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ADA News - 02/05/2007

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ADA NEWS®

FEBRUARY 5, 2007 VOLUME 38 NO. 3

Dental leaders support student loan, tax measures

BY CRAIG PALMER

Washington—Professional leaders, asserting dentistry's voice early in the 110th Congress, offered support for student loan and tax legislation important to dental students and dentists.

The elected presidents of the ADA, American Dental Education Association and American Association for Dental Research, whose "strong voice" advocated for dental research in the 109th Congress, spoke in unison again in supporting one of the first measures taken up in the 2007 session of Congress.

■ NHII: what the Association is doing, page 21

"On behalf of thousands of dental students and dentists, we write in support of your proposal to reduce the costs of higher education by lowering the interest rates from a fixed rate of 6.8 percent to 3.4 percent on subsidized Stafford loans," said their Jan. 10 letter to Rep. George Miller (D-Calif.), who chairs the House Education and Labor Committee. "By doing so, you will greatly assist undergraduate students as they pursue the American dream of a college education.

"While we support H.R. 5, we also believe that the same reduction should

See LEADERS, page 15

California law calls for dental exams for schoolchildren

BY JENNIFER GARVIN

Sacramento, Calif.—A new California law requires all children to undergo a dental check-up by May 31 of their first year in public school.

The legislation, AB-1433, was sponsored by the California Dental Association and was introduced by State Assemblymen Bill Emmerson (R-Redlands), an orthodontist, and John Laird (D-Santa Cruz.)

For most children, the evaluation should be completed in their kindergarten year. For children who did not attend a public kindergarten, the check-up is required for first grade. Evaluations performed 12 months before

See CHECK-UP, page 11

Leadership: Members of the Institute for Diversity in Leadership and corporate sponsors discuss upcoming projects at their Dec. 11 meeting. Pictured (from left) are Institute members Dr. Sandeep Mammen, Dr. Karen-Lee Jones Stewart and Sydney Rollock of GlaxoSmithKline. For more about the Institute, see page 26.

BRIEFS

Antitrust: Dentists have long been aware that violations of the federal antitrust laws can subject dentists and dental societies to significant financial penalties and even jail time. Congress recently stiffened the penalties for antitrust law violations: up from $350,000 to $1,000,000 for individuals and to $100 million for professional societies (and potentially more) per violation.

To help keep member dentists and tripartite societies aware of antitrust developments, ADA's Division of Legal Affairs has updated its publication, The Antitrust Laws in Dentistry. Subtitled, a Primer of "Dos, Don'ts and How Tos" for Dentists and Dental Societies, the publication is designed to help dentists and dental societies learn how to assess relative levels of risk and make safe choices with the help of their legal counsel without taking on undue antitrust exposure.

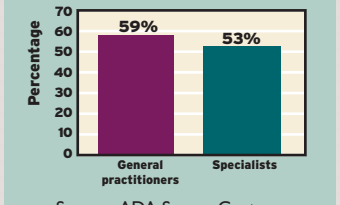
The good news is that there are positive paths that dentists and their professional societies may safely travel in pursuit of their legitimate interests and the interests of their

See ANTITRUST, page 19

JUST THE FACTS

Practice expenses

2004 expenses as a percentage of gross billings for solo dentists.



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

Members urged to read proposed dental anesthesia guidelines, offer comment

BY KAREN FOX

The Council on Dental Education and Licensure issued its call for comment on proposed changes to the ADA's anesthesia guidelines documents last month, and since then staff at ADA Headquarters have fielded a number of calls both supportive and critical.

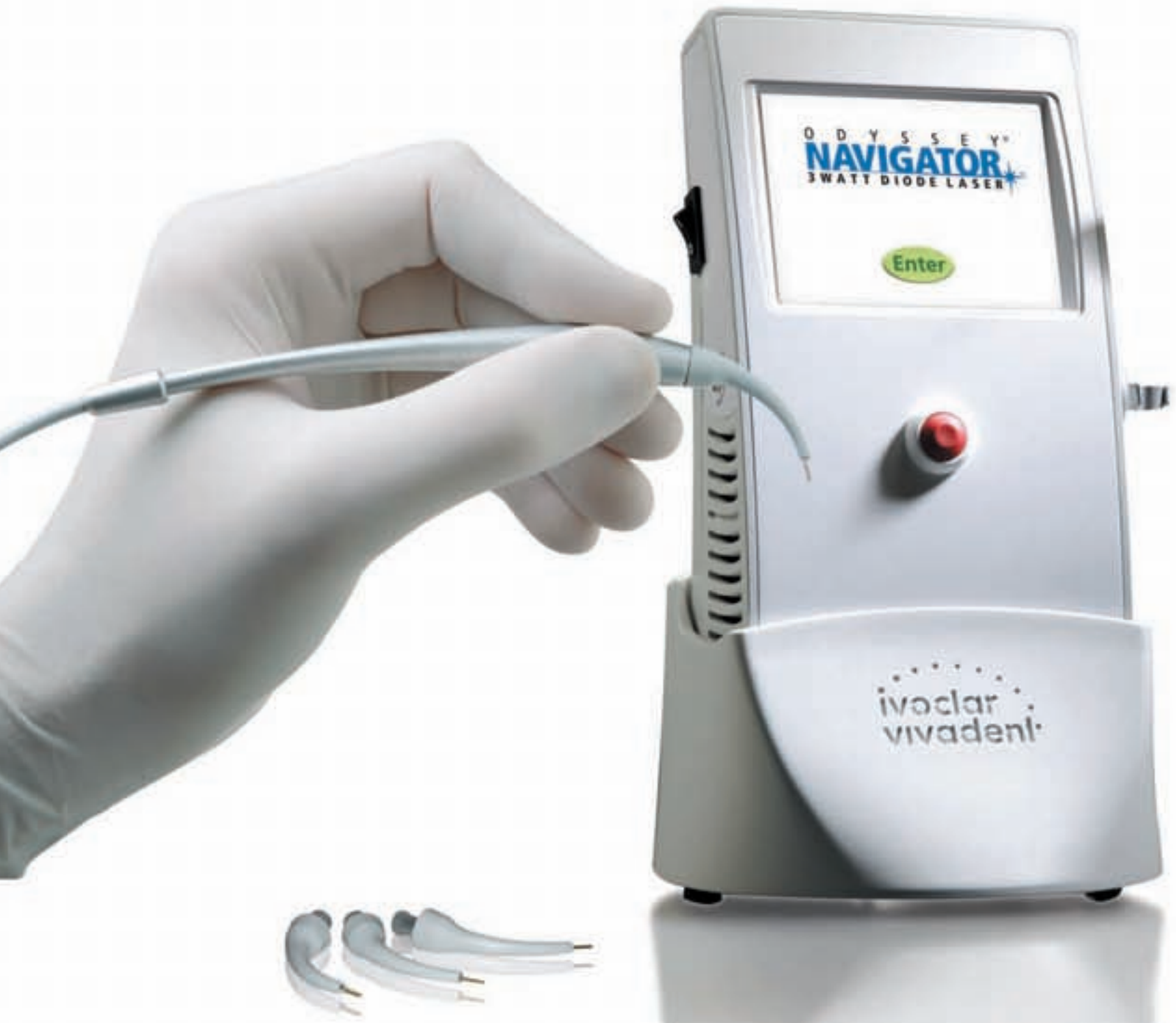
The revisions are the result of a comprehensive review of the existing anesthesia guidelines by the CDEL's Committee on Anesthesiology, which includes a cadre of anesthesia experts from other well-respected dental and medical organizations.

■ Bisphosphonates update, page 10

"The review of the proposed guidelines and feedback from the communities of interest are essential to the ADA Committee on Anesthesiology in the final stages of refinement of the documents prior to submission to the ADA House of Delegates," said Dr. Guy Shampaine, Committee on Anesthesiology chair. "During this period, we would like members to read the proposed revisions carefully and submit detailed comments to the ADA."

See GUIDELINES, page 18

Follow the Leader...



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FBI seeks dentistry's help in hunt for fugitive couple

Fugitives: James "Whitey" Bulger and Catherine Elizabeth Greig in photos circa 1994.

The FBI is offering a $1 million reward for information leading to the arrest of a mob boss who is wanted for multiple murders and is believed to be traveling with his girlfriend, a former dental hygienist.

An agency spokesman said the pair, at large since January 1995, are conscious of their health and appearance and may seek dental care from time to time. They're likely to pay cash for services rendered, the spokesman said, and are known to use aliases.

James "Whitey" Bulger, 77, an organized crime leader from South Boston, Mass., is wanted in connection with 19 murders and has been on the FBI's 10 Most Wanted list since August 1999.

He and longtime girlfriend Catherine Elizabeth Greig, 55, a former dental hygienist wanted for harboring a fugitive, were last seen in London in 2002 but have been known to travel extensively throughout the United States, Canada, Mexico and Europe.

The FBI said the couple may have visited dental offices since they've been on the run. Whitey Bulger, armed and dangerous, has been known to take Atenolol for a minor heart condition and may take Xanax for depression.

Readers with information on the couple's whereabouts should contact their local FBI office or the agency's Boston Division at 1-617-742-5533. For more information, visit the FBI's Web site at "www.FBI.gov". ■

ViewPoint

MyView

Dentistry following retirement

Volunteer service brings retired dentist back to the place he loves

Lawrence A. Berger, D.D.S.

I had it all, or so I thought. Retirement at 57. Great marriage. Financial security. Good health. Successful children. Home on Saratoga Lake. Sleep till 10. Play sports day and night. Vacations.

I'm sure anyone reading the above is saying, "Is this guy serious? How can this not be paradise?" Well, it is paradise, but still something was missing and, believe it or not, it was dentistry.

I was missing some of the things we can't ordinarily put our fingers on when we are in an active practice, making a day-to-day living. Two things in particular weren't there any more. First, is the respect our patients give to us and the wonderful way they look up to us as their professional consultants—you just don't get that respect on a tennis or basketball court. Second is the social interaction that I had with my wonderful dental staff, my patients and colleagues.

Thus, six months after retiring, I went back to dentistry part time. For the next three years I worked at nursing homes and at a center for the disabled in upstate New York. I tried retiring again, for three years, but just like Roger Clemens, I came out of retirement, again. What lured me was an article in JADA, the Journal of the American Dental Association, looking for volunteers to work on an Indian reservation in northern Minnesota. My love of dentistry was rekindled, and on September 9, 2006, I left to help out for two weeks on the Chippewa Reservation in Red Lake, Minn., a remote area in the northwest part of the state, not far from the Canadian border.

The middle of nowhere

A very big problem for the Indian Health Service is staffing these facilities with competent physicians and dentists, since most of the reservations are in extremely remote areas. The nearest town to the reservation I served on, Bemidji, Minn. (population 10,000), is an hour away. This is where most of the staff lives. Duluth is over two hours away, and Minneapolis is five hours away.

The dental clinic is part of the hospital. It is administered by the I.H.S., which is a branch of the Public Health Service. The clinic serves a population of

See MY VIEW, page five

LettersPolicy

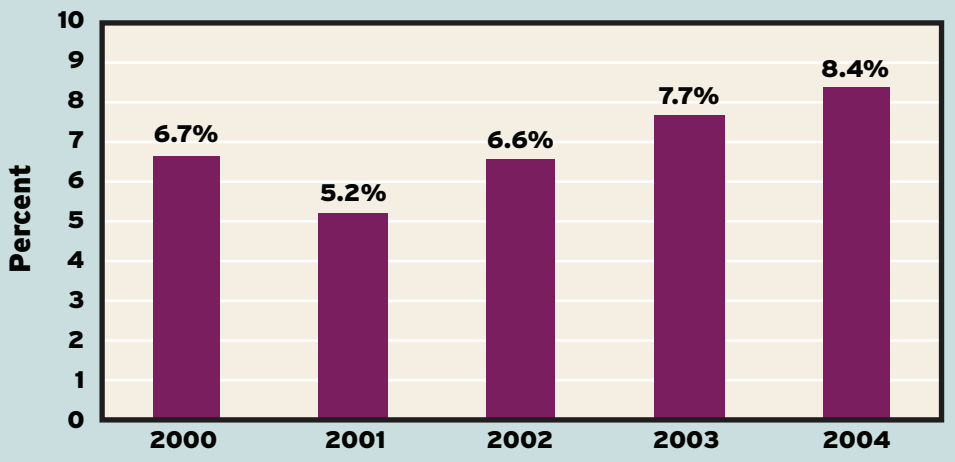
ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views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

SNAPSHOTS OF AMERICAN DENTISTRY

Dental practice

Managed care, as a percentage of gross billings, have been increasing since 2001 from the private practices of independent dentists.

Managed care as a percentage of gross billings received from the primary private practice of independent dentists, 2000-2004.



Source: American Dental Association, Survey Center, *Surveys of Dental Practice.*

Letters

Think twice

It is extremely difficult to find sympathy for the orthodontic residents and graduates of Jacksonville University, the University of Colorado and the University of Nevada, Las Vegas who made a financial agreement with OEC/Imagine ("His Dream Derailed? New Orthodontist Claims Failed Agreements Have Put Him in a Tough Spot," Dec. 11 ADA News).

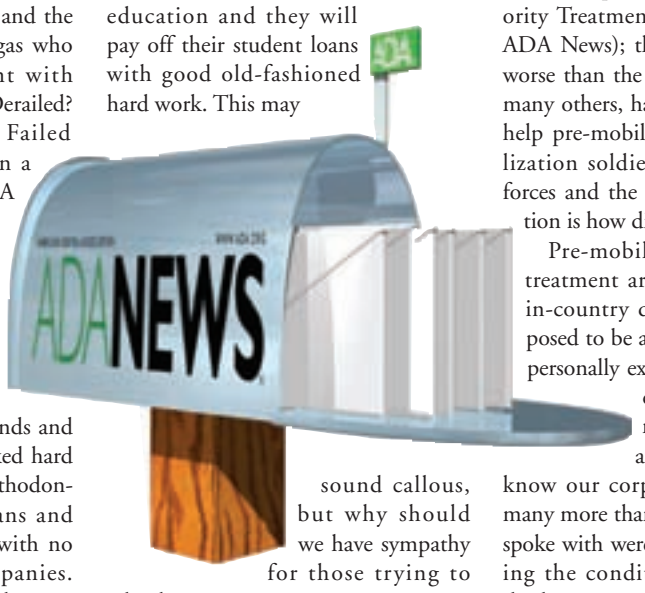
Perhaps these doctors should have thought twice before making a deal with OEC/Imagine.

