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BRIEFS

ADA Foundation grant program application deadline in July

The ADA Foundation is accepting applications for its Semi-annual Grants Program: Access to Care.

The application deadline is 11:59 p.m. Central Daylight Time on July 29.

The Foundation supports U.S.-based organizations whose charitable activities provide access to care and

ADA Foundation

Charitable Assistance | Access to Care | Research | Education

dental homes to the underserved. Access to care is one of the four pillars of the Foundation, which provides more than \$850,000 in grants, awards and scholarships each year.

Grants of up to \$10,000 each will be awarded.

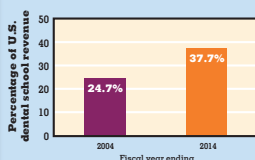
All grant applications must be submitted online. To apply, visit ADAFoundation.org/how-to-apply/access-to-care.

Those with questions can contact Tracey Schilligo, grants manager, at schilligot@ada.org or 1-312-440-2763. ■

JUST THE FACTS

Revenue from tuition and fees

By 2014, student tuition and fees made up a larger share of the revenue at U.S. dental schools, climbing from one-quarter in 2004 to 37.7 percent in 2014.



Source: ADA Health Policy Institute, ADA.org/hpi, hpi@ada.org, ext. 2568

ADA tells Sen. Durbin dentists have improved opioid prescribing record

BY JENNIFER GARVIN

Washington — The ADA May 12 challenged a letter and press release from Sen. Richard Durbin claiming that dentists have not done enough to prevent the widespread abuse of opioid pain medications.

“We disagree with your assertion that the ADA and its members have failed to ‘take responsibility for its

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Bill calls for opioid task force, Page 6.

role contributing to the opioid and heroin epidemic,’ and that dentists are taking advantage of ‘perceived financial incentives to overtreat

pain,’ ” wrote ADA President Carol Gomez Summerhays and Executive Director Kathleen T. O’Loughlin.

Drs. Summerhays and O’Loughlin also included a summary of what the Association has been doing to help keep opioid pain medications from being abused.

Between 2010 and 2012, dentists dropped from the third largest

to the fifth largest group of opioid prescribing specialties, according to the letter.

“This is a testament to what dentistry has been doing to address this issue,” wrote Drs. Summerhays and O’Loughlin.

“We can all do more to keep

See DURBIN, Page 11

First female majority class graduates from Case Western

BY KIMBER SOLANA

Cleveland — Founded in 1892, Case Western Reserve University School of Dental Medicine has held its share of commencement ceremonies. However, its most recent one made school history.

Of the 66 students who received their dental degrees on May 15, 42 of them were women — making it the first majority female graduating class of Case Western dental school.

ADA President Carol Gomez Summerhays highlighted the milestone in her commencement speech to Case Western dental school’s class of 2016.

“When I graduated from dental school, one in every 20 dentists was female,” Dr. Summerhays said. “We’ve come a long way to make sure that the opportunity to practice dentistry is available to every qualified individual.”

The commencement ceremony highlights a change in dental

See CASE WESTERN, Page 12

If he builds it, they will come

California dentist constructs clinic in Philippines

BY DAVID BURGER

Pambujan, Northern Samar province, Philippines — Dr. Ed de la Vega, a Canoga Park, California-based dentist and ADA member for more than 40 years, enjoyed his numerous trips abroad to serve the impoverished in the Philippines, the land in which he was born, but it wasn’t enough. He was frustrated that he wasn’t able to do more. He would always

come home back to the States, knowing he was leaving behind many needing dental care.

So Dr. de la Vega decided to do something different.

On his latest trip to the Philippines in April, with the help of his nonprofit Dentistry For Every Village

See PHILIPPINES, Page 15



Shared smiles: Dr. Ed de la Vega poses with children he and his team treated at a new dental clinic that opened in the Northern Samar province in the Philippines in April.

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ATSU Missouri dental school names new dean

Kirkville, Mo. — A.T. Still University announced May 13 it named Dr. Dwight E. McLeod as the new dean of its Missouri School of Dentistry & Oral Health, effective July 18.

“Dr. McLeod’s professional and leadership experiences match the university’s mission of producing highly competent health professionals and serving the underserved,” said Norman Gevitz, Ph.D., ATSU’s senior vice president of academic affairs, in a news release.

