

Dr. Ethan Fox of Escondido, Calif., drove 50 miles for the day's event. The 2004 dental school graduate has performed charity services in facilities equipped for access programs in the past, "but nothing like this."

TDOT on tour: Tomorrow's Dental Office Today hits the highway en route to the West Coast for an access program in California.

"This is great because everything is right here. Usually you just have few supplies and are limited with what you can do. This is impressive," said Dr. Fox.

"These are students who really need help," added Dr. Ryan Vahdani of Santa Margarita. "This facility is good because it has the finest equipment we can use, and it's nice to have two chairs. These are low-income families and they rely on the goodwill of society. This unit can help us give care to a lot of kids."

In partnership with the ADA, Sullivan-Schein introduced the interactive mobile dental office showcasing the future of dental technology last year. TDOT enables visitors to experience how technology can enhance productivity through digital tools, patient records and scheduling, case prevention, clinical outcomes, financial and cash-flow management, and patient diagnosis and education.

The mobile exhibit had its first tour of duty as a dental office April 15-16 when the Virginia Dental Association utilized its operatories for the Mission of Mercy outreach program in Springfield, Va.

"Since its inception, Tomorrow's Dental Office Today was designed to not only help advance the dental profession, but also serve as a fully-functional, mobile dental office and resource for voluntary dental treatment initiatives," said Tim Sullivan, president of Sullivan-Schein.

"Our support of outreach programs is part of our ongoing commitment to corporate social responsibility, which is why TDOT's efforts to date have targeted communities where large segments of the population have lacked access to oral health care," said Mr. Sullivan.

Donating use of TDOT is no small commitment on the company's part. It takes some 20 hours and no fewer than three staff members to assemble the exhibit for full-service dentistry.

"We are honored to have partnered with the Virginia Dental Association and the California Dental Association in support of these important outreach efforts, and to have provided resources, including donated dental supplies, to support these projects," said Mr. Sullivan. "It is through partnerships such as this, which mobilize the resources of the public, private and professional sectors, that we are able to help improve community health outcomes and increase oral health awareness."

The May 18-19 event marked the Orange County Dental Society's sixth visit to San Juan Elementary.

"This week we treated some kids who had very serious dental concerns, and everyone felt good about the work that was done. All the equipment was new, and the environment was spacious. The doctors were kind of wowed by it."

"We never run out of kids here," said Laura Petersen, OCDS executive director. "Ninety percent of the students are on federally funded school lunch programs. It's a low-income patient population that is predominately Hispanic, and the school tends to have a lot of transition because the parents go where they find work. The nearest community health center has a three-month wait for appointments."

Having access to the Tomorrow's Dental Office Today exhibit was a singular experience, added Ms. Petersen, the OCDS' executive director for 18 years who was called into duty as a dental assistant for the event.

"We have had more than a few problems with equipment at access events in the past," she said. "We showed up to see patients once only to find we had no equipment in the mobile van. Another time vandals had tampered with our electricity and we ended up losing power."

Added Ms. Petersen: "This week we treated some kids who had very serious dental concerns, and everyone felt good about the work that was done. All the equipment was new, and the environment was spacious. The doctors were kind of wowed by it."

The mobile exhibit is part of a three-year multifaceted campaign that focuses on digital technology and software for managing all aspects of a dental practice. ■

Tough soda, junk food law waits for Connecticut gov's signature

BY STACIE CROZIER

Hartford, Conn.—Possibly the most stringent state bill in the nation restricting junk food and soda in schools passed the Connecticut House and Senate last month after contentious debate, and Gov. M. Jodi Rell has indicated she might veto the measure.

Connecticut General Assembly Bill 130, sponsored by state Sen. Donald E. Williams Jr. (Dem.), gained the active support of the Connecticut State Dental Association as well as many other health, community and church groups and concerned citizens.