The traditional route into our specialty has worked for doctors from various backgrounds and financial situations. They worked hard in dental school, applied to orthodontics through traditional means and were accepted to universities with no connections to private companies. Many had spouses and children to support.

Most didn't have nine years of previous employment from which they could have saved money. Many had large student debt. But through a combination of student loans, part-time jobs and living frugally, they completed a rigorous training program. Few had guaranteed positions after graduation and found employment with persistence and patience.

While this may sound like the hard way to do it, they graduated with integrity and pride.

They know that the American Association of Orthodontists supports their education and they will pay off their student loans with good old-fashioned hard work. This may



sound callous, but why should we have sympathy for those trying to take the easy way out?

Courtney A. Dunn, D.D.S.
Matthew D. Dunn, D.D.S.
Litchfield Park, Ariz.

Military career

Recent articles have finally motivated me to write in. I have been in private practice as a general dentist since 1981 but I have been an officer in the military since 1969. I recently served a one-year tour in Iraq 2004-05 with the 39th Brigade Combat Team, 1st Cavalry Division as a General Dental Officer.

I can appreciate Dr. Robert Frame's call for help ("Give Returning Vets Priority Treatment: Delegates," Nov. 20 ADA News); the situation is probably worse than the article indicated. I, like many others, have answered this call to help pre-mobilization and post-mobilization soldiers both in the reserve forces and the regular army. My question is how did things get like this?

Pre-mobilization screening and treatment are a stated priority and in-country dental services are supposed to be available. While in Iraq I personally examined and treated soldiers from all commands whose teeth were an absolute wreck. I know our corp support dentists saw many more than I did, and the people I spoke with were in agreement concerning the condition of the soldiers. I think we can all pitch in and help the present-day soldiers, but there needs to be an independent study of what organizational problem is allowing this to occur.

I have some ideas concerning the issue but this is not the forum for my opinions. My year in Iraq also consisted of assessing many public health clinics and speaking with dentists like your guest last month about improving the

See LETTERS, page six

MyView

Continued from page four

approximately 10,000 Chippewa Indians. There has been one permanent dentist on staff for the last 20 years, Dr. Bill Canada. A second dentist, Dr. Tracy Charles, recently joined the staff. The equipment, supplies and the quality of dentistry are first-rate, and the entire staff is to be commended. All treatment is given to the Indians at no charge, but the wait for treatment can easily run into two to three months.

For two weeks I was treating mostly emergencies, doing a lot of surgery, with a little restorative dentistry mixed in. All phases of dentistry were done in the clinic and done extremely well. I can't tell you how gratifying it was to get back into a profession that I loved, even for this short period of time.

Difficult existence

There are problems on the reservation. There is an unusually high incidence of alcohol and drug abuse. Many of the patients I served had a low pain tolerance. Smoking is prevalent, and the average life expectancy seems to be much lower than it is for the general population.

Since a school shooting in 2005, enrollment in the high school has dropped significantly. A minority of children complete a traditional secondary education.

Jobs are limited on the reservation, and the unemployment rate is generally high, though seasonal. A large percentage of the population is on some form of public assistance, and gang and domestic partner violence are problems.

There is a small casino on the reservation, but because of the reservation's remote location, very few outsiders frequent it. A larger, more successful tribal casino is an hour's drive from the reservation communities, but, it is still in a rural, low-population area. Gaming is not a big source

I was missing some of the things we can't ordinarily put our fingers on when we are in an active practice, making a day-to-day living.

of revenue for this tribe, like it is for other urban tribes around the country.

The diets of the children and adults are excessively high in carbohydrates and sugary foods, and, thus, the incidence of rampant caries is excessive among the children. A great majority of the children and adults are overweight. The tribe has responded by implementing a school screening and sealant/varnish program. Getting the kids into the dental clinic for follow-up, however, is a problem, though toothaches are a major motivator.

Most people living on the reservation are related to one another, and large extended families, including grandparents, are commonly involved in the rearing of the children. Many children are brought to the clinic by their grandparents or other relatives with whom they are living. In Indian country, most people see the large family structure and child-rearing by the extended family as strengths.

In spite of the many issues facing the reservation, I still found the people friendly and appreciative.

Retired dentists appear to be an excellent source for volunteers. Malpractice insurance is provided by the federal government. The only drawback is that the Public Health Service requires a fully paid and active license, which most retired dentists do not have.

Nevertheless, we're talking about dentists who are still licensed in New York State, many of whom have been in practice for at least 30 years.

Requiring these dentists to activate their licenses, to pay $250 and to complete 45 hours of CE in one year to spend two weeks providing volunteer service seems a little ridiculous and should be addressed by the state dental association and the New York State Department of Education. If the government is providing malpractice insurance for them, it obviously feels retired dentists are more than qualified to do the job.

Dr. Berger is a retired life member of the Suffolk County Dental Society, a component of the New York State Dental Association. His comments, reprinted here with permission, originally appeared in the December 2006 NYSDA News.

If you have comments that you'd like to share with Dr. Berger, contact him at "lilarry@spa.net".

Editor's note: The ADA, in partnership with local Indian Health Service/Tribal clinics and state dental societies, continues to seek service-oriented dental professionals to donate two weeks or more to provide oral health care to American Indian/Alaska Native communities.

The ADA's American Indian/Alaska Native Dental Placement Program's goals are to increase access to oral health care and disease prevention services; reduce oral health disparities; develop, pilot and evaluate innovative, culturally responsive strategies to address oral health needs of these populations; support IHS efforts to fill vacant dental positions; and create meaningful volunteer opportunities for ADA member dentists.

To learn more about ADA volunteer opportunities, contact Gary Podschun by calling toll-free, Ext. 7487, or e-mail "podschung@ada.org".

According to the ADA Department of State Government Affairs, at least 22 states have statutes and/or regulations concerning licensing of retired volunteer dentists. Some states allow only their own previously licensed dentists to qualify for licenses to provide charitable dental care; others grant them to dentists who are licensed in any jurisdiction in the U.S.

For more information on a particular state, contact the state's dental board; or contact the DSGA for its current list by calling toll-free, Ext. 2799, or e-mail "hansenja@ada.org".

Looking for ways to get your message across?

AMA Medical Communications Conference set for April

Tampa, Fla.—The American Medical Association hosts its 27th Annual Medical Communications Conference here April 12-14.

The conference offers a variety of training and workshops aimed at helping medical and dental spokespersons and health care communication professionals deliver their messages more effectively.

Keynote speakers include:

• Julie Gerberding, M.D., director of the Centers for Disease Control and Prevention;

• Newt Gingrich, former speaker of the U.S. House of Representatives;

• Tedd Mitchell, M.D., of USA Weekend;

• Brian Duffy, editor, U.S. News & World Report;

• Robert Bazell, chief science correspondent, NBC News.

In addition, a panel discussion examines how health professionals and advocates can leverage news media to raise the visibility of the problem of the uninsured.

Participants will gain new skills in interview techniques, reading from a teleprompter and developing an on-camera persona. Sessions will cover how to balance a communications career with a practice, effective media relations, writing about the science of medicine for print media and successful podcasting.

Visit the AMA's Web site at "www.ama-assn.org/go/mcc2007" for more information and to register. ■

Letters

Continued from page four

clinical situation. One constant complaint was a lack of supplies, especially anesthetic, to which I always offered a case or two from my vehicle. I would also request a list of what else they needed that I might get for their clinic. The reply was consistent, supplies must be given first to the Ministry of Health so they can be assessed for purity; the public health clinic could not accept the supplies directly.

While providing care in a village one day, I was thanked by a patient because I used anesthesia for an extraction. I was told that anesthesia was only available in private offices and it doubled the price of an extraction.

Getting the supplies to the truly needy is always difficult. One list of needed equipment from a small public health clinic included 72 cell phones. Dealing with Iraq is a very complex issue and defies the ability of most of us to help.

The role of a dentist in disaster preparedness must begin within the profession. The basic science background of a dentist is second to none in the health care professions and should remain that way. The training we receive brings that knowledge to focus on the oral cavity and the associated problems. Training to treat emergencies outside of that area is not encouraged by our own profession. I have not received one hour of CE credit for pre-hospital trauma life support, advanced trauma life support, emergency medical technician (basic) and basic disaster life support. The profession needs to encourage and recognize this type of training. One day, heaven forbid, this type of skill may be valuable and we can do our part with everyone's confidence.

Jim Orsini, D.D.S.
Col. (Ret.)
39th Brigade Combat Team
Little Rock, Ark.

Editor's note: The issue of who is responsible for the soldier's dental care prior to coming on active duty is complicated, says the ADA Washington Office. Staff members there have engaged the military services and Department of Veterans Affairs in discussions on this issue in the past.

There is a basic understanding that reserve and guard members are responsible for their own health (including dental care) and, in fact, the TRICARE Dental Program is designed to help the reserve or guard members obtain that care.

However, the program requires that the service member pay a monthly fee, which involves plan limits and co-payments. Many soldiers say they can't afford the dental insurance and even if they could, the limits are quickly exceeded and the co-payments too high for patients most in need of care.

Another view is that this dental care should be the responsibility of the services. However, there is no funding for a comprehensive dental benefit for these guard and reserve members. The services are studying ways to provide this level of care, but it can't be solved anytime soon. The services, along with the VA and members of Congress, are well aware of the problem and are working toward solving it.

Regarding Dr. Orsini's question about receiving no CE credit for disaster preparedness training, the ADA Division of Education notes that an important reason for reporting and tracking of CE courses is to comply with state requirements for re-licensure. Regardless of how any organization handles this process, dentists should keep their own records of CE course participation to verify attendance if requested by their state board. In 2004, the ADA adopted policy stating that military deployment is a learning experience and urging state boards to waive the CE requirements of deployed military dentists who are serving on active duty. The ADA has communicated this policy to all state boards of dentistry.

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ADAReports

ADA leaders brainstorm best ways to reach goals

BY JENNIFER GARVIN

The goal was to implement ADA's top priorities for 2007. But that didn't mean they couldn't have fun in the process.

ADA officers, Board of Trustees, council and committee chairs and vice chairs gathered here Jan. 4-5 to attend this year's "Silo Busting: Working Together to Align ADA Priorities."

What about this: Dr. Pamela Baldassarre, vice chair of the ADA Council on Membership raises a point during a question-and-answer session.

Write it down: ADA Second Vice President Jane Grover participates in a breakout session.

"There is no shortage of good ideas across the ADA. The challenge is for leaders to pick among many good ideas and determine which ones are the most important for the Association to undertake now."

For two days, the group brainstormed, networked and listened to presentations, often laughing in the process, as they looked for ways to increase focus on ADA strategic priorities through cross-agency collaboration.

"This was an ideal time, as all councils begin their work, to network with other councils and understand a comprehensive picture of activities and priorities facing the Association," ADA President Kathleen Roth said. "It was clear from all those in attendance, the ADA has been honored by being recognized as one of nine great national organizations and intends to continue its dedication to improving the way we do our work within the ADA."

Major topics discussed included oral health literacy, workforce models and elder care.

"One of the ways to make sure we are successful in the future is to maintain focus on those initiatives that are critical," Dr. James Bramson, ADA executive director, told the group of 86. "There is no shortage of good ideas across the ADA. The challenge is for leaders to pick among many good ideas and determine which ones are

Break time: Trustees Mary Krempasky Smith and Ronald Tankersley, 11th and 16th Districts, respectfully, share a moment during a networking break at the Jan. 4-5 conference.

the most important for the Association to undertake now."

Robert Gleason, vice president of Revere Group Consulting, facilitated the gathering and guided the group through question-and-answer sessions, breakout exercises and a discussion of the book, "7 Measures of Success: What Remarkable Associations Do That Others Don't," in which the American Society of Association Executives and the Center for Association Leadership named the ADA one of the best associations in the country. ■

Mail fraud form on ADA.org for dentists seeking to take action against New Hill

BY ARLENE FURLONG

An Oct.16, 2006, ADA News article to alert members to complaints about New Hill Services generated calls and correspondences from dentists interested in taking some sort of action.

Dentists complained of receiving what they called "fake invoices" that suggest they've received publications they haven't in envelopes with return addresses that sound like collection departments. The print stating the mailing is not an invoice is designed not be noticed, some dentists say.

Copies of return envelopes dentists sent to the ADA show such mailings were sent to them from Boston, Seattle and Washington.

The Better Business Bureau file on New Hill Services, Naples, Fla., which does business as The Coding Institute, National Subscription Bureau, National Litigation Bureau, Orthopedic Coding Alert and Eli Research, reports an unsatisfactory record with the Bureau due to a pattern of complaints stating that customers are being billed for a product that was never ordered.

The ADA Division of Legal Affairs recommends dentists who feel wronged fill out the U.S. Postal Inspection Service Mail Fraud Report and mail it in.

There is a space on the form for false subscription notices.

The form is now available for downloading at ADA.org at "www.ada.org/prof/center/feature_member_newhill_form.pdf".

To read the Oct. 16 ADA News story go to ADA News Today at ADA.org. ■

New fee report available from Survey Center

Results of the ADA Survey Center's Survey of Dental Fees are out. The 200-plus page report lists mean, median and percentile fees for over 180 different dental procedures as reported by private practicing dentists in the U.S.