Dr. McLeod, who received his dental de-



Dr. McLeod

science degree and certificate in periodontics

gree from Howard University, is currently professor and chair for the Department of Applied Dental Medicine and section head of Periodontology at the Southern Illinois University’s School of Medicine.

Dr. McLeod earned a master of science degree and certificate in periodontics

from University of Iowa School of Dentistry.

In addition, he is a member of the ADA, American Dental Education Association, American Board of Periodontology, Missouri Dental Society, St. Louis Dental Society and American Academy of Periodontology. In 2000, Dr. McLeod founded the Jamaica Dental Mission, which operates three clinics in western Jamaica and has provided dental care to more than 16,000 patients.

Dr. Don Altman will continue to serve as interim dean until July 18. ■

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MyView

Keeping pace with technology



Stanley Markman, D.D.S.

One of the more challenging aspects of private practice is staying current with new technology. A new aspect of technology is the use of intraoral scanners for impression taking. The technology is expensive but may be even more so than you may anticipate, as I will shortly show. I decided to get involved with a new aspect of technology about two years ago as I found the idea of taking impressions with a digital device intriguing. The idea of taking an impression by simply suspending a scanner over a prepared tooth was fascinating. In addition, the

image obtained could be sent over the Internet to have the crown fabricated; and it could be done without creating a model. Wow!

When I opened my first office in 1962, I had to make but one technology decision at that time. Should I go into extra debt and buy a Cavitron or should I wait until I had the money to make the purchase later. I opted for waiting. Times have surely changed.

My experience with the scanner has been less than good. In order to use it, a consultant was required to teach the technique of its use and associated software technology. Actually, the technology wasn't so daunting. The technique of learning how to physically manipulate the scanner was daunting. I guess my cerebral cortex has shriveled over the years. During my career in dentistry, I received four fellowships; took over 500 hours of implant instruction and learned to place implants; took coursework in orofacial pain; and received both a fellowship and a diplomate of the American Board of Orofacial Pain. However, I was simply not alert or tenacious enough to learn how to use a scanner on a patient. "User-unfriendly" is way too kind of a criticism.

Yet, there I was, toiling and struggling how to manipulate the scanner in order to obtain a good image. I simply could not master the technique. I realized with the passage of time, that the scanner never really solved a problem. Unfortunately, I understand now that technology should solve a problem. There was and still is no problem in taking impressions. The scanner didn't solve a problem. Often, I would schedule a patient for an image, after tooth preparation, and found after 45 minutes I was stuck. Yet, I was able to continue with the operative appointment and obtained an excellent impression in less than 15 minutes.

A significant problem I found with the technology was when I had to prepare a tooth with mesial and distal subgingival restorations. Using gingival retraction in conjunction with some minor laser soft tissue treatment, I easily obtained an impression. I found that using the scanner was difficult, for often, the sulcus would weep and I could not obtain a clear image of the margin. But then again, I had difficulty in obtaining mesial and distal images of the walls of the preparation too.

Another interesting aspect of modern dental technology I learned was that maintaining a warranty (something that you need to pay for) after five years of ownership, of say, a cone beam computed tomography X-ray, will leave you breathless.

With the device less than two years old, I recently saw an advertisement

See MY VIEW, Page 5

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; email to ADANews@ada.org.

SNAPSHOTS OF AMERICAN DENTISTRY

Large dental office employees

The percentage of all dental office employees employed by large dental offices increased from 0.5 percent in 1992 to 3.9 percent in 2012, while the percentage employed by very small dental offices decreased from 89.3 percent in 1992 to 80.7 percent in 2012.



Source: American Dental Association, ADA Health Policy Institute Research Brief, "Considering Large Group Practices as a Vehicle for Consolidation in Dentistry." Available at ADA.org/researchbriefs

Letters

Student debt solutions

In a letter published on April 18, Dr. John W. Sparkman of Amarillo, Texas, offered this advice for dental students graduating with large amounts of debt: "Get a job." This suggestion is an oversimplification of a complex issue and unfairly represents today's dental students and new dentists.

Dental school tuition has increased significantly since Dr. Sparkman graduated in 1976. In the past 15 years, the cost of dental school has far outpaced inflation and nearly doubled. The reason for this increase in tuition, and therefore an increase in the average student loan debt of graduating dental students, is mostly due to the way dental schools are funded.