If Gov. Rell signs the bill, Connecticut will limit elementary schools to selling water, water sweetened with fruit juice, milk, nondairy milk drinks and fruit and vegetable juices. On May 18, after an eight-hour debate in the state house—the longest debate of 2005—the bill was amended to allow high schools to sell sugar-free soft drinks and some sports drinks before it passed by a vote of 88-55. The Senate approved the amended bill May 25.

The bill would also require elementary schools to provide students with 20 minutes of physical activity each day in addition to physical education classes and limit sales of snack foods to those on a list approved by the state department of education.

Sen. Williams

The CSDA lobbied for the bill by sending letters supporting the measure to all state lawmakers and having staff lobbyists get involved in promoting it. "The health of our children is important to us all, but the teeth of our children are of particular concern to the CSDA," wrote Dr. Robert Schreibman, president. "This bill will go a long way in protecting the dental health of our state's children."

"This will help to provide healthy choices for our children and put them on a path to being healthier adults," said Sen. Williams in a press release. "It is important that we set the right example through our schools, to educate them about the importance of good nutrition and physical activity."

Strong objections from House and Senate Republicans centered on the issues of letting local governments and school districts make policies on an individual basis and allowing parents to be the decision-makers regarding nutrition for their children. But bill supporters note that food and beverage industries have a strong financial interest in securing vending machine "pouring rights" contracts in school districts in return for funding school and extracurricular activities, giving them not only exclusive contracts to sell their products in schools but also the opportunity to market their products to students.

According to the ADA Department of State Government Affairs, at least 70 bills addressing nutrition, exercise, soda and junk food sales, commercial advertising for these items on school property and disclosure of funds received through pouring rights contracts have appeared in state legislatures in 2005. Though many have already failed, it shows a growing movement to address children's health issues, said Paul O'Connor, legislative liaison for the ADA Department of State Government Affairs.

"News of poor nutrition and increasing obesity among school-aged children has led to a noticeable increase in bills attempting to limit the sale of non-nutrition vending items in schools," Mr. O'Connor said. "A number of these bills would limit marketing of non-nutrition items on school property as well."

On May 18, Sen. Tom Harkin (D-Iowa) also introduced legislation in the U.S. Senate which would restore authority to the Federal Trade Commission to issue regulations that restrict the marketing or advertising of non-nutritious foods and beverages to children under age 18 and prohibit its marketing in schools. (Text of Senate Bill 1074 can be found online at "thomas.loc.gov".)

The ADA offers resources on diet and oral health, including frequently asked questions and information on pouring rights. Log on to "www.ada.org/public/topics/diet.asp" for information, or log on to "www.adacatalog.org" to purchase patient education materials. If you have questions about school soft drink pouring rights issues, call the ADA Council on Access, Prevention and Interprofessional Relations toll free, Ext. 2868. ■

A toast to better oral health

Grand Rapids marks 60 years of community water fluoridation

BY STACIE CROZIER

Grand Rapids, Mich.—An old Chinese proverb bubbled up to dentists, political leaders and citizens May 12 as the Michigan Dental Association and the West Michigan District Dental Society marked the 60th anniversary of community water fluoridation in its birthplace.

"When drinking water, don't forget to remember those who dug the well," said Dr. James L. Wieland, a Grand Rapids dentist representing the WMDDS.

Initiating a tap water toast at the gathering, Dr. Wieland said, "It only seems fitting that we remember those individuals who 'dug the well' so to speak, and made this remarkable health discovery. A discovery that continues to impact the oral health of people throughout not only this entire country, but the world."

Guests gathered in sunny spring weather at the city's monument honoring community water fluoridation to recognize Grand Rapids' unique role in oral health worldwide. The celebration was held during the Michigan Dental Association's annual session May 11-14 at the DeVos Place convention center, a five-minute walk from the monument.

Dr. Wieland also noted that brief celebration was bittersweet because the monument, erected a decade ago to honor fluoridation's 50th year, would soon be taken down and stored as construction of a new hotel would begin soon just steps away from its spot overlooking the Grand River.