Along with the fee information, each procedure includes a brief description as well as its corresponding CDT-2005 code. Results are provided for nine regions of the country for general practitioners and nationally for each of six specialties.

New, beginning with this fee survey report, some Survey Center reports can be downloaded electronically by going to "www.adacatalog.org". Dentists can download an electronic copy of the report for the same price as the paper copy.

The Survey of Dental Fees is available by calling ADA Catalog Service at 1-800-947-4746 or visiting "www.adacatalog.org".

The cost of the report (catalog number SDF-2005) is $125 for ADA members, $187.50 for nonmembers and $375 for commercial firms, plus shipping and handling. ■

Health&Science

Bisphosphonates guidelines

ADA urges dentists to consult council recommendations

BY JENNIFER GARVIN

By now dentists are aware that patients taking bisphosphonates may be at risk for developing osteonecrosis of the jaw.

In July 2006, the ADA Council on Scientific Affairs released a set of recommendations for practitioners to consult when treating patients taking the oral form of these drugs (such as Fosamax, Boniva and Actonel). These guidelines also were printed in the August issue of the Journal of the American Dental Association.

Because of the attention the subject has received from mainstream media, some physicians have questioned whether dentists are doing more harm than good. There are some who think dentists are being overly cautious by suggesting to patients that they may need to get off the drugs, when doing so may complicate a patient's medical status.

The ADA bisphosphonates recommendations do not tell dentists to take their patients off the drug, but instead say patients "should be encouraged to consult with his/her treating physician about any health risks." The guidelines also say dentists should talk to their patients about alternative treatments, how any treatment relates to the risk of ONJ, other risks associated with various treatment options, and the risk of foregoing treatment, even temporarily.

One physician believes that "dentists are scaring their patients into stopping bisphosphonates when there is only a remote chance of them developing ONJ," said Beatrice Edwards, M.D., director of the bone health and osteoporosis program at Northwestern University Feinberg School of Medicine. Dr. Edwards also was a member of the ADA's expert panel that put together the recommendations.

Dr. Edwards cited a case where a physician who also was a dental patient in need of a root canal couldn't find a dentist to treat her. The patient had taken Fosamax for three years and went to three community dentists before finally being treated at Northwestern's Dental Department, Dr. Edwards said.

"The ADA (bisphosphonates) guidelines clearly state that there is no reason to discontinue bisphosphonate therapy," she continued. "There's just no data."

The ADA wants to remind dentists that osteoporosis is a major cause of morbidity, functional dependence and institutionalization in older Americans.

"It is important to establish good communication between dentist and patient and in cases involving bisphosphonates, between dentist, patient and physician," said Dr. Ron Zentz, CSA director.

Some patients aren't consulting their dentists at all. Dr. Peter Hurst, chief of dental service and professor of dental surgery at Northwestern University Feinberg School of Medicine who has talked with Dr. Edwards about the problem, reports that he has encountered an increasing number of patients who have voluntarily taken themselves off the drugs due to what they have heard in the popular press.

Dr. Hurst said that he believes members of the medical community are saying that the dental community is doing a disservice to patients and that some dentists may not understand the guidelines.

"This is an educational problem between patients and dentists," Dr. Hurst said.

The recommendations say that patients should have a dental exam prior to beginning oral bisphosphonate therapy or as soon as possible after they begin therapy. In some cases, patients may want to schedule any needed dental treatment before starting bisphosphonate therapy. Maintaining excellent oral hygiene is the best way to prevent most dental and periodontal disease. Since reports indicate that osteonecrosis associated with bisphosphonate therapy occurs most often after oral surgical procedures, oral disease prevention is a critical part of reducing the risk of developing ONJ.

ADA.org features bisphosphonates info for patients

Confused about what to tell your patients about bisphosphonates? You can visit ADA.org and direct them to the patient information page at "www.ada.org/public/topics/osteonecrosis.asp". ■

The guidelines also focus on conservative surgical procedures, proper sterile technique, appropriate use of oral disinfectants and the principles of antibiotic therapy.

The CSA wants to remind members that the known risk for developing ONJ is much higher for patients taking bisphosphonates intravenously, as part of cancer treatment, than orally. The recommendations are a resource for dentists to use when treating patients taking oral bisphosphonates. The dentist—knowing the patient's health history and vulnerability to oral disease—is still in the best position to make treatment recommendations in the interest of each patient.

The majority of reported cases of bisphosphonate-associated ONJ have been diagnosed after tooth extractions. It is critical for dentists to report any cases to the MEDWATCH system and/or the manufacturer so that everyone can better understand the true rate of the adverse event.

To see the recommendations online, visit "www.ada.org/prof/resources/topics/osteonecrosis.asp" or call the ADA toll-free, Ext. 2878. ■

UConn School of Dental Medicine receives $12 million from state to study stem cells

Farmington, Conn.—The University of Connecticut School of Dental Medicine has received $12 million in grants to study stem cells, part of a 10-year, $100 million commitment from the state's governor and general assembly.

The school and several Connecticut nonprofit institutions received $20 million total in the first disbursements from the initiative.

David Rowe, M.D., director of the center for regenerative medicine and skeletal development in the School of Dental Medicine, received a $3.5 million grant to study how to produce reparative cells from human embryonic stem cells.

"We view this grant as an opportunity to begin human-based embryonic stem cell research and acquire sufficient experience in preclinical small animals models that will position us to acquire more funding in the future to apply this knowledge to large animal studies and eventually human trials," Dr. Rowe said in a school news release.

For more information about the UConn Health Center, visit "www.uchc.edu". ■

Check-up

Continued from page one

a child's enrollment fall within the requirements.

"I think it's landmark legislation," Dr. Emmerson said. "We already require our children to have medical evaluations. Our thought was there should be dental screenings as well.

"This is an issue we've been concerned with for a long time," he continued. "We know that severe dental decay is a major reason children miss school in California. Our goal is to get those children into their seats at school rather than in pain from dental neglect.

The three main goals of this bill are to raise awareness of the importance of children's oral health (with parents, teachers and others); connect children with a regular source of dental care; and to identify barriers to receiving care and use that information to seek legislative and funding solutions.

The ADA and CDA recommend that a child see a dentist as soon as his or her first tooth erupts and by the latest at the first birthday.

"We certainly hope most children are in care and have received care prior to this, but for those who have made it this far without, this is one more opportunity to say, 'Now is the time.' Clearly getting in earlier is better," said Gayle Mathe, a legislative advocate for the CDA. "The ultimate intent is to connect children with a regular source of care."

According to the legislation, schools will send home a form that educates parents on the importance of oral health and another form for parents to take to dentists to fill out on the condition of their children's teeth. Parents who object to the law, who cannot find a dentist to treat their child or who cannot afford to pay for the exams can be exempted from this requirement. The exemption form asks specific questions about the barrier the parent faced in meeting this requirement.

The CDA has posted information regarding the legislation on its Web site, which says the assessment can be a complete examination and treatment plan performed by a dentist, or it can be a more basic oral health evaluation, such as a screening, which can be performed by a dentist, hygienist or a registered dental assistant with supervision.

"It's a first step in raising the awareness of parents about the need for good oral health," Ms. Mathe said. "Two-thirds of the children in California who have dental decay experience it by the third grade and we are looking at ways to catch it earlier."

California joins Illinois, Georgia, Rhode Island, Massachusetts, New York, Oregon, Pennsylvania and the District of Columbia in requiring dental examinations for children.

For more information about the new law, visit "www.cda.org". ■

Drug abuse studies highlight significance of ADA guidelines

BY ARLENE FURLONG

Experts on drug abuse say results of newly released surveys highlight the significance of the ADA's leadership role in minimizing the risk among young people.

That leadership role was established when the 2005 ADA House of Delegates adopted policy on guidelines related to alcohol, nicotine and/or drug use by child or adolescent patients. (See story, page 13).

"The Council on Dental Practice viewed the development of these policies as a priority," says Dr. Wade Winker, CDP member and chair of the ADA Dentist Well-Being Advisory Committee. "Their adoption enables the ADA to position itself as an authority to its members in what is both a critical clinical and social issue for our adolescent patients."

Various studies agree there is an increase in pharmaceutical drug use for nonmedical purposes among children, adolescents and young adults.

While the 2006 Monitoring the Future survey of eighth-, 10th- and 12th-graders offers hope in some areas—the past-month use of illicit drugs has dropped 23.2 percent since 2001—abuse of prescription opioids remain at unacceptably high levels, according to the National Institute on Drug Abuse, which funded the study. NIDA is part of the National Institutes of Health.

Dr. Broderick

Dr. Hanson

In addition, the Substance Abuse and Mental Health Services Administration learned that the average number of people using prescription drugs nonmedically for the first time exceeds the number of new marijuana users.

An independent operating division under the Department of Health and Human Services, SAMHSA also found 12.4 percent of 18- to 25-year-olds used prescription pain relievers nonmedically within the past year.

For people ages 12 and over, SAMHSA reports that individuals who used prescription pain relievers nonmedically during the past year most often got one or more prescription for pain relievers from just one doctor, according to the 2005 National Survey on Drug Use and Health. The second most common way to obtain the prescriptions was from more than one doctor.

"The Council on Dental Practice viewed the development of these policies as a priority."

Although surveys did not distinguish between the types of providers, experts in the field of drug abuse say dentists are susceptible to many of the same prescribing practices that may be problematic for physicians. Dentists routinely prescribe opioid and other analgesics for pain that accompanies dental problems or procedures, but may not be aware that some patients create or exacerbate such problems in order to obtain these medications.

These surveys aren't necessarily common reading among the dental community, says Dr. Eric Broderick, a dentist, who is also SAMHSA's acting deputy administrator.

"When I was practicing it wasn't uncommon for young adults to come in with complaints that were difficult to verify," says Dr. Broderick. "However, as an oral surgeon I would typically prescribe prescription pain medication for removal of the third molars. Both patients and their parents have to be counseled so they're aware that whatever they don't use should be thrown out."

Dr. Mary E. Martin, who was a member of DWAC when the policies were written, says that when she prescribes narcotics to adolescent patients she never gives them more than 16.

"I tell them and their parents that, if they have any left, they should dispose of them," she explains. "I've learned that, when friends come over, the bathroom is the one place they're alone and they look in the medicine cabinets. Kids who wouldn't ever think of buying drugs think they're 'safe' when they get them from their friends' mothers' medicine cabinets."

Dr. Glen Hanson, a dentist and senior advisor at NIDA, as well as a professor in the department of pharmacology and toxicology at the University of Utah, says he's learned that

Dr. Winker: "These policies enable the ADA to position itself as an authority to its members in what is both a critical clinical and social issue for our adolescent patients."

Mr. Califano

many kids are very street smart so it's important to be absolutely accurate when talking to them about drug use.

"One of the biggest mistakes we make with kids is exaggerating," Dr. Hanson says. "That convinces them we don't know what we're talking about."

Dr. Hanson says for example, it's useless to tell kids that if they use Vicodin nonmedically they will become drug addicts because they see too many kids using prescription pain medications who are still functioning well and popular in school.

He says it's more effective to tell them that there's no way to know if they fall into the segment of the population that is vulnerable to repetitive use and that if they do, they will wrestle with the problem for the rest of their lives.

"If you have the capacity to be a good student and everything a good student has access to that might change," Dr. Hanson offers as an example of an effective way to talk to teens about drug use.

He says it's a challenge for dentists to detect a potential risk situation because these kids usually don't have enough of a medical record to be able to sort that out.

"Counseling parents when prescribing medications is as important as counseling young patients," Dr. Hanson says. "Parents don't often understand the linkage between different drugs. They don't understand how smoking or drinking stimulate a reward pathway. It might be coming through a different receptor, but when it comes to addiction, all roads lead to Rome."

Dr. William Kane, a member of DWAC, says he takes for granted that all the kids know about Vicodin, and some know about Oxycontin.

"They get it from their friends and relatives, who get it from doctors," explains Dr. Kane. "When I need to prescribe narcotics to my adolescent patients, I always take extra time with them and their parents, emphasizing their therapeutic uses and warning them about driving and sports activities while under the influence."

The ADA provides a wealth of resources on how dentists can help their patients through the ADA CELL Seminar Series and at ADA.org. ■

OnlineXtra
www. ada.org/goto/newsextra
For more information related to this story, visit the ADA's Web site, using the Web address above.

ADA policy addressing children and adolescent patients 'will help minimize their risk for drug abuse'

The 2005 ADA House of Delegates adopted policy on guidelines related to alcohol, nicotine and/or drug use by child or adolescent patients.

Joseph Califano Jr., chair and president for the National Center on Addiction and Substance Abuse at Columbia University congratulates the ADA on addressing the importance of having a policy related to drug use by children and adolescent patients. The nonprofit social action/think tank focuses on the study of all forms of substance abuse and how it affects society.

"It's important for all health care providers, especially dentists, to be aware of the high rates of abuse of prescription drugs like OxyContin, Vicodin and Percocet among teenagers in the U.S.," says Mr. Califano.

"In 2003, 2.3 million 12- to 17-year olds abused at least one controlled prescription drug and for 83 percent of them, that drug was an opioid. This knowledge coupled with ADA policy guidelines will enable dentists to send effective messages to both adolescent patients and their parents that may help minimize their risk for abuse."

Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients are:

1. Dentists are urged to be knowledgeable about the oral manifestations of nicotine and drug use in adolescents.

2. Dentists are encouraged to know their state laws related to confidentiality of health services for adolescents and to understand the circumstances that would allow, prevent or obligate the dentist to communicate information regarding substance use to a parent.

3. Dentists are encouraged to take the opportunity to reinforce good health habits by complimenting young patients who refrain from using tobacco, drinking alcohol or using illegal drugs.

4. A dentist who becomes aware of a young patient's tobacco use is encouraged to take the opportunity to ask about it, provide tobacco cessation counseling and to offer information on treatment resources.