In 1975, according to the National Academy of Sciences, private and public schools received nearly 65 percent of their total revenue from federal and state funds. At that time, the tuition at dental schools accounted for less than 17 percent of total revenue.

Federal and state funding was drastically reduced during the 2007-09 recession. As these funds depleted, the burden of funding dental school was transferred to students through higher tuition and fees. According to the ADA Health Policy Institute,

student tuition and fees accounted for more than 37 percent of dental school revenue in 2014. State and local support has dropped to roughly 11 percent. Federal funding has fallen below 1 percent.

The American Dental Education Association reports that the average amount of educational debt for 2015 dental school

graduates was \$262,364. Many of these students do have jobs. Some have two. But minimum wage can't keep pace with the rise in dental tuition costs. There are not enough hours in a day to work off this amount of debt while also attending dental school.

Dr. Sparkman may be right that

getting a job is "part of the solution." This is why you'll find content on personal finance in all of the American Student Dental Association's publications and at our national meetings. But that part of the solution doesn't go nearly as far today as it did 40 years ago.

Dental student debt should concern more than just dental students. That's why both ASDA and the ADA lobbied bills on the issue this year. Sure, student loan reform would personally benefit each and every one of us, but reform would also affect all of dental education. We want dental school to be accessible to a diverse applicant pool.

We want dentistry to remain one of the best career options for graduates. Student debt reform is as much about protecting the profession as it is about minimizing our own loan payments.

Sohaib Soliman
President, American
Student Dental Association
Seattle

Editor's note: The ADA News has received numerous letters to the editor in response to Dr. Sparkman's letter. We thank the readers who took the time to write in, but chose the ASDA letter because it encapsulates the essence of what many members wrote in their letters.



CDHC honored for helping kids get dental care

BY MICHELLE MANCHIR

Ardmore, Okla. — Lisa Flatt knows her work has meaning, but perhaps not more so than when she meets children in a clinic or facility who have never had their own toothbrush.

"They either have to share one, or don't have one," said Ms. Flatt, a Community Dental Health Coordinator for the Chickasaw Nation Ardmore Health Clinic. "This breaks my heart. I say 'I will give you a toothbrush, floss and mouthwash.' The look on a child's face that receives a gift is priceless."

For her work as a CDHC, Ms. Flatt was honored in May with an Influential Hero award from The Chickasaw Nation, a federally recognized Native American nation. The nation cited her "passion for outreach in our community," including ensuring dental care for hundreds of children, providing education to parents and children at the local Head Start program, securing grants and donations and coordinating an onsite mobile unit visit with help from the Oklahoma Dental Foundation.

The ADA in 2006 helped launch the Com-

munity Dental Health Coordinator program, partnering since then with colleges for a program that trains people to help respond to the need for oral health literacy and access to preventive and restorative care among underserved populations, including places like where Ms. Flatt works — Native American nations and reservations. These coordinators can help patients bridge such barriers as poverty, geography, language, culture and a lack of understanding of oral hygiene.

Today, seven CDHC training programs exist, or are preparing to launch, in the U.S.

Ms. Flatt, who graduated in 2012 from a CDHC program at the University of Oklahoma, spends much of her time in the dental clinic on The Chickasaw Nation, but also travels to Head Start programs and other children's education centers, helping educate youth about oral health, including tobacco and other health-related topics.

"I have always had a passion to help the



Ms. Flatt

underserved," said Ms. Flatt, who worked in private practice dentistry as a dental assistant for 12 years before becoming a CDHC.

Ms. Flatt said she is committed to her current role.

"I'm honored to receive (the award), but it does not affect the way I look at my job or continue to do my CDHC job," she said. "I plan on educating and getting Native Americans access to care. I have committed to making a difference."

For more information about CDHC programs, visit ADA.org/CDHC. ■

MyView

Continued from Page 4

for a new and improved scanner by the same company. Being a masochist, I called to learn about the details. The first thing I learned was that my high-end laptop, purchased specifically for the original scanner, could not be used for the new, updated scanner. While I did not obtain the price for the new scanner, I did learn that it was more expensive than the original scanner. There was no offer to reduce the price of a new scanner even though I explained that my existing scanner was but 2 years old.