The WMDDS, said State Rep. Jerry O. Kooiman, "was the driving force behind the monument where we are today, which recognizes the 50th anniversary of water fluoridation. This monument is also a tribute to the dedication and compassion of the dental community to do what's right for the community and to improve oral health for everyone.

"The single most effective public health measure to prevent tooth decay all started right here in Grand Rapids," Rep. Kooiman continued. "As a result, communities throughout the country as well as the world enjoy better oral health because of the bold moves of a few scientists."

Tap water toast: With glasses of Grand Rapids' finest public water system water, guests toast community water fluoridation's 60th anniversary May 12.

Noting that more than 86 percent of Michigan's citizens who use public water systems enjoy the benefits of fluoridated water, he cited that the average cost for a community to fluoridate its water is about 75 cents per year per person, making its cost over a lifetime less than the cost of having one cavity treated. "It makes me wonder why the remaining 14 percent of Michigan's communities do not take advantage of water fluoridation."

Celebration: Michigan State Rep. Jerry O. Kooiman, left, and Dr. James L. Wieland confer before the 60th anniversary celebration.

"Today we celebrate the single most important clinical event in the history of dentistry," said MDA President-elect Josef N. Kolling. "No longer do people expect to lose all their teeth. We have had successive generations of children who have never experienced the excruciating pain of a toothache. This monumental public health achievement was a victory for everyone in the community—young and old, rich and poor, of all ethnic and socioeconomic backgrounds. The advent of community water fluoridation was an act of compassion and caring for mankind." ■

Fluoridation symposium set for July 13-16

It's time to mark your calendar and register for one of the most important fluoridation events held since Grand Rapids, Mich., turned on its fluoridated taps 60 years ago—the National Fluoridation Symposium 2005.

July 13-16, the ADA, in conjunction with the Centers for Disease Control and Prevention, will gather with a host of researchers, public health officials, community leaders, legal experts, legislators and private citizens to celebrate the impact of community water fluoridation on three generations and the estimated 170 million citizens who currently benefit from fluoridation.

The symposium will also offer strategies for community leaders to bring fluoridation to their own cities and towns. Attendance is open to the public.

The symposium kicks off with a 60th anniversary celebration at Chicago's newest outdoor venue, Millennium Park, on July 13.

A two-day symposium at ADA Headquarters July 14 and 15 will focus on a variety of issues, including: fluoridation benefits, safety and cost-effectiveness; how national and state organizations can support communities who want to initiate or continue fluoridation; public health law and legislation; and the status of fluoridation today.

On July 16, participants can sign up for a special fluoridation spokesperson training seminar. Symposium participants can earn continuing education credit.

A complete list of speakers, including representatives from the ADA, CDC, the National Institute of Dental and Craniofacial Research and other scientific and university settings, water system engineers, public health officials, attorneys, legislators, insurance providers, health organizations and more, is available online. Online registration for the symposium is now open. Log on to "www/ada.org/goto/symposium" for more details and registration forms.

Attendees who register for the 60th anniversary celebration, the two-day symposium and spokesperson training will receive a special package rate. Special conference rates are also available at three Chicago hotels: The Ritz-Carlton, Doubletree Suites Chicago and Best Western Inn of Chicago.

Log on today for more information or call toll-free, Ext. 2879, to request a registration form. No on-site registrations will be accepted. ■

ADA's Jane McGinley receives fluoridation merit award

BY STACIE CROZIER

Pittsburgh—Jane McGinley, the ADA's manager of fluoridation and preventive health activities for the Council on Access, Prevention and Professional Relations, received a special merit award from the ADA, the Association of State and Territorial Dental Directors and the Centers for Disease Control and Prevention.

Ms. McGinley received her award at the American Association of Public Health Dentistry and ASTDD annual meeting/National Oral Health Conference May 4.

"Jane is an asset to our organization," says Dr. Robert C. Lauf, CAPIR chair. "She works tirelessly toward our goals and is very committed to improving oral health for all. Her enthusiasm and dedication for our profession is endless and I am privileged to be able to work with her."