5. Dentists may want to consider having age-appropriate anti-tobacco literature available in their offices for their young patients.

6. Dentists who become aware of a young patient's alcohol or illegal drug use (either directly or through a report to a team member), are encouraged to express concern about this behavior and encourage the patient to discontinue the drug or alcohol use.

7. A dentist who becomes aware that a parent is supplying illegal substances to a young patient may be subject to mandatory reporting under child abuse regulations. ■

Dr. Felix Crawford, past ADA vice president, dies at 69

BY JENNIFER GARVIN

Plainview, Texas—He was a "stalwart" in Texas dentistry, but it was his personal relationships for which Dr. Felix C. Crawford will be remembered.

Dr. Crawford, a past ADA vice president from Plainview, Texas, died Jan. 23 at the Covenant Medical Center in Lubbock, Texas. He was 69 years old.

"He was one of those people who was always thinking of someone else," recalled Dr. Thomas C. Harrison, current Texas Dental Association president. "He was a force."

A general dentist who received his dental degree from the University of Texas Dental Branch in Houston in 1963, Dr. Crawford spent two years in the U.S. Army before opening his dental practice in Plainview in 1965.

An ADA member for more than 40 years, he was a past president of both the TDA and the Texas Dental Association Foundation. On the national level, he served as vice chair of the ADA Council on Government Affairs and was elected ADA vice president for 2001-2002.

Dr. Harrison considered Dr. Crawford a friend as well as a mentor and credited him with his own rise in organized dentistry. He said Dr. Crawford gave him a huge opportunity when he got involved with the Texas political action committee, DENPAC.

"And I'm not the only one," Dr. Harrison said. "I know direct stories of what Felix has done for other young dentists."

Dr. Kathleen Nichols, a general dentist in Lubbock, agreed: "He was one of the people who really influenced my decision to get involved. He gently guided me into becoming interested in the issues."

Dr. Nichols, a member and past chair of the TDA's Dental Care Program's Council and past chair of the Ethics and Judicial Affairs Council, said "there will be some big shoes to fill" with the loss.

Dr. Crawford

"He was incredible to me," she said. "I would hope that I can do for someone else what he did for me."

In his candidate profile for his 2001 election bid, Dr. Crawford said he wanted to be an ADA officer because he believed in "the merits and the ethics of our profession" and wanted to "stand up for those ideals."

According to the TDA, in 1990, Dr. Crawford was instrumental in helping establish the Texas Dental Association Foundation to promote advancement of health care through continuing education for Texas dentists. Last year, the foundation merged with the Texas Dentists for Healthy Smiles to form the Texas Dental Association Smiles Foundation and the TDASF Felix Crawford Endowment Fund, which helps finance dental education scholarships and other activities.

"The members of the board who worked with Felix thought so much of him that they did that to honor him," Dr. Harrison said.

Dr. John Findley, ADA 15th District trustee, remembered Dr. Crawford as someone who loved "renewing relationships" with ADA friends.

"He delighted in every opportunity to be part of our Association," Dr. Findley said. "He will be missed."

In addition to his participation in organized dentistry, Dr. Crawford was a past president of the Plainview Chamber of Commerce, the Plainview Country Club, the Plainview Rotary Club and the Plainview Toastmasters Club. He also was a former soccer, football and baseball coach.

Dr. Crawford is survived by his wife, Marian; children, Boyd Crawford and Christy Gray; and three grandchildren. He also leaves two stepsons, Ross and Lee Perry.

The funeral was Jan. 26 at the United Methodist Church in Plainview.

In lieu of flowers the family has asked that contributions be sent to the TDASF Felix Crawford Endowment Fund, 1946 South International Highway 35, Ste. 300; Austin, Texas 78704. ■

Rep. Norwood in cancer treatment

BY CRAIG PALMER

Washington—Dentist/Rep. Charlie Norwood, recuperating from ongoing chemotherapy, thanked President Bush for wishing him a speedy recovery. "It is a real honor to be mentioned in the State of the Union address in front of the entire nation," Rep. Norwood (R-Ga.) said in a statement posted at his Web site ("www.house.gov/apps/list/press/ga10_norwood/GetWell.html").

President Bush opened the speech on a historic note, the first president to begin a State of the Union message congratulating "Madam Speaker." Rep. Nancy Pelosi (D-Calif.), the elected Speaker of the House of Representatives, is the first woman to hold that post.

He then told the nation, "Two members of the House and Senate are not with us tonight and we pray for the recovery and speedy return of Senator Tim Johnson and Congressman Charlie Norwood."

Rep. Norwood began chemotherapy treatments in early December. He is being treated for a recurrence of non-small cell lung cancer, which was initially treated in November 2005. He will continue to receive periodic chemotherapy to eliminate the new tumor located near his liver, his congressional staff reported. Sen. Johnson (D-S.D.) underwent surgery Dec. 13 for an intracranial hemorrhage caused by an arteriovenous malformation and "continues to make encouraging and steady progress in his recovery," a statement on the senator's Web site said ("http://johnson.senate.gov"). ■

Time to update: All Give Kids A Smile program participants are asked to return to the ADA's Web site to enter the results of their GKAS programs. Doing so gives the ADA the ability to gauge national participation in Give Kids A Smile. Those who return to the Web site to update their statistics are eligible to win $500 toward their next GKAS program. (Two $500 prizes will be awarded.) Visit "www.ada.org/goto/gkas" to enter your program results from the 5th annual Give Kids A Smile on Feb. 2. Complete coverage of nationwide events will appear in the Feb. 19 ADA News and on ADA News Today ("www.ada.org/goto/adanews").

Pictured during 2006 GKAS is Claire Darling (left) holding a mirror as dad Dr. Robert P. Darling flosses Bailey Klug's teeth in Sheboygan, Wis. Thanks to an annual teachers' in-service day that gives her a day off school, Claire lends a hand at her father's office on GKAS. Besides, "little kids are much more likely to listen to other little kids," she says.

give kids a smile!
National Children's Dental Access Day
ADA
American Dental Association
www.ada.org

Photo courtesy The Sheboygan Press/Sam Castro

Leaders

Continued from page one

apply for graduate and professional students borrowing subsidized Stafford loans," said the letter signed by Dr. Kathleen Roth, ADA president; Dr. Kenneth L. Kalkwarf, ADEA president; and Dr. E. Dianne Rekow, AADR president.

The House of Representatives passed the student loan legislation Jan. 17. It is the first legislation in the 110th Congress affected by a budget rule that requires lawmakers to offset new spending with cuts elsewhere in the budget. The legislation, which goes to the Senate, would cut by half interest rates for federally subsidized undergraduate loans at a cost of $7.1 billion over five years. Extending coverage to include post-graduate student loans would increase the costs, nearly doubling the expense by some estimates.

The ADA also offered "strong support" in a Jan. 16 letter to bipartisan Senate leaders for the Small Business and Work Opportunity Act of 2007, in particular tax provisions important to dentists as owners of small businesses. The bill would extend the Section 179 expensing provision through 2010 and expand to more small businesses and dental practices eligibility to use the cash method of accounting for tax purposes.

The tripartite profession has long supported both measures. The profession's assertive and effective challenge of IRS rules in the late 1990s gave dentists the right to choose practice-appropriate accounting systems. The IRS in 2001 conceded the rules were "unclear" and said it would no longer challenge dentists' use of cash-based accounting for tax purposes. The Senate legislation would make more small businesses eligible for cash accounting by raising the average annual gross receipts measure from $5 million to $10 million.

"The vast majority of the 150,000 plus dentists that we represent are small business owners," the ADA told the Senate Finance Committee. "Your provisions in the Small Business and Work Opportunity Act would greatly enhance their ability to deal with many of the financial challenges facing our small businesses today." Dr. Roth, ADA president, and Dr. James B. Bramson, executive director, signed the Senate letter. ■

Military dentists close out year on high note

BY KAREN FOX

Garmisch, Germany—Looking back on the ceremonies commemorating the 50th Annual Dental Training Conference of the Europe Regional Dental Command and the enriching continuing education that followed, Col. Priscilla Hamilton paused to find the words to sum up her experiences.

"This is the type of forum that you just won't find unless you're in the military services," said the senior dental corps staff officer in the Office of the Surgeon General. "I attend most conferences, bringing the policy arm of army dentistry, but this year's was truly unique."

Held Oct. 22-27, 2006, at a resort in the Alps, the Annual Dental Training Conference offered a blend of CE and networking for the dental corps stationed in Europe, who often lack opportunities for affordable CE programs. A total of 148 dentists from the Army, Air Force and Navy attended the conference, along with dentists from Britain, Germany, the Netherlands and Canada.

"If you're stationed in Germany, this is the conference to go to," said Col. Hamilton. In celebration of its 50th year, former Army Dental Corps chiefs and general officers were on hand in 2006.

"Each officer shared their focus area, talked about the commitment to academics and mentoring, and their sense of what service meant to them as they transitioned to civilian life," said Col. Hamilton. "It made the meeting even more special."

Maj. Gen. Russell Czerw, commanding general, AMEDD Center and School, and Ft. Sam Houston chief, U.S. Army Dental Corps, delivered the State of the Dental Corps address in Garmisch, discussing trauma care and protection of soldiers in the field.

"What the ADA does for us is give us a voice with decision-makers, which is something we can't do directly."

Other speakers included Col. Hamilton; Col. Michael Cuenin, commander, Europe Regional Dental Command; Col. Larry Hanson, commander, U.S. Army DENCOM; and Col. Edward Chesla, commander, U.S. Army Dental Laboratory, Fort Gordon, Ga.

A week prior to the Annual Dental Training Conference, Col. Hamilton was a panelist at the ADA annual session's "Exploring Careers in Federal Dentistry" event in Las Vegas, which offered a glimpse into the lives of dentists serving in the military, U.S. Public Health Service and Department of Veterans Affairs.

"This session gave us a chance to clear up some misconceptions regarding military dentistry," said Col. Hamilton. "Yes, it is a very fulfilling career.

"People tend to think you serve because the military paid your scholarship, but practicing in the military is unparalleled," she continued. "You will be able to serve your patients whether they wear a uniform or not. Those who devote their lives to become program mentors in academic programs, they are setting the standard as leaders in dentistry."

Federal service dentists are an important segment of ADA membership, and as such the Association maintains an interest in meetings like the Annual Dental Training Conference and the Association of Military Surgeons of the U.S. meeting that took place in San Antonio Nov. 6-8. About 277 dentists were among the nearly 3,500 medical military personnel who attended the AMSUS meeting.

Addressing an AMSUS Dental Section Luncheon, ADA President Kathleen Roth expressed gratitude to the federal dentists and team members for playing such vital roles in America's military preparedness and public health system, and in the care of veterans.

"On behalf of all the officers, trustees and staff of the ADA, I want to assure you that we will continue doing everything we can to support federal service dentists, and see to it that you

Armed Forces: Above left, Col. Michael Cuenin, commander of the Europe Regional Dental Command, addresses military dentists in Garmisch in October 2006. Above right, ADA President Kathleen Roth (third from left) pauses for a photograph with dentists at the November meeting of the Association of Military Surgeons of the U.S. From left are Col. Priscilla Hamilton, senior dental staff officer, Army Dental Corps; Rear Adm. Carol Turner, chief, Navy Dental Corps; Dr. Roth; Brigadier General Garb S. Graham, U.S. Air Force, Dental Corps, Assistant Surgeon General for Dental Services; Rear Admiral Lou Libby, U.S. Navy, Dental Corps, deputy medical officer, Reserve Affairs, United States Marine Corps HQ; and Dr. Robert T. Frame, then Assistant Undersecretary for Health for Dentistry.

receive the recognition and fair treatment you deserve," Dr. Roth said.

ADA membership is a "strong link with our civilian counterparts," said Col. Hamilton. "It's been said, you're in the Army for a while, but you're always a dentist. The ADA is the continuum. What the ADA does for us is give us a voice with decision-makers, which is something we can't do directly. We greatly appreciate that."

Recent ADA accomplishments on behalf of dentists in the federal services include:

- Achieved long-standing ADA policy by lobbying to change the rank of the senior dental officer for the Air Force to major general.
- ADA provided the support that allowed dental officers to continue to receive additional special pay while undergoing residency education.
- Increased the maximum stipend for the Health Professions Scholarship Program to $30,000 per year and the maximum grant amount for the Financial Assistance Program for residents in specialty training from $15,000 to $45,000.
- Increased the maximum amount eligible for loan repayment from $22,000 to $60,000.
- Obtained significant additional funding for military dental research in 2006—increasing the funding by $600,000 to a level of $4 million. ■

NY Headache Center plans 19th Annual Symposium

New York—The New York Headache Center will hold its 19th Annual Symposium on the treatment of headaches and facial pain here April 15 at the New York East Side Marriott.

For more information, contact Alexander Mauskop, M.D., by telephone at 1-212-794-3550, by fax at 1-212-794-0591 or by e-mail at "nyheadache@aol.com". ■

Guidelines

Continued from page one

All three of the proposed guidelines documents are at "www.ada.org/goto/statements". Click on "Anesthesia and Pain Control." Comments are due Feb. 23.

"When submitting comments, whether you favor the proposed changes or not, we ask that you note the specific text you are referring to," said Dr. Shampaine. "Some of the comments that we are seeing are generalizations about the documents which do not specifically reference language from the documents. Some seem to be the result of a misunderstanding of the documents' content.

"Unfortunately, some people have been very upset because they have been told that the proposed guidelines would prevent the administration of these services by general dentists," he continued. "The ADA unequivocally supports the use of oral sedation in dental practice, and the introduction of each document includes language stating that the use of sedation and anesthesia by appropriately trained dentists is an integral part of dental practice."

Dr. Shampaine: "The ADA unequivocally supports the use of oral sedation in dental practice, and the introduction of each document includes language stating that the use of sedation and anesthesia by appropriately trained dentists is an integral part of dental practice."