Here is my new plan. Instead of purchasing another scanner, hoping I will be able to use it to embrace new technology that doesn't solve a problem, I will purchase a dividend paying stock from a list of the "Stock Aristocrats." These are stocks, whose dividends have increased for 40 or more years in a row. At the end of five or 10 years, I will have a stock that will produce income without work; I will own something whose value will not likely depreciate to zero and is more than likely to increase. Also, I will be able to take impressions using old-fashioned regular dentistry. Furthermore, I will be able to pass on the investment to others when I shuffle off my mortal coil.

Technology should solve a problem. It should make what we do better. It should reduce operative time or using the same time, be more productive. A digital radiograph produces instant results. It saves time and has other benefits. When the learning curve is mountainous, the technology is not ready for prime time. I believe that what was sold to me was "sucky" technology. Fortunately, my unused scanner will not affect my life because I can afford the loss. You may not be in the fortunate position that I am in.

Think ahead. When you buy that magnificent, glorious CBCT that will tell the world that you are not just a normal mortal person but a high-tech progressive dentist, be mindful of the warranty support needed down the road. ■

Dr. Markman practices in Fort Lee and Newark, New Jersey, and is a clinical assistant professor at the Rutgers School of Dentistry.

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GOVERNMENT

ADA praises FDA for including added sugars in updated Nutrition Facts labels

BY JENNIFER GARVIN

Washington — The Food and Drug Administration announced May 20 that it has finalized new requirements for Nutrition Facts labels, which for the first time emphasize the amount of added sugars in packaged foods.

The new label is consistent with the 2015-2020 Dietary Guidelines for Americans, which advise limiting added sugars to less than 10 percent of the total calories consumed each day. FDA said it hopes the new label will make it easier for consumers to make “better informed food choices.”

“We applaud FDA for giving consumers another tool to make informed decisions about their added sugars intake,” said Dr. Carol Gomez Summerhays, ADA president, in a statement. “For years, we’ve encouraged consumers to monitor — and minimize —

their added sugar intake. Now they can do so simply by reading a nutrition label.”

The ADA has long advocated for greater scrutiny of added sugar’s effect on oral health. In May 2015, the Association filed comments on the Scientific Report of the 2015 Dietary Guidelines Advisory Committee, which served as the basis for developing the new guidelines. In November 2015, the ADA House of Delegates formally endorsed the World Health Organization’s recommendation to limit added sugar consumption to less than 10 percent of daily caloric intake.

“We need more data about the extent to which dental caries rates fluctuate with changes in total added sugar consumption, and over what periods of time,” Dr. Summerhays said. “Until we have better data, limiting added sugar intake to less than 10 percent of energy intake seems like a reason-

able public health goal.”

Most food manufacturers will be required to use the new label by July 26, 2018, according to FDA, although “manufacturers with less than \$10 million in annual sales” will have until 2019 to comply. The FDA said it plans to “conduct outreach and education efforts” on the new label requirements.

“For more than 20 years, Americans have relied on the Nutrition Facts label as a leading source of information regarding calories, fat and other nutrients to help them understand more about the foods they eat in a day,” said Robert Califf, M.D., FDA commissioner, in a news release. “The updated label makes improvements to this valuable resource so consumers can make more informed food choices — one of the most important steps a person can take to reduce the risk of heart disease and obesity.”

Other key updates to the nutrition label include:

- A new design to highlight calories and servings.
- For packages that are between one and two servings, the calories and other nutrients will be required to be labeled as one serving because people typically consume it in one sitting. For instance, a 20-ounce soda will be considered one serving.
- Updated daily values for nutrients such as sodium, dietary fiber and vitamin D that are consistent with Institute of Medicine recommendations and the 2015-2020 Dietary Guidelines for Americans.

For more information about the new labels, visit FDA.gov. For more information about the ADA’s advocacy efforts on nutrition, visit ADA.org/nutrition. ■

—garvinj@ada.org

Organized Dentistry Coalition urges committee to increase annual flexible spending account cap

BY JENNIFER GARVIN

In a time when out-of-pocket costs for health care “have never been higher,” the Organized Dentistry Coalition is urging the House Ways and Means Subcommittee to increase the annual flexible spending account cap from \$2,550 a year to \$5,000.

In a May 25 letter drafted by the American Association of Oral and Maxillofacial Surgeons and signed by 10 dental organizations, including the ADA, the ODC urged the committee to increase the limit so that consumers are able to put more of their pre-tax dollars toward health care expenses.