Ms. McGinley is a nationally known advocate of community water fluoridation. For the ADA she works closely with individual members, dental societies, states, federal agencies and the public health community to help initiate and maintain community water fluoridation. She has produced two editions of the ADA's "Fluoridation Facts," the Association's comprehensive resource on fluoridation and is the primary planner of the ADA's upcoming National Fluoridation Symposium and 60th anniversary celebration.

Ms. McGinley

"The Fluoridation Merit Award recognizes Ms. McGinley's dedication, passion and tireless efforts as a true champion of community water fluoridation—and as a colleague, collaborator and friend of public health," the award reads.

Before coming to the ADA, Ms. McGinley worked as a registered dental hygienist for more than three decades—including 15 years in private practice and 15 years in a long-term care facility for people with developmental disabilities.

Other fluoridation honors bestowed at the conference included:

- Fifty Year Awards—recognizing 88 water systems in 31 states that reached 50 years of continuous water fluoridation during 2004;
- State Fluoridation Quality Awards—this year recognizing Indiana, Nebraska, Nevada and North Dakota for maintaining the quality of fluoridation during the year as determined by the ability of water systems to conduct monitoring and maintain optimal fluoride levels during 2004;
- Community Fluoridation Initiative Awards—recognizing 26 communities in seven states that adopted water fluoridation in 2004;
- Community Fluoridation Reaffirmation Awards—recognizing nine communities in five states that defeated initiatives to discontinue community water fluoridation or approved initiatives to maintain community water fluoridation in 2004;
- State Fluoridation Initiative Awards—this year recognizing Florida and Mississippi as the states that had the most new systems fluoridating and/or the state that had the greatest increase in population with access to optimally fluoridated water in 2004. ■

NPI

Continued from page one

Topic at "www.ada.org". The campaign began May 23 with 57,656 eGRAMs to member and nonmember dentists describing the NPI and encouraging applications.

The Centers for Medicare & Medicaid Services began accepting NPI applications as the Association initiated "a lengthy and energetic awareness campaign for NPI registration." Physicians, dentists and pharmacists and organizations such as hospitals, nursing homes, pharmacies and group practices are eligible for NPIs.

The Association "stands ready to provide assistance to its members," said the eGRAM from Executive Director James B. Bramson. NPI-related announcements and information will appear in the ADA News, JADA and Legal Adviser and online at ADA.org.

Although some dentists are not covered by the NPI requirement, dentists who use only paper, voice and fax "are certain to encounter health plans that require NPIs," the ADA statement says. Dentists using standard electronic transactions such as electronic claims, eligibility verifications, claims status inquiries and claim attachments will have to use NPIs on electronic transactions no later than May 23, 2007. Some health plans may require earlier use.

See the National Provider Identifier Dental Topic ("www.ada.org/prof/resources/topics/npi.asp") for application instructions and direct questions, comments or concerns to "NPI@ada.org".

The Centers for Medicare & Medicaid Services offers three application procedures:

- A Web-based application began May 23 at "https://nppes.cms.hhs.gov";
- A paper application process begins July 1; an application and NPI Enumerator mailing address are available at the Web site above or by calling 1-800-465-3203 or TTY 1-800-692-2326;
- An organization application process begins this fall.

CMS contracted with Fox Systems Inc. to serve as the NPI Enumerator. ■

Thank You! From the ADA Foundation

As the charitable arm of the American Dental Association, the ADA Foundation provides grants to support dental research, education, scholarships and access to care programs. In addition, the Foundation supports Charitable Assistance Programs such as relief grants to dentists and their families who are unable to support themselves due to an injury, a medical condition or advanced age; and grants and loans to those who are victims of disasters.

The names of contributors who provided a donation or pledge of $250 or more to the ADA Foundation from January 1 – December 31, 2004 are listed below in appreciation for their support. For a complete list of 2004 donors or to learn more about the Foundation's grant programs, please go to www.adafoundation.org or call us at 312-440-2547.

Together, we can improve health and make lives better, one person at a time.