What's more, said Dr. Shampaine, the revisions actually allow dentists to do more than the existing guidelines. The committee also included a "grandfather clause" so that it would be clear that the ADA is not proposing new basic educational requirements for dentists who are currently appropriately and safely administering these services.

The call-for-comment period is essential to developing guideline documents that constitute the framework of the profession's position on the appropriate training and conditions for use of outpatient sedation and general anesthesia in dentistry.

"However, keep in mind this is the first step in proposing changes," said Dr. Shampaine. "The ADA has not adopted any changes to the anesthesia documents yet. This is how the process works: the committee recommends changes, the communities of interest review and comment on the changes, the comments are reviewed by the committee and CDEL to propose further refinement, if necessary, then the House of Delegates decides whether to adopt the revisions."

To clarify the proposed changes, Dr. Shampaine answered a number of questions printed here. Members with concerns are encouraged to contact CDEL staff member Lois Haglund at Ext. 2694 or "haglundl@ada.org". Comments on the proposed documents may be submitted by Feb. 23 to Dr. Stephen K. Young, CDEL chair, 211 East Chicago Ave., Chicago 60611; fax to 1-312-440-2915; or e-mail to "haglundl@ada.org".

What is included in the proposed revisions to the ADA's anesthesia documents?

• A complete reorganization of content in the Guidelines for Teaching and the Guidelines for Use that focus on the sedation-anesthesia continuum, including minimal, moderate and deep sedation and general anesthesia.

The organizational format and definitions of the proposed guideline documents bring the ADA documents in close alignment with other dental and medical anesthesia documents and literature. (The existing guidelines are organized by educational level and route of administration.)

• The existing guidelines prohibit multiple dosing of oral agents when providing enteral sedation. The new guidelines provide for multiple oral dosing of medications in both minimal and moderate sedation. The new guidelines have a new definition of "incremental dosing" in minimal sedation and a refinement of the definition for "titration" in moderate sedation.

• The ADA's existing (2005) guidelines limit training for deep sedation and general anesthesia to formal advanced education. Proposed guidelines require training at the same level, but add qualifying language that the advanced education program must be accredited by the ADA Commission on Dental Accreditation. CODA now has existing standards for all of the relevant advanced education programs, so the ADA will no longer include such guidelines as part of its anesthesia documents. This does not raise the bar from previous guidelines.

The documents specifically state that the guidelines should not exclude individual dentists who may be grandfathered by the state board of dentistry.

• The requirement for moderate sedation training in situations where the patient is managed exclusively by the enteral or enteral-inhalation route has been reduced from 20 to 10 patient experiences per participant, but requires that they be hands-on under specified conditions rather than observational experiences. (Moderate parenteral sedation training is unchanged and requires 20 patient experiences.)

Will the proposed new guidelines eliminate the use of sedation and anesthesia in general dental practice?

No. The proposed guidelines make recommendations for the safe use of sedation and anesthesia and the appropriate levels of education for dentists to safely administer these modalities.

What do the proposed guidelines say about multiple dosing or titration of oral medications for the purposes of sedation?

The existing guidelines do not support multiple dosing or titration of oral medications. The proposed guidelines allow for incremental dosing up to the maximum recommended therapeutic dose of a drug approved for unmonitored home use, and for titrating doses for deeper levels of sedation by appropriately trained dentists.

What educational requirements are included in the proposed guidelines?

The proposed educational guidelines allow minimal sedation to be taught either in the dental school curriculum or in a 16-hour CE course. Moderate sedation requires further educational experiences (60 hours of instruction including at least 10 patient experiences). Dentists using deep sedation and general anesthesia are still required to complete a post-graduate program, but now the program must be accredited by the Commission on Dental Accreditation.

The proposed guidelines also call for an alternative to the currently required advanced cardiac life support certification. This would be a newly developed course concentrating on dental sedation and anesthesia emergency management. CDEL has requested funding from the ADA Foundation to develop this course.

Will I need a permit from my state board of dentistry for minimal sedation?

The proposed guidelines do not recommend a permit for minimal sedation. The proposed guidelines recommend required permits for only moderate sedation, deep sedation and general anesthesia. Of course, each state makes the decision on how to regulate dentists providing sedation and anesthesia in that state. State dental boards do look to the ADA for guidance when establishing their rules and regulations.

Will I need to have an IV permit to administer minimal or moderate sedation?

The concept of an "IV permit" is not in the existing guidelines. This notion is probably the most misunderstood area of the new educational guidelines document. The old documents were organized by route of administration rather than therapeutic endpoints and therefore permits associated with parenteral sedation were sometimes referred to as "IV permits." However, the proposed guidelines do call for training programs in moderate sedation to include clinical experience in establishing IV access. This is only for the purposes of training for emergencies and is not a recommendation for establishing an IV if the patient's sedation is managed through the enteral route. A permit is not needed to establish IV access.

Is it true that the proposed guidelines require the dentist to remain in the room with the sedated patient until that patient meets criteria for discharge for post-sedation and anesthesia care?

Yes. This requirement has remained unchanged from the current guidelines and is the standard of care for all health care personnel who provide sedation and anesthesia. The criteria for discharge to post-sedation care would be based on the dentist's training and experience. For minimal sedation, discharge could be as soon as active dental care is completed.

The dentist must monitor the patient while the patient is sedated and he or she is actively providing dental care; however, as soon as that dental care is completed, in almost all cases the patient would meet the criteria for the post-sedation care and/or discharge. In a minimally sedated patient, almost always when the treatment stops, the requirement for monitoring ceases.

Provisions in state statutes or regulations that allow appropriately trained individuals (other than dentists) currently authorized to monitor patients under sedation would continue.

When will the proposed guidelines become effective?

The CDEL plans to transmit an updated version of the proposed guidelines to the 2007 House of Delegates for consideration. If adopted, they would become effective immediately.

Do the proposed changes eliminate use of certain sedation drugs—such as triazolam and benzodiazepines?

Absolutely not. The guidelines do not make recommendations on the therapeutic agents used by the dentist. This is an area of professional judgment based on the treating dentist's training and experience.

Why is the committee recommending hands-on CE courses for teaching moderate sedation instead of observational courses?

The definition of conscious sedation in the existing guidelines and the definition of minimal sedation in the proposed guidelines are essentially identical, with no significant change in the training requirements.

To accurately reflect the current consensus in dentistry and medicine, moderate sedation has been added to the proposed guidelines. The definition is more closely aligned to the existing definition of deep sedation.

The dentist is required to rescue a patient who inadvertently enters deep sedation, so the committee and its advisory experts felt that hands-on training was appropriate to familiarize the dentist with the administration, monitoring and patient-rescue issues. However, the patient management requirement was reduced to 10 patients from 20 in the educational program for enteral moderate sedation only. ■

BRIEFS

Continued from page one

patients without creating undue antitrust exposure.

"Extremely well written … in language that dentists can understand. … This document does an exemplary job of clarifying as well as offering potential solutions and practical advice. … I give this two thumbs up and would make it required reading for graduating dental students, executive directors of all state societies, and dentist volunteers…," are just a few of the comments Dr. Jon Tilton made in reviewing the book.

The ADA Legal Division encourages dentists to read this publication for essential information about antitrust and dental societies to use as a training tool for their volunteer leaders and staff. At the Jan. 30 President-Elect's Conference, ADA President-Elect Mark Feldman handed out copies citing the publication as an example of the critical resources the ADA develops for the tripartite. The antitrust primer is available online as a member benefit, in PDF format, at "www.ada.org/goto/antitrust".

The Feb. 19 ADA News will examine what's happening in the case of a Chicago-area physician group charged with price fixing by the Federal Trade Commission. ■

Dr. Robert J. Fitzgerald, caries etiology researcher, dies at 88

BY JAMES BERRY

Miami—Dr. Robert James Fitzgerald, a research scientist renowned for his pioneering work in oral biology, died Jan. 18 at the Veterans Administration Medical Center in Miami, Fla., where he spent 25 years as chief of the dental research unit.

Dr. Fitzgerald was 88 years old.

He was best known for his work in identifying bacterial causes of dental caries in animals. He also collaborated with other scientists on landmark discoveries related to dental calculus formation, periodontal diseases and root canal infection.

Born in the Bronx, N.Y., Nov. 3, 1918, Dr. Fitzgerald earned a doctorate in microbiology and pharmacology from Duke University, where his studies focused on streptomycin, a powerful antituberculosis drug.

In 1945, he married Dorothea "Dottie" Babbitt, also an accomplished scientist, who co-wrote several research papers with her husband. In 1948, the couple moved to Bethesda, Md. Dr. Fitzgerald worked with the National Institute of Dental Research (now the National Institute of Dental and Craniofacial Research), part of the National Institutes of Health.

In 1969, Dr. Fitzgerald was attracted to Miami by plans for a research unit at the University of Miami's new School of Medicine. When that project fell through, he became chief of the dental research unit at the VA Medical Center and professor of microbiology at the School of Medicine. He retired in 1994.

Over a 20-year span, Dr. Fitzgerald wrote more than 50 peer-reviewed articles for what is now NIDCR.

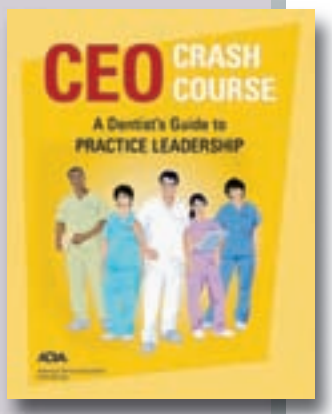
The honors and awards he earned include the Dental Research Prize of the International Dental Federation, the Scientific Award of the International Association for Dental Research and the Distinguished Service Award of the National Institute of Dental Research. He also received the Secretary of Veterans Affairs Exceptional Service Award, the highest honor bestowed on VA personnel.

Dr. Fitzgerald's wife, Dorothea, died in 2006. The couple had been together for 60 years. His survivors include two nieces. A funeral service is planned for Feb. 9 at the Miami VA Medical Center Chapel. ■

ADA offers business guide for dentists

A dental practice is a business. As owners, many dentists find themselves juggling much more than clinical dentistry.

But how do you develop the leadership strategies necessary to help your practice succeed?



The ADA has a new publication designed to help.

CEO Crash Course: A Dentist's Guide to Practice Leadership explores the art of balancing work with the rest of life by drawing inspiration from proven business leaders. The guide is filled with expert tips from top practice management consultants, including Dr. Roger Levin, Dr. Mark Hyman and Linda Miles.

To order a copy of CEO Crash Course, contact the ADA Catalog by phone at 1-800-947-4746, by fax at 1-312-440-3542 or visit "www.adacatalog.org"

The book is available in hard copy (item J712) and as a downloadable e-book (J712D). The cost is $39.95 for members and $59.95 for nonmembers. ■

ADA executive management 2007 program dates change

The September dates for this year's ADA/Kellogg Executive Management Program have changed. Course dates for 2007 are now July 20-25, Sept. 15-20 and Nov. 1-5. The advanced program meets July 21-26.

The Executive Management Program is designed for dentists who want to learn more about business management. The curriculum draws from the core content areas for Kellogg MBA students, including business strategy, organizational leadership, marketing, finance, accounting, economics and more. Classes are held on Kellogg's Chicago campus.

For more information, contact Connie Paslaski at Ext. 3541, or go to "www.ada.org/prof/events/featured/kellogg/index.asp". ■

SECOND IN A SERIES

ADA: Your NHII resource, advocate

BY JAMES BERRY

The National Health Information Infrastructure is expected to be fully operational by the year 2015, which probably seems like a long way off.

It isn't, say ADA officials who are working to ensure that dentists are prepared for the NHII's arrival and that dentistry's voice is heard in the federal government's plan for what has been described as an electronic network of highways, roads and pathways along which all patient health information will travel.

"The date for implementation seems to get closer and closer every time we meet," says Dr. William G. Glecos, the ADA's 3rd District trustee and vice chair of an Association Task Force on the NHII.

Dr. Joel F. Glover, 14th District trustee, is chair of the Task Force, appointed by the ADA president in 2005.

The 14-member group held its first meeting in July of that year. It has met 10 times so far—either face-to-face or via conference call—and has segmented the NHII into "logical topics for ease of discussion," as noted in a Task Force report to the 2006 House of Delegates.

The Task Force also noted in its House report that its future assignments include "development of plans for implementation and long-term oversight of NHII activities."

These are clear signs that the Association appreciates the reality that the NHII is coming, that dentistry must be ready for it and that the profession's needs and involvement must be understood in the halls of government—in particular, at the U.S. Department of Health and Human Services, which is driving the NHII initiative, mandated by President Bush in 2004.

"As the federal government looks to build an infrastructure of electronically transferred patient information, it is critical that the dental community be part of that structure," says Dr. Kathleen Roth, ADA president and a Task Force member.

She adds, "As personal information is made available for patients to secure when seeking medical and dental care, the profession must be poised to interact within that network of information transfer."

The ADA supports the NHII as a potential benefit to both patients and professionals.

"Looking at this in terms of my own private dental practice," says Dr. Roth, a general dentist from West Bend, Wis. "I can see clear value in the patient record of current medications accurately accessed through an electronic record, as opposed to a scribbled note from some of my patients trying to self-report.

"As all of us interact with digital records for referrals," adds the ADA president, "a uniform, interoperable plan will be most valuable in the practicing community."

With the NHII, observes Dr. Glecos, "We'll have fewer errors, less paper, better patient management, better health histories. You'll be able to get records that are accurate, not relying only on the say of the patients telling you their medical histories. You'll get it right the first time, up front. And if you need to communicate with other providers, there will be a standard language that everyone understands."

ADA leaders and lobbyists are working with government officials to ensure that the unique character of dental practice is understood and maintained within the context of the NHII. At the same time, the Association, through the Task Force and appropriate ADA divisions, is busy establishing itself as the profession's primary resource on the NHII.