“We believe this restriction on consumer health care spending has been a major step back for consumers at a time when out-of-pocket costs for health care have never been higher,” stated the letter, addressed to Chairman Pat Tiberi, R-Ohio, and Ranking Member Jim McDermott, D-Wash.

“Out-of-pocket costs for traditional

medical insurance easily exceed the current \$2,550 annual cap,” the letter continued. “When you factor in the rising costs of deductibles, copays and prescription medication, this inflexibility forces some patients to forgo necessary care, including dental care.”

The coalition points out that in 2015 consumers spent an average of \$4,065 for out-of-pocket expenses, according to the 2015 Milliman Medical Index, noting that dental procedures often require out-of-pocket expenses — even for those consumers with dental insurance.

“Many common and necessary dental procedures such as dental implants, a set of braces, a root canal, or even the extraction of an abscessed tooth require out-of-pocket spending,” they wrote. “By restricting consumers to save only 50 percent of what they can expect to spend out of pocket, we are forcing them to make critical medical decisions based on what they can afford, not on

what is medically necessary.”

The ODC also asked the committee to consider legislation which would enable consumers to drive their own health care spending, citing H.R. 1185 as one such example.

In addition to increasing the annual FSA cap to \$5,000 per year H.R. 1185 would:

- Add an additional \$500 to the FSA savings cap for each dependent above two dependents.
- Better prepare for expected and anticipated health care costs by carrying over unused funds and eliminating the IRS’s onerous “use it or lose it rule.”

“This common sense legislation would be a huge step in the right direction and we would strongly encourage the committee to include this legislation as it considers tax-related proposals to improve health care,” concluded the letter. ■

—garvinj@ada.org

Salary threshold guaranteeing overtime pay doubled

BY JENNIFER GARVIN

Washington — The U.S. Department of Labor finalized a rule May 18 that expands the number of full-time workers eligible for overtime pay.

The final rule, which takes effect Dec. 1, doubles the salary threshold — from \$23,660 to \$47,476 per year — under which most salaried workers are guaranteed overtime, according to a White House release.

The rule does not affect hourly workers.

According to the White House, the rule will also:

- Extend overtime protections to 4.2 million additional workers not currently eligible for overtime under federal law.
- Update the salary threshold every three years, ensuring that it “is maintained at the 40th percentile of full-time salaried workers in the lowest income region of the country.”
- Allow bonuses and incentive payments to count toward up to 10 percent of the new salary level — as long as the bonuses are provided on at least a quarterly basis.

The Department of Labor said it received more than 270,000 public comments on the rule, including the Association’s September 2015 letter.

Responses in 2015 from the ADA’s volunteer leaders suggest around 39 percent of all dental offices have at least one employee in a salaried position. ■

—garvinj@ada.org

House bill calls for task force to combat opioid epidemic

BY JENNIFER GARVIN

Washington — The U.S. House of Representatives May 11 passed bipartisan legislation that will establish an interagency task force to provide updated guidance for doctors on prescribing opioid painkillers.

The Association considers the task force, which the ADA supported in a similar measure, an important step towards curbing the rates of addiction, overdoses and deaths associated with prescription opioid abuse.

“Opioid pain medications, such as hydrocodone and oxycodone, have become a leading source of drug abuse among teens and young adults,” wrote ADA President Carol Gomez Summerhays and Executive Director Kathleen T. O’Loughlin in a Feb. 24 letter to the House Judiciary Committee. “As prescribers of these painkilling medications, dentists have a role to play in preventing their diversion, misuse and abuse.”

The bill identifies dentists as one of several

health professions that must be consulted.

“A dental perspective will help clarify the differences between pain management in dentistry and pain management in medicine,” wrote Drs. Summerhays and O’Loughlin.

In addition to forming the task force, the bill also calls for new guidelines for consumer education programs.

For more information about prescription opioid use in dentistry, visit ADA.org/opioids. ■

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* vs. end-rounded regular bristles. † vs. a soft, ordinary toothbrush with end-rounded bristles.

References: 1. Subgingival Access Efficacy Study. Data on file. 2. Interproximal Access Efficacy Study. Data on file.

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New ADA resource offers tips on managing finances

BY KELLY SODERLUND

Successful dental practice owners not only provide the best clinical care, they're also business savvy.