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Please accept our apology for any inaccuracies in these listings. Notify the ADAF of any corrections.

Tsunami Donor Tribute

Early on the morning of December 26, 2004, a magnitude 9.3 earthquake ripped apart the seafloor off the coast of northwest Sumatra. Over 100 years of accumulated stress was released in the second biggest earthquake in recorded history. This catastrophic event unleashed a tsunami that traveled thousands of miles across the Indian Ocean, taking the lives of nearly 300,000 people in countries as far apart as Indonesia, the Maldives, Sri Lanka and Somalia.

Within a week, the ADA Foundation mounted a fundraising campaign to secure contributions for the Red Cross International Response Fund. Over 1,000 dentists, ADA staff and friends provided more than $250,000 in response to this call to action. The ADA and ADA Foundation matched these funds with an additional $110,000 of support and sent a combined contribution to the Red Cross for provision of nutritious food, basic supplies such as tents and hygiene items, basic healthcare for the tsunami survivors in order that they might cope with the unbelievable trauma they experienced. Further support to aid in reconstruction efforts will be provided later in 2005 when appropriate oral health related projects have been identified.

Individuals, corporations, associations and others who thoughtfully responded to this disaster with a gift over $100 are listed below in appreciation for their support.

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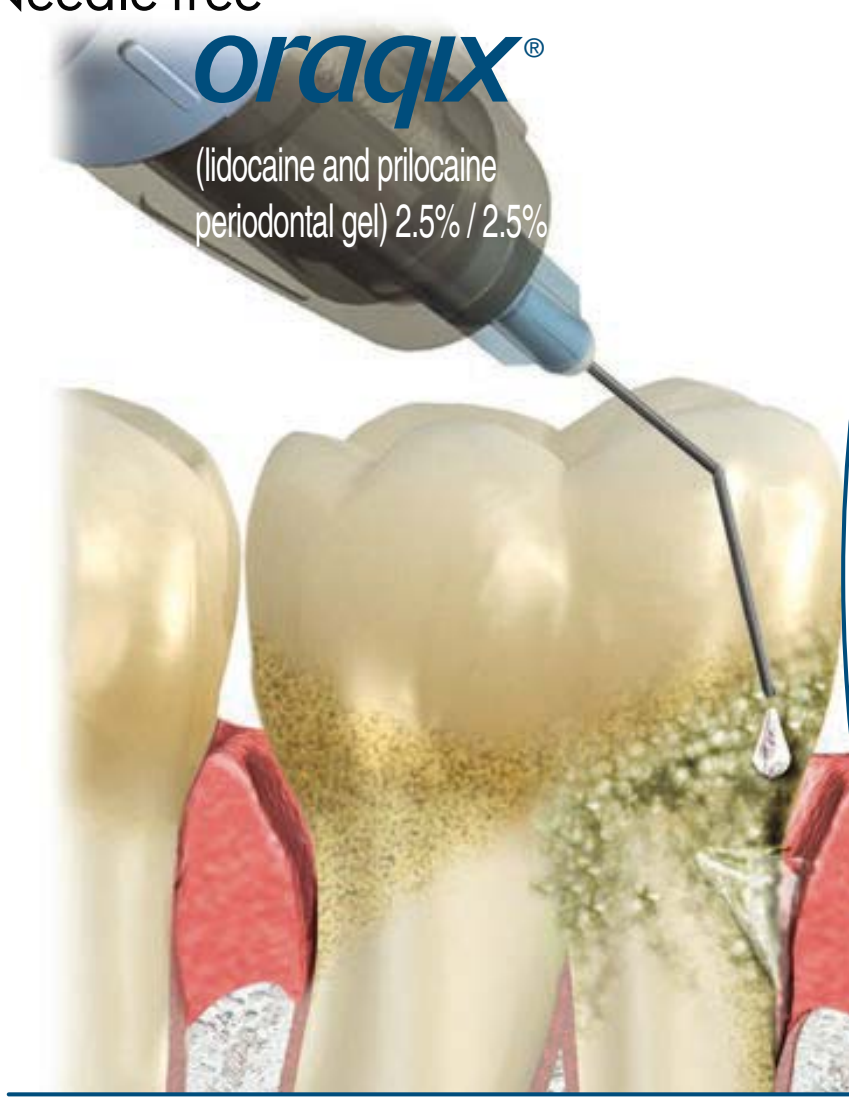