Dr. Roth


Dr. Glecos

Dentists will be able to call on the ADA for information on such nuts-and-bolts issues as in-office hardware and software needs, insurance filings, record-keeping, clinical records, drug prescriptions, patient referrals and more.

"This enormous effort will take many partners within the dental community working together to make progress," says Dr. Roth. "The energy and dedication required to make this work is mind-boggling at this point."

All of which makes 2015 seem just around the corner. ■

Future installments of this ongoing, occasional series will explore the details of how dental practices can prepare for the advent of the NHII and how the ADA can help with that.

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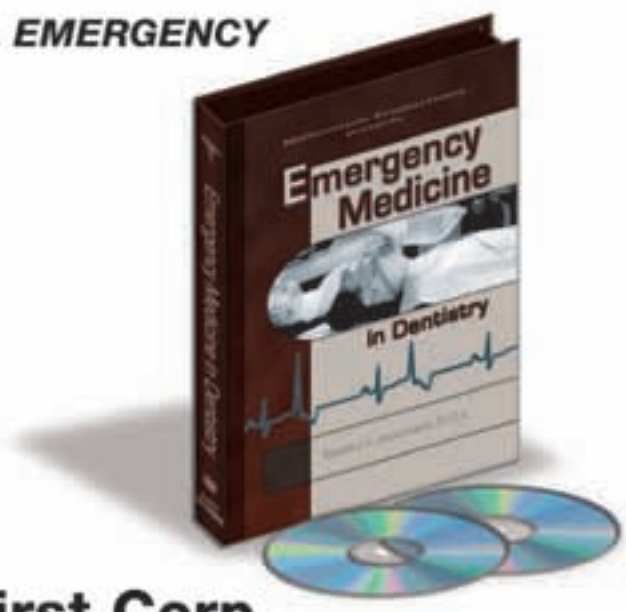

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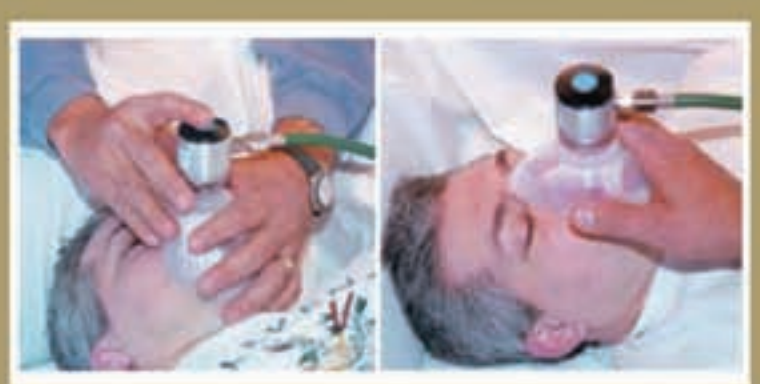

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news PRODUCT

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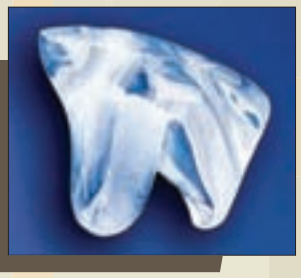

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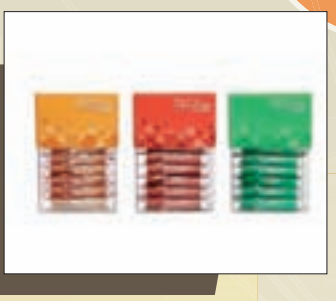

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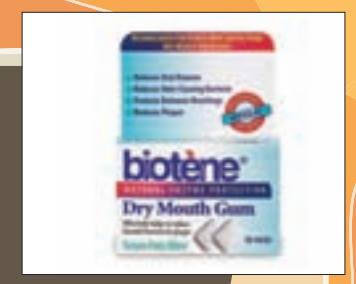

The makers of Biotene and Oral Balance, the #1 dentist and hygienist recommended products for dry mouth relief also feature Biotene Dry Mouth Chewing Gum. Only Biotene Dry Mouth Chewing Gum contains Biotene's exclusive salivary enzyme system to help reduce odor-causing bacteria while protecting the mouth from harmful bacteria growth and plaque build-up between brushings. This fast-acting, non-sticking chewing gum reduces mouth sugars as you chew, helps stimulate saliva production and its unique gum base stays soft to help prevent TMJ problems.

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Sirona Dental Systems, Inc., one of the world's leading manufacturers of high-technology dental equipment, has developed its own range of millable ceramic blocks for the Sirona CAD/CAM systems CEREC and inLab. The feldspath ceramics for chairside restorations (CEREC) are available to customers as CEREC Blocs. Sirona's inCoris product line for dental labs will be expanded to include aluminum and zirconium oxide blocks. The new ceramics assortment will complement the current selection available from Sirona's partners including VITA, Ivoclar Vivadent and 3M ESPE for the CEREC and inLab CAD/CAM systems.

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[* Visit us the Chicago MidWinter Meeting, Feb. 22-25.]

It's time to say thanks

March 4-10 is Dental Assistants Recognition Week

BY ARLENE FURLONG

Delivering Excellence Throughout the World is the theme for the 30th annual Dental Assistants Recognition Week March 4-10. It's a time when dental practices recognize dental assistants for their unique and diverse contributions to the dental profession and the dental health care of the public.

The American Dental Assistants Association, the ADA, the Canadian Dental Association and the Canadian Dental Assistants Association sponsor DARW, which ADA members say is a good week to set aside some time for dental assistants.

"The ADA and dentists across the country take great pride in recognizing dental assistants as a key member of the dental team," says Dr. Billie Sue Kyger, chair of the Council on Dental Practice. "The value of an outstanding dental assistant is truly immeasurable."

A promotional contest is held each year to learn what dentists, dental assisting associations, schools and other organizations do to honor their dental assistants during this week.

Treat time: Dr. Robin Henderson's staff pose with an edible bouquet during DARW 2006.

Dr. Barbara Bates joined three other dentists at Perfect Smile Dentistry in Wellington, Fla., to watch their assistants win second place in the dental practice category in the 2006 DARW contest. Dental assistants there enjoyed luncheons, a brunch, and the publication of an interview with them in the local newspaper. In addition, they visited a local grade school and provided toothbrushes, toothpaste and a presentation on preventive dentistry.

"Dental assistants don't always feel that important," says Cindy Hopkins, office administrator at Perfect Smile Dentistry. "Recognition through DARW is one way they learn they are a vital part of the dental team."

Dental assistants and hygienists consistently report that appreciation for staff efforts is key to professional satisfaction. Employees want feedback, they want to feel appreciated and they want opportunities for professional development, according to employee surveys studied by the Council on Dental Practice.

"As busy as we are, without our dental assistants we wouldn't be able to do it," says Dr. Bates.

Children's Dental Care, Batesville, Ind., won first place among dental offices with its celebrations, which included an ad in the local paper listing each dental assistant. Assistants there reported that the publication created a very positive response from patients who got a kick out of seeing the names they recognized from office visits. Each assistant received a card with a certificate for extra vacation days and a gift certificate from Bath & Body Works.

"Dental assistants anticipate our clinical needs, provide comfort to our patients, multitask, and adapt quickly to new procedures and techniques," says Dr. Kyger, who encourages dentists to recognize their dental assistants during DARW this year. "They are often the glue for providing a smooth and productive day in the dental office."

"It's the one opportunity the dental commanders and noncommissioned officers have to say thanks to their dental assistants," says Pamela Richter, the U.S. Army Dental Command's health promotion director for DARW.

OnlineXtra
www. ada.org/goto/newsextra
For more information related to this story, visit the ADA's Web site, using the Web address above.

Dr. Robin Henderson of Perfection Dental in Clarkston Wash., prepared homemade cakes for her staff throughout the week and on the last day, a cookie bouquet with tooth and toothbrush shaped cookies was presented to each assistant. The team went out for dinner together and each received a card and photo in the ADA's DARW picture frame as a lasting souvenir of the week.

Types of DARW activities that are eligible for contest entry typically fall into two categories—educational/charity events and team rewarding activities. DARW participants and dentists can enter the competition by describing in 100 words or less how they celebrated DARW 2007. All entries must be postmarked by April 2.

For entry forms, ready-to-use ad slicks for state publications and promotional kits, call the ADA toll-free, Ext. 2895 or download copies from ADA.org. The ADA offers a downloadable certificate that can be personalized and framed for display, as well as a complete selection of personalized products at "www.adacatalog.org". ADA CE Online offers courses and special pricing for dental team members. For more information, visit "www.adaceonline.org".

Bath & Body Works is offering a special package designed for DARW. Details are included in the DARW kit or dental practices can call Bath & Body Works directly at 1-800-688-7075. ■

Institute for Diversity in Leadership gains ground on projects serving oral health care, communities

BY KAREN FOX

The newest members of the ADA's Institute for Diversity in Leadership spent the fall of 2006 honing the details of their personal leadership projects, resulting in an array of innovative programs that benefit the communities in which they live.

"Institute class members come to the ADA with wonderful ideas of what they want their leadership project to be," said Dr. Jeanne P. Strathearn, ADA 1st District trustee and chair of the Board of Trustee's Standing Committee on Diversity.

"This may include an event or initiative that they've always wanted to do, but perhaps lacked some skill necessary to complete it," she said. "The Institute is designed to stimulate ideas and provide innovative ways to draw on colleagues, the tripartite system, the Kellogg School of Management, mentors, community contacts and peer support to accomplish their goals."

Added Dr. Strathearn: "The result is programs designed to improve patient health, help practitioners treat patients in need, provide valuable access to oral health care for their communities and encourage diverse high school students to pursue dentistry as a profession."

Made possible by the ADA Foundation through generous corporate contributions from GlaxoSmithKline, Procter & Gamble and Sullivan-Schein, the Institute for Diversity in Leadership is designed to enhance leadership skills of dentists who belong to racial, ethnic and/or gender backgrounds that have been historically underrepresented in leadership roles.

The personal leadership projects are the centerpiece of the Institute, providing members with hands-on leadership experience on a civic or professional issue with guidance from faculty and mentors.

Now entering its fifth year, the Institute continues to garner positive returns for the ADA.

Class of 2007: Drs. Alex Gutierrez (above) and Celia Mendoza (right) describe the rewards and obstacles of their projects Dec. 11.

Several alumni have gone on to pursue leadership roles in their component or constituent societies. Every year, a number of qualified applicants vie for the 12 spaces in the program.

"During the selection process for the 2006 class, the Standing Committee on Diversity was overwhelmed with quality applicants," noted Dr. Strathearn. "It's so difficult to choose just 12 candidates when presented with such a strong pool."

Brochures for the 2007 program are now available. For more information, see story, this page. ■

From elder care to special needs patients, innovation on display

Short descriptions don't do justice to the vision of the Institute for Diversity in Leadership dentists whose projects focus on key oral health needs in their communities. (For more details, contact Joe Martin at "martinj@ada.org" or Ext. 2597.)

Current Institute projects are under way with some expected to be completed by this fall; others are part of ongoing programs that will continue for many years to come:

• Dr. Alejandro Aguirre, Plymouth, Minn.—Developing a mentoring program through which Minnesota dentists can help foreign-trained dentists adapt to practice in Minnesota as they move through the dental school's advance standing program, earn licenses and enter practice.

• Dr. Keith Beasley, Vienna, Va.—Collaborating with families, dentists, churches and educators to increase the number of Northern Virginia dentists who treat special needs patients.

• Dr. Oshmi Dutta, Portland, Ore.—Launching a Web site for dentists on the special challenges and decisions for successfully developing and leading multi-site practices.

• Dr. Alex Gutierrez, Tampa, Fla.—Building an oral health education Web site for parents, teachers, teens and teachers in the Tampa area.

• Dr. Lisa Jacob, Millinocket, Maine—Helping underserved communities benefit from National Health Services Corps programs for mentoring and repaying dental education loans.

• Dr. Conrad Journee, Liberty, Mo.—Launching outreach project to county dentists to help increase access for low-income seniors by joining Missouri's Donated Dental Services program.

• Dr. Marilyn Ketcham, Farmington, N.M.—Bringing together a college, regional medical center, nonprofit agency and dental society to improve access to dental care for severely handicapped individuals.

• Dr. Sandeep Mammen, Bloomfield, Conn.—Communicating the mission of Connecticut's community health centers to the state's wider dental community, informing the state's dental students of career opportunities in the health centers and increasing access to care for those with limited or no access.

• Dr. Karen Mays, Columbia, Mo.—Educating the community and dental professionals about the effects of methamphetamine abuse and encouraging strategies for prevention and early intervention.

• Dr. Celia Mendoza, Montebello, Calif.—Designing an oral hygiene education program for elementary school children for lifelong health.

• Dr. Karen Stewart, Ann Arbor, Mich.—Working with the public library systems to offer "stories-to-go" bags with books and DVDs on first dental visits, oral hygiene, dental conditions and dental careers.

• Dr. Grace Su, New York, N.Y.—Piloting new dental outreach, education and access strategies from the New York University College of Dentistry for the city's Chinese immigrants. ■

Institute seeks new members

Applications are now being accepted for the 2007 ADA Institute for Diversity in Leadership.

New brochures are available by mail, or you can download information from ADA.org. Visit "www.ada.org/goto/diversity".

Upcoming Institute dates are Sept. 5–7; Dec. 10–11; and Sept. 10–12, 2008. Events take place in Chicago.