Having a knack for business may not come naturally to some dentists, which is why the ADA Council on Dental Practice, with input from dental practice management consultants and content authorities, is developing a series of practice management resources to help them navigate certain business aspects they may not have learned in dental school.

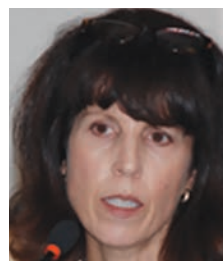
The ADA Guidelines for Practice Success: Managing Finances offers tips on overseeing the revenue and expenses in a dental practice. Dentists can learn how to handle patient financing options; resolve credit card disputes; budget for rent and mortgage; payroll; taxes and more. The module also offers information about different dental benefit plans, including indemnity, managed care, capitation and government-funded like Medicaid and Medicare.

"Running a dental practice means dentists have to be smart business owners as well as masters of clinical work," said Dr. Andrew Brown, chair of the Council on Dental Practice. "Dental practices become successful when their owners understand the importance of tracking expenses, maximizing revenue and minimizing risk. We're developing these guidelines so that all ADA members succeed."

Dentists can access this member-only re-

source on the ADA Center for Professional Success website at Success.ADA.org/gps using their member login and it will be available to purchase in print this summer. The development of the guidelines came from House of Delegates Resolution 62H-2014.

The first module, Managing Patients (P552), is also available online and in print through the ADA Catalog at ADACatalog.org. The book is \$29.95 for members and retails for \$44.90. Use promo code 16121 by July 29 to receive a 15 percent discount on all ADA Catalog product orders.



Dr. Creasey



Dr. Brown

Future modules will include Managing the Dental Team; Managing Marketing; Manag-

ing the Regulatory Environment; and Managing Technology.

"These guidelines are a response to what members have said they need: information on practice management," said Dr. Jean Creasey, chair of the ad hoc advisory committee overseeing the project. "They have the clinical side covered. We're trying to make it easy for them to run the business side of the practice while providing the best patient care. I think members who take the time to visit the practice management guidelines will feel rewarded and inspired to implement many of the ideas in their offices." ■

UCLA dental school announces new dean

Los Angeles — The University of California Los Angeles School of Dentistry announced May 18 it named Dr. Paul Krebsbach, a researcher in tissue engineering and stem cell biology, as its new dean, effective June 30.



Dr. Krebsbach

"Paul brings to UCLA a national reputation as an exceptional leader as well as a deep understanding of the unique mission of public research universities," said Scott Waugh, UCLA executive vice chancellor and provost, in a news release. "I am confident that he will build upon the school of dentistry's tradition of excellence."

Dr. Krebsbach, who received his dental degree from the University of Minnesota, has been a faculty member at the University of Michigan since 1996. He is a Roy H. Roberts Professor of Dentistry and a professor of biomedical engineering. In addition, he served as chair of the department of biologic and materials sciences and division of prosthodontics since 2005. Prior to that, he was a senior staff fellow for three years at the National Institute of Dental and Craniofacial Research.

"I am thrilled to become part of the UCLA community of scholars," Dr. Krebsbach said. "The school of dentistry attracts the very best students and the faculty is exceptional. I'm looking forward to working together to take on the new challenges in dental education and to seizing new and exciting opportunities." ■

Periodontal disease treatment in progress

People have busy lives. ARESTIN® (minocycline HCl) Microspheres, 1 mg gives your appropriate patients a convenient way to keep fighting their periodontal disease, even after they've left your chair. In a clinical study, ARESTIN + scaling and root planing (SRP) reduced harmful bacteria by nearly twice as much as SRP alone.^{1-3*}

Recommend ARESTIN, the treatment that lasts.†

When incorporated into a routine oral maintenance program along with SRP, ARESTIN:

1 | MONTH*

Targeted periodontal bacteria to fight infection at **30 days**¹

3 | MONTHS‡

Provided significantly greater pocket depth reduction for up to **90 days** vs SRP alone⁴

9 | MONTHS‡

Resulted in reduced pocket depth after 1 month and maintained at **9 months**⁵

The effects of ARESTIN on microorganism overgrowth have not been studied beyond 6 months.

†ARESTIN, a sustained-release locally applied antibiotic, remains active in the pocket for an extended period of time.

INDICATION

ARESTIN® (minocycline HCl) Microspheres, 1 mg is indicated as an adjunct to scaling