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- Needle-free anesthesia for adults for scaling and root planing procedures
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- Oraqix is a novel formulation of lidocaine and prilocaine that dispenses as a liquid, then sets as a gel at body temperature.
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- Indicated for adults who require localized anesthesia in periodontal pockets during SRP procedures.
- Contraindicated in patients with hypersensitivity to amide type local anesthetics or any other product component.
- Oraqix is applied first to the gingival margin, then periodontal pocket with the use of an Oraqix™ Dispenser and a blunt-tip applicator.
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Not for Injection

oraqix®
(lidocaine and prilocaine periodontal gel) 2.5% / 2.5%

Brief Summary of Prescribing Information

INDICATIONS AND USAGE
Oraqix® (lidocaine and prilocaine periodontal gel) 2.5%/2.5% is indicated for adults who require localized anesthesia in periodontal pockets during scaling and/or root planing.

CONTRAINDICATIONS
Oraqix® is contraindicated in patients with hypersensitivity to amide type local anesthetics or to any other product component.

WARNINGS
Prilocaine can cause elevated methemoglobin levels particularly in conjunction with methemoglobin-inducing agents. Methemoglobinemia has been reported in a few cases in association with lidocaine treatment. Patients with glucose-6-phosphate dehydrogenase deficiency or congenital or idiopathic methemoglobinemia are more susceptible to drug-induced methemoglobinemia. Oraqix® should not be used in those patients with congenital or idiopathic methemoglobinemia and in infants under the age of twelve months who are receiving treatment with methemoglobin-inducing agents. Signs and symptoms of methemoglobinemia may be delayed some hours after exposure. Initial signs and symptoms of methemoglobinemia are characterized by a slate grey cyanosis seen in, e.g., buccal mucous membranes, lips and nail beds. In severe cases symptoms may include central cyanosis, headache, lethargy, dizziness, fatigue, syncope, dyspnea, CNS depression, seizures, dysrhythmia and shock. Methemoglobinemia should be considered if central cyanosis unresponsive to oxygen therapy occurs, especially if metHb-inducing agents have been used. Calculated oxygen saturation and pulse oximetry are inaccurate in the setting of methemoglobinemia. The diagnosis can be confirmed by an elevated methemoglobin level measured with co-oximetry. Normally, metHb levels are <1%, and cyanosis may not be evident until a level of at least 10% is present. The development of methemoglobinemia is generally dose related. The individual maximum level of metHb in blood ranged from 0.8% to 1.7% following administration of the maximum dose of 8.5 g Oraqix®.

Management of Methemoglobinemia: Clinically significant symptoms of methemoglobinemia should be treated with a standard clinical regimen such as a slow intravenous injection of methylene blue at a dosage of 1-2 mg/kg given over a five minute period.

Patients taking drugs associated with drug-induced methemoglobinemia such as sulfonamides, acetaminophen, acetanilide, aniline dyes, benzocaine, chloroquine, dapsone, naphthalene, nitrates and nitrites, nitrofurantoin, nitroglycerin, nitroprusside, pamaquine, para-aminosalicylic acid, phenacetin, phenobarbital, phenytoin, primaquine, and quinine are also at greater risk for developing methemoglobinemia.

Treatment with Oraqix® should be avoided in patients with any of the above conditions or with a previous history of problems in connection with prilocaine treatment.

PRECAUTIONS
General:
DO NOT INJECT
Oraqix® should not be used with standard dental syringes. Only use this product with the Oraqix™ Dispenser, available from DENTSPLY Pharmaceutical.