The application deadline is April 30. For more information, contact Stephanie Starsiak at the ADA at Ext. 4699 or "starsiaks@ada.org". ■

$1 million donation 'sets the bar'

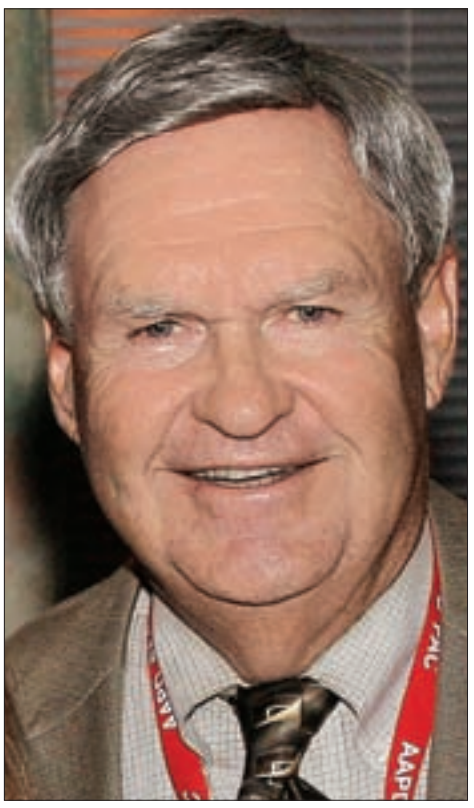
BY KAREN FOX

Pediatric dental education got a major boost in November 2006, thanks to a $1 million pledge from Dr. Jerome B. Miller of Oklahoma City.

The Miller Pediatric Dental Education Fund is a donor-advised fund within the American Academy of Pediatric Dentistry Foundation, a partner organization of the Dental Education: Our Legacy–Our Future campaign.

Through July 1 of this year, AAPD members and benefactors are asked to take Dr. Miller's lead and contribute to a newly established AAPD Foundation fund to support pediatric dental education.

"Dentistry has been wonderful to me," said the past AAPD and AAPD Foundation president who has already donated $131,000 to the pediatric foundation. "I'm so lucky to be a dentist and enjoy a fun practice and career, I felt like it was time to give back. Now is the time to step up and set the bar for my colleagues to support the profession and our specialty."



Dr. Miller: "I felt like it was time to give back."

DENTAL EDUCATION
OUR LEGACY-OUR FUTURE

Funds will be used to "generate bright ideas" to address issues like faculty shortages and escalating educational costs, said Dr. Miller. "How can we recruit new dental educators? How can we better retain the ones we have when private practice is often the more lucrative option? These are things we need to address."

Dental Education: Our Legacy–Our Future, spearheaded by the ADA Foundation, was the impetus for creating the Miller Pediatric Dental Education Fund. Dr. Miller's decision was further influenced by friends and colleagues Dr. Richard Haught, co-chair of Our Legacy–Our Future, past ADA president and fellow Oklahoman, and Dr. Robert T. Ferris, past ADA first vice president, who last year donated $1 million to the Florida Dental Health Foundation and the American Academy of Periodontology Foundation.

"We have to find solutions for the challenges facing our educational system, and these are a few of the people who say there's an urgency and we have to get people who can help," said Dr. Miller. "That really rings my bell." ■

ACD becomes OLOF partner

The American College of Dentists is the newest facilitating partner to join the Dental Education: Our Legacy—Our Future initiative.

The collaborative effort involves the input and participation of hundreds of dental stakeholders and 76 partners to date. Its goals are:

- to raise awareness of the challenges facing dental education in the United States—faculty shortages, lack of diversity, aging physical and clinical facilities, lagging local and state government support, as well as escalating costs;
- to promote a culture of philanthropy within dentistry to address these issues;
- to deliver a call to action—starting within the dental community—to support dental education.

For the latest news on OLOF, its partners, a "donor spotlight" feature or to view a special video on the initiative, log on to "www.ourlegacyourfuture.org". ■

Marketplace

Understanding pay for performance

BY ALBERT H. GUAY, D.M.D.
Special to the ADA News


Dr. Guay

Health care costs in the United States are among the highest in the industrialized nations of the world, while the health status of Americans in several areas falls below that of citizens of other nations that spend less. That's the driver for the "spend less and improve the quality of health care" quest by both governmental and private third party payers. We have seen many efforts in the past that attempted to accomplish this, managed care and consumer driven health plans being recent examples.

A new initiative with strong backing by the federal government has been introduced that, if successful, will have a major impact on the delivery of dental care; an impact far beyond that which is evident at a casual glance. That initiative is called pay for performance (P4P)—a reimbursement plan built upon the philosophy that those who perform well should be reimbursed more than those who perform at a lower level.

More than 100 health plans and some dental benefit plans across the nation have introduced pay for performance reimbursement incentive programs under a variety of names and with varying provisions. In some cases, consortia of insurers with P4P programs have been formed to pool data and to study the effects of those incentives on the cost and the quality of care.

The U.S. government, as the largest purchaser of health care in the nation, is actively investigating the implementation of P4P programs for Medicare and Medicaid. Although the exact nature of the programs is not yet known, it is a certainty that some sort of a P4P program will be adopted. It can be assumed that, with such an economically powerful a program as Medicare taking the lead, P4P programs will be adopted by most payers.

What is pay for performance?

Pay for performance in health plans is a generic term for programs that provide incentives to providers to meet evidence-based performance criteria in clinical care and who document that care through office management systems that track services provided, patient satisfaction and clinical outcomes. Data from such programs should lead to consumer "value-based purchasing" of health care by differentiating among providers based on the quality of their care and their efficiency of operation.

There are essentially two categories of incentives that have been employed in P4P programs to encourage providers to increase the quality of the services they provide: financial incentives and reputational incentives. Financial incentives provide increased reimbursement for preferred behavior—the "carrot" approach to behavior change. The public release of provider performance data affects the reputation of the provider in the community—the "stick" approach to behavior change.

Pay for performance programs have four essential elements, the details of which vary from program to program. Emphasis on any particular element can be an indication of the primary goal of the administrator employing the program. The essential elements are performance measures, data collection, performance targets and performance incentives.

Performance measures

Performance measures for most categories of provider activity have either already been developed or should be fairly easy to develop. Utilization or cost measures are not new, nor are patient satisfaction measures. Patient safety measures, for example, the percentage of patients who were questioned about allergic drug reactions, are easily understood and will probably not be controversial. Administrative efficiency measures are new to health care and will be related to the level of implementation of information technology.

The most difficult area of performance measurement will be in the area of evidence-based clinical quality or the effectiveness of care—meaning outcomes. This area has been the focus of a great deal of activity for many years and one that is rife with controversy. Because of the great variation in patients and the many complications from co-morbidities commonly seen, data individualized to specific patients are not a reliable basis upon which to draw conclusions. Cross-sectional data may be more useful, but only with a very large sample so that patient variations cancel each other out.

Measures of clinical outcomes must be developed by providers, or at least with provider input, in order to be valid, reasonable and acceptable to the practitioner community. Interpretation of the outcomes measures should also be done by practitioners or under practitioner supervision. The American Medical Association Physician Consortium for Performance Improvement has developed almost 100 performance measures that are now in use in physicians' offices and in government P4P demonstration projects.

Data collection

In order to facilitate the process, data collection should be easily accomplished with a minimum of effort and cost on the part of practitioners. Claim forms and the administrative data generated by the plan administrator provide the least intrusive method of generating data, but they may not provide data adequate for the purposes of administering P4P programs. Encounter forms completed at the time of service can provide a greater depth of data, but require additional efforts on the part of practitioners. Electronic data collection and transmission is the ultimate goal of P4P programs.

Retrospective data gathering, such as from chart reviews, is generally shunned in P4P programs. Data are gathered on a contemporary basis at the time of service. The mere fact that performance data are recorded at each patient visit in itself tends to enhance performance.

Performance targets

Performance targets are the essence of P4P programs. They are the "standards" the plan seeks to have its providers achieve. They also indicate what the administrator's real goals are in establishing a P4P program; for example, if the goal is to reduce the per patient expenditures for care, the performance targets will reflect that.

It is important that practitioners are part of the establishment of performance targets. Absent that, "performance" could be defined as just about anything a health plan says it is, with the concomitant effect on providers' compensation and/or reputation.

Performance incentives

When incentives, positive or negative, are the driving force behind attempts to change providers' behavior in health care plans, one can expect considerable discussion of the incentives and how they are used.

Financial incentives should be of sufficient mag-

ADA House addresses pay for performance

The 2006 ADA House of Delegates adopted Resolution 24H-2006, which lists the following 10 principles:

"Principles for Pay for Performance or Other Third-Party Financial Incentive Programs

1. The primary objective of pay for performance (P4P) or other third-party financial incentive programs must be improvement in the quality of oral health care, so performance measures in those plans shall be quality-related.

2. The provisions of P4P or other third-party financial incentive programs must not interfere with the patient-doctor relationship by injecting factors unrelated to the patient's needs into treatment decisions.

3. The incentives in P4P or other third-party financial incentive programs must reward both the achievement of desired quality levels and significant improvement in quality directed toward meeting the desired quality levels.

4. P4P or other third-party financial incentive programs must not limit access to care for patients requiring extraordinary levels or types of care.

5. The incentives in a P4P or other third-party financial incentive program must be positive and of a type and magnitude that will drive improvement in the quality of care or support consistently high quality care.

6. The measure upon which incentive payments are based:

- must be exact, clear, measurable and based on valid science;
- must be standard and have broad acceptance within the dental community;
- must be risk-adjusted to account for patient differences;
- must factor in patient compliance;
- must require a minimum of measurements.

7. Reporting of quality to the public must be fair and provide an opportunity for dentists to comment on ratings. Payers must discuss quality problems they identify with dentists before any public action is taken.

8. Participation by dentists must be voluntary, with no financial penalties for not participating.

9. Savings in costs must not accrue to plans but must be returned to patients in reduced co-payments or expansion of benefits.

10. Regular reassessment of P4P or other third-party financial incentive programs must be done, with input from participating dentists."

The resolution also directs that the ADA use these principles in discussions with organizations designing P4P or other third-party financial incentive programs and also monitor and continue to evaluate pay for performance or other third-party financial incentive programs being implemented in dental benefit plans.

Finally, the resolution states that Association advocacy efforts regarding P4P or other third-party financial incentive programs be guided by these principles. ■

nitude to change behavior. A small compensation bonus will have little effect in changing a behavior that has resulted in a significant increase in practice revenue, particularly in plans that already are driving down compensation. The amount of compensation bonuses in private P4P programs currently is in the 5 percent to 20 percent range. It is a matter of debate whether practitioners should be eligible for incentives only upon achieving performance targets or also for making significant progress toward achieving those targets. In order to be effective, P4P programs must design incentive programs that reward both performance and improvement at levels significant enough to motivate practitioners to modify their behavior.

There are two basic schemes that are being discussed to fund P4P programs: a redistribution of existing funds and the infusion of additional money beyond that already being expended. The revenue neutral redistribution of existing funds is accomplished by withholding a specific amount of practitioners' revenue, usually in the 2 percent to 5 percent range, and those monies are used to fund the incentive bonuses. The "poor" performers are subsidizing the "good" performers, in essence. Obviously, there must always be a pool of "poor" performers to provide this subsidization.

When new money is put into the system to fund incentive bonuses, there is usually no absolute penalty imposed upon "poor" performers; "good" performers are rewarded for their behavior. Although they do not lose any money, "poor" performers may consider receiving no bonus as a penalty. They may look at their situation as reduced compensation compared to the "good" performers.

If P4P programs actually reduce the costs of health care, some feel the "new money" required to finance bonus incentives should come from those savings rather than from reimbursement reductions to "poor" performers. If quality of care improvement is the real goal of P4P programs, actual costs may increase, at least in the short run, since many of the performance measures at this stage of development are measures aimed at identifying areas of under use of diagnostics or treatment. Relying on saved money to fund bonus incentives may have the effect of having cost experience become a significant part of performance targets established for the plan.

Information technology

The operation of a full pay for performance program will depend greatly on the use of information technology, both for administrative purposes and for the individual patient record. A great deal of information must be reported and analyzed in order to make a fair determination of the quality of care provided by a practitioner. This would be prohibitively expensive both for the provider and the administrator without the use of electronic technology.

This poses a significant problem for practitioners, especially individuals and small groups. With the amount of bonus money available in most programs, it is difficult to realize an adequate return on the investment in information technology required for participation in these programs. The cost of establishing an electronic record system is high and its operation is estimated to cost between $12,000 and $24,000 per year. In addition, the successful implementation of electronic records is difficult at this time, adding to the costs, frustrations and disruptions in office administration. It is important that there be significant incentives or cost sharing for practitioners to employ electronic technology if these programs are to reach their full potential for improving health care.

Potential concerns

Pay for performance can evolve into such an all-encompassing program that it has the potential for significant unintended negative consequences. Probably the greatest risk is gaming of the system, a phenomenon frequently seen in P4P programs not related to health care. Individuals with the highest chances of success are preferentially selected for participation. In prospective payment health plans, physicians and hospitals have been found to attempt to enroll healthier patients in order to maximize net revenues. Other potential unintended consequences are decreased access to care for marginal populations, reduction in the quality of care to cut expenses, minimization of treatment in areas not targeted for financial rewards or in areas not included in performance measures.

There are also some concerns about using claims-based information for quality determination, particularly for individuals and small groups. Because of the tiny size of the sample of patients from an individual practitioner, quality determinations may be difficult and the conclusions invalid.

In dentistry, using claims data is even more of a problem since diagnoses, modifying conditions and co-morbidities are not reported. Reporting only "what was done" for consideration of the quality of care provides only one-third of the quality determination equation: what was the diagnosis, what treatment was provided and what was the outcome?

See P4P, page 30

IDS meeting set for March

Cologne, Germany—It's not too late to plan a trip to Germany's "Cathedral City" and the 32nd IDS—International Dental Show—March 20-24.

The world's largest dental trade show, IDS will feature 1,600 exhibitors from some 50 countries worldwide, presenting the latest trends and innovations in the international dental market. The biannual event offers opportunities for dentists, team members and dental laboratory technicians to shop, learn and network through the exhibition and supporting programs organized by the Association of German Dental Technicians Guilds and the German Dental Association.

Meeting stager Koelnmesse makes it easy for visitors to make transportation, hotel, meeting and special weekend package arrangements. Log on to "www.ids-cologne.de" for details. ■

P4P

Continued from page 29

Pay for performance in dentistry

As is frequently the case, innovations in the health care delivery system come to dentistry only after having been developed and tried in the general medical-surgical-hospital sector. We know from long experience that there is often little general transferability of these effects and experiences between medicine and dentistry, notwithstanding the fact that transfer is still attempted regularly.

There are several examples of P4P programs in commercial dental plans, although they may not be identified with that terminology. In Minnesota, Delta Dental participating dentists are classified according to the total cost of oral health care they provide, with the "good" performers receiving a higher level of reimbursement than the "poor" performers. In Rhode Island, Delta Dental will pay participating dentists a bonus per claim if they submit claims electronically directly to Delta. Note that neither of these incentive programs are related to the quality of the dental care provided, but are cost related.

In Colorado, Delta has begun a model P4P which provides financial bonuses to dentists whose practice patterns suggest, according to Delta standards, efficiency, comprehensiveness and compliance with professional standards. Providers whose claims patterns suggest they are providing continuing, comprehensive, prevention-oriented care that does not suggest overtreatment are financially rewarded, while others

are encouraged to modify their practices to qualify for the incentives. Practitioners whose claims suggest inappropriate care can be identified and removed from the network should they not modify their practice patterns to better meet professional standards.

Overall, in dentistry there are no generally accepted/universal quality guidelines or measures developed by the profession, other than some preventive or process measures. Quality guidelines in use in dentistry have mostly been developed by insurers.

In the absence of credible quality guidelines, dental plans wishing to incorporate P4P programs will have to focus their attention on financial goals, patient satisfaction, processes or IT employment. Quality improvement, one of the cornerstones of the rationale for employing P4P programs, most likely becomes unattainable except through very indirect means. This will most likely not be a significant barrier to implementation of P4P programs by insurers, since reduction of their costs is a strong incentive (some would argue, the primary incentive) for insurers to pursue P4P programs, and financial performance measures and targets are very easily calculated from data the carriers already possess.

Where does dentistry go from here?

The implementation of mature and full-blown pay for performance programs in both the private and public sectors will take some time to occur in medicine and, most likely, even longer in dentistry. There is little doubt that they will eventually come, going through an uncertain evolutionary process. They will start with financial considerations and cost reduction, and most likely will progress to true quality of care issues.

When considering the role the ADA should play in this area, it might be well to consider a recent statement by Nancy H. Nielsen, M.D., speaker of the AMA House of Delegates: "There's not a good evidence-based way for most conditions to measure what is exactly the right thing to do—no less and no more. And that's where our profession really needs to be involved, because, if we're not there, frankly, the bean-counters are going to decide what the issues and measures are."

Pay for performance is an urgent situation for medicine, now. Although the same level of urgency does not now exist for dentistry, it may be the time to get ready for that eventuality.

The ADA 2006 House of Delegates adopted Principles for Pay for Performance or Other Third-Party Financial Incentive Programs to be used by payers as guidance in the development of P4P and other similar programs that do not compromise patient care or interfere with the patient-doctor relationship. (See story, page 28.)

For a look at what the government is saying about pay for performance, do a search for that term on the following Web sites: Centers for Medicare and Medicaid Services, "www.cms.hhs.gov", the Agency for Healthcare Research and Quality, "www.ahrq.gov," Health resources and Services Administration, "www.hrsa.gov." ■

Dr. Guay is the ADA chief policy advisor. This is a summary of an analysis he presented to the Board of Trustees in December 2006.

Cosmetic dentistry meeting set for May

Atlanta—The American Academy of Cosmetic Dentistry will hold its 23rd annual scientific session, "Excellence in Cosmetic Dentistry 2007," here May 15-19.

The event will feature more than 100 educators and will provide dentists, laboratory technicians and dental team members with the opportunity to learn through lectures, hands-on workshops and general sessions.

For more information, contact the AACD by phone at 1-800-543-9220 or visit "www.aacd.com". ■

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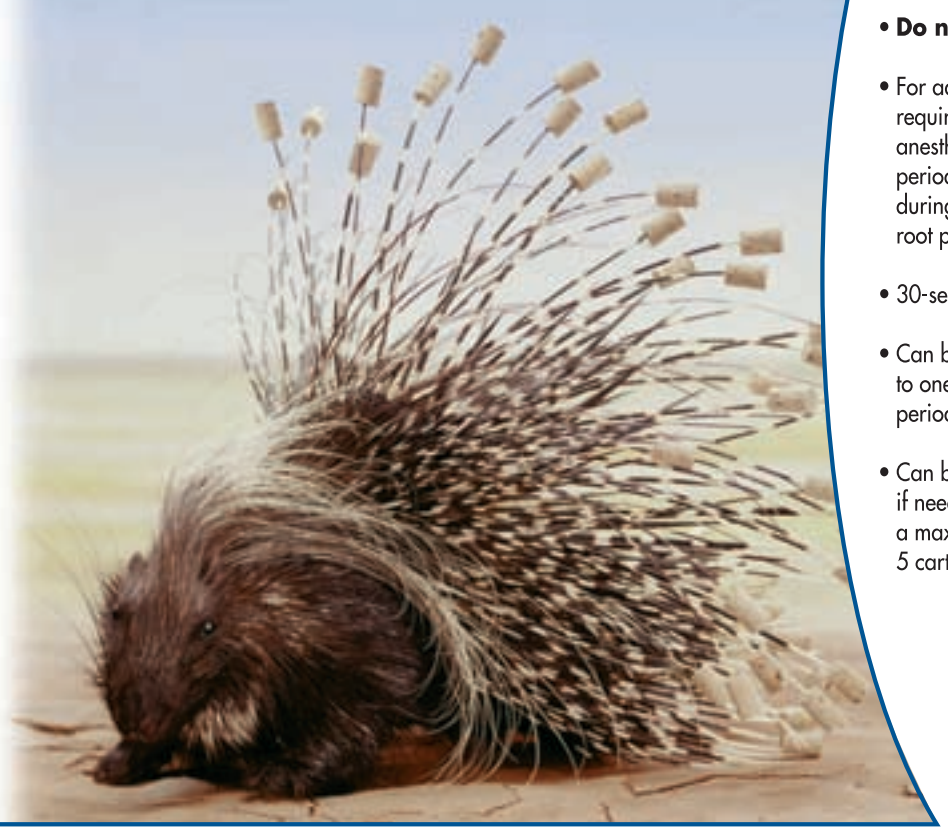
Needle-free, Patient Friendly Anesthesia for Scaling & Root Planing

Needle-free

oraqix®

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



- **Do not Inject**
- For adults who require localized anesthesia in periodontal pockets during scaling and/or root planing
- 30-second onset
- Can be applied to one or several periodontal pockets
- Can be reapplied if needed up to a maximum of 5 cartridges

Don't Get Stuck Without It!

Oraqix provides pain relief and its needle-free application avoids patient concern(s) regarding needles and injections.

- Oraqix should not be used in those patients with congenital or idiopathic methemoglobinemia.
- Novel formulation allows Oraqix to change from a liquid to a gel at body temperature.
- Oraqix is contraindicated in patients with hypersensitivity to amide type local anesthetics or any other product component.
- The most common adverse reactions in clinical studies were application site reactions, headaches and taste perversion.

Please see the accompanying brief summary of the prescribing information.

To order or for more information on Oraqix, contact your authorized DENTSPLY distributor or call DENTSPLY Customer Service at 1.800.225.2787.
Visit our website at www.oraqix.com.

DENTSPLY PHARMACEUTICAL

PM-Oraqix-0118 11/06

48 000 24 80
Local anesthetic for periodontal administration
Not for Injection

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

INDICATIONS AND USAGE
Oraqix® is indicated for adults who require localized anesthesia in periodontal pockets during scaling and/or root planing.

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

WARNINGS
Prilocaine can cause elevated methemoglobin levels particularly in conjunction with methemoglobin-inducing agents. Methemoglobinemia has also 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 infection 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 these 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. If these reactions occur they should be managed by conventional means.

Oraqix® coming in contact with the eye should be avoided because animal studies have demonstrated severe eye irritation. A loss of protective reflexes may allow corneal irritation and potential abrasion. 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, as indicated.
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 should be 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 - Long-term studies in animals have not been performed to evaluate the carcinogenic potential of either lidocaine or prilocaine. 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).

Mutagenesis -o-Toluidine, 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/m^2) 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 (60mg/m^2 and 180 mg/m^2 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. 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% topical cream (See WARNINGS).

Geriatric Use: In general, dose selection for and 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
Following SRP treatment with Oraqix® in 391 patients, the most frequent adverse events were local reactions in the oral cavity (see following table). These events, which occurred in approximately 15% of patients, included pain, soreness, irritation, numbness, vesicles, ulcerations, edema and/or redness in the treated area. Of the 391 patients treated with Oraqix®, five developed ulcerative lesions and two developed vesicles of mild to moderate severity near the site of SRP. In addition, ulcerative lesions in or near the treated area were also reported for three out of 168 patients who received placebo. Other symptoms reported in more than one patient were headache, taste perversion, nausea, fatigue, flu, respiratory infection, musculoskeletal pain and accident/injury.

Table 1.Number (percent) of patients with adverse events occurring in more than one patient in any of the treatment groups. Each patient is counted only once per adverse event. The occurrence in a single patient is included in this table if the same symptom has been seen in at least one patient in another group.

System Organ Class Preferred Team	Oraqix® gel* (N=391) n (%)	Placebo gel (N=168) n (%)	Lidocaine injection* (N=170) n (%)
Muscular-Skeletal System Disorders			
Myalgia	1(0)	2(1)	
Arthralgia and/or Arthropathy	1(0)	1(1)	
Central & Peripheral Nervous System Disorders			
Headache	8(2)	3(2)	5(3)
Dizziness	1(0)	1(1)	1(1)
Special Senses Other, Disorders			
Taste Perversion[1]	8(2)	1(1)	
Gastro-Intestinal System Disorders			
Nausea	3(1)		1(1)
Respiratory System Disorders			
Respiratory Infection	2(1)		1(1)
Rhinitis		2(1)	
Body as a whole-General Disorders			
Accident and/or Injury	2(1)	2(1)	
Fatigue	3(1)		2(1)
Flu-Like Disorder	2(1)		
Pain (remote from application site)	1(0)	1(1)	1(1)
Application Site Disorders**			
Anesthesia Local	2(1)		
Application Site Reaction***	52(13)	20(12)	

[1] includes complaints of bad or bitter taste lasting for up to 4 hours after administration of Oraqix®
* in a cross-over study, 170 subjects received either Oraqix® or lidocaine injection 2% in each test period
** i.e.,symptoms in the oral cavity
*** includes pain, soreness, irritation, numbness, ulcerations, vesicles, edema, abscess and/or redness in the treated area

Allergic Reactions: Allergic and anaphylactic reactions associated with lidocaine or prilocaine can occur. They may be characterized by urticaria, angioedema, bronchospasm, and shock. If they occur, they should be managed by conventional means.

OVERDOSAGE
Local anesthetic toxicity emergency: Oraqix® used at the recommended doses is not likely to cause toxic plasma levels of lidocaine or prilocaine. However, if other local anesthetics are administered at the same time, e.g. topically or by injection, the toxic effects are thought to be additive and could result in an overdose with systemic toxic reactions. There is generally an increase in severity of symptoms with increasing plasma concentrations of lidocaine and/or prilocaine. Systemic CNS toxicity may occur over a range of plasma concentrations of local anesthetics. CNS toxicity may typically be found around 5000 ng/mL of lidocaine, however a small number of patients reportedly may show signs of toxicity at approximately 1000 ng/mL. Pharmacological thresholds for prilocaine are poorly defined. Central nervous system (CNS) symptoms usually precede cardiovascular manifestations. The plasma level of lidocaine observed after the maximum recommended dose (5 cartridges) of Oraqix® in 11 patients exposed over 3 hours ranged from 157-552 ng/mL with a mean of 284 ng/mL ± 122 SD. The corresponding figure for prilocaine was 53-181 ng/mL with a mean of 106 ± 45 SD. (see CLINICAL PHARMACOLOGY, Absorption).

Systemic adverse effects of lidocaine and/or prilocaine are manifested by central nervous system and/or cardiovascular symptoms.

Clinical symptoms of systemic toxicity include CNS excitation and/or depression (light-headedness, hyperacusis, visual disturbances, muscular tremors, and general convulsions). Lidocaine and/or prilocaine may cause decreases in cardiac output, total peripheral resistance and mean arterial pressure. These changes may be attributable to direct depressant effects of these local anesthetic agents on the cardiovascular system. Cardiovascular manifestations may include hypotension, bradycardia, arrhythmia, and cardiovascular collapse.

Management of Local Anesthetic Emergencies: Should severe CNS or cardiovascular symptoms occur, these may be treated symptomatically by, for example, the administration of anticonvulsive drugs, respiratory support and/or cardiovascular resuscitation as necessary.

See warnings on methemoglobinemia on Oraqix® full prescribing information at www.oraqix.com.

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.

DOSAGE AND ADMINISTRATION
The maximum recommended dose of Oraqix® at one treatment session is 5 cartridges, i.e., 8.5g gel.

When administered, Oraqix® should be a liquid. If it has formed a gel, it should be placed in a refrigerator (do not freeze) until it becomes a liquid again. When in the liquid state, the air bubble visible in the cartridge will move if the cartridge is tilted.

DO NOT FREEZE. Some components of Oraqix® may precipitate if cartridges are frozen. Cartridges should not be used if they contain a precipitate.
Do not use dental cartridge warmers with Oraqix®. The heat will cause the product to gel.

Rx only

Manufactured for:
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Karlskoga
Sweden

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DENTSPLY PHARMACEUTICAL