Allergic and anaphylactic reactions associated with lidocaine or prilocaine can occur. These reactions may be characterized by urticaria, angioedema, bronchospasm, and shock.

Eye contact with Oraqix® should be avoided. Animal studies have demonstrated severe eye irritation. Corneal irritation and potential abrasion may occur. If eye contact occurs, immediately rinse the eye with water or saline and protect it until normal sensation returns. In addition, the patient should be evaluated by an ophthalmologist.

Oraqix® should be used with caution in patients with a history of drug sensitivities, especially if the etiologic agent is uncertain.

Patients with severe hepatic disease, because of their inability to metabolize local anesthetics normally, are at greater risk of developing toxic plasma concentrations of lidocaine and prilocaine.

Information for Patients: Patients are cautioned to avoid injury to the treated area, or exposure to extreme hot or cold temperatures, until complete sensation has returned.

Drug Interactions: Oraqix® should be used with caution in combination with dental injection anesthesia, other local anesthetics, or agents structurally related to local anesthetics, e.g., Class 1 antiarrhythmics such as tocainide and mexiletine, as the toxic effects of these drugs are likely to be additive and potentially synergistic.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:
Carcinogenesis - Chronic oral toxicity studies of o-toluidine, a metabolite of prilocaine, have shown that this compound is a carcinogen in both mice and rats. The tumors associated with o-toluidine included hepatocarcinomas/adenomas in female mice, multiple occurrences of hemangiosarcomas/hemangiomas in both sexes of mice, sarcomas of multiple organs, transitional-cell carcinomas/papillomas of urinary bladder in both sexes of rats, subcutaneous fibromas/fibrosarcomas and mesotheliomas in male rats, and mammary gland fibroadenomas/ adenomas in female rats. These findings were observed at the lowest tested dose of 150 mg/kg/day or greater over two years (estimated daily exposures in mice and rats were approximately 6 and 12 times, respectively, the estimated exposure to o-toluidine at the maximum recommended human dose of 8.5g of Oraqix® gel on a mg/m2 basis).

o-Toluidine, a metabolite of prilocaine, was positive in Escherichia coli DNA repair and phage-induction assays. Urine concentrates from rats treated orally with 300 mg/kg o-toluidine were mutagenic to Salmonella typhimurium in the presence of metabolic activation.

USE IN PREGNANCY:
Teratogenic Effects: Pregnancy Category B
Treatment of rabbits with 15 mg/kg (180 mg/m2) produced evidence of maternal toxicity and evidence of delayed fetal development, including a non-significant decrease in fetal weight (7%) and an increase in minor skeletal anomalies (skull and sternebral defects, reduced ossification of the phalanges). The effects of lidocaine and prilocaine on post-natal development was examined in rats treated for 8 months with 10 or 30 mg/kg, s.c. lidocaine or prilocaine (60 mg/m2 and 180 mg/m2 on a body surface area basis, respectively up to 1.4-fold the maximum recommended exposure for a single procedure). This time period encompassed 3 mating periods. Both doses of either drug significantly reduced the average number of pups per litter surviving until weaning of offspring from the first 2 mating periods. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, Oraqix® should be used during pregnancy only if the benefits outweigh the risks.

Nursing Mothers: Lidocaine and, possibly, prilocaine are excreted in breast milk. Caution should be exercised when Oraqix® is administered to nursing women.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established. Very young children are more susceptible to methemoglobinemia. There have been reports of clinically significant methemoglobinemia in infants and children following excessive applications of lidocaine 2.5% and prilocaine 2.5% topical cream (See WARNINGS).

Geriatric Use: In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS
In clinical studies, the most common adverse reactions are application site reaction (including pain, soreness, irritation, numbness, ulcerations, vesicles, edema, abscess and/or redness), headache and taste perversion.

Rx only.
For more detailed information, consult your DENTSPLY Pharmaceutical representative and read the full Prescribing Information.

Manufactured by Recip AB for DENTSPLY Pharmaceutical, York, PA 17404

Form No. PM-Oraqix-PI-0024 Rev 11/04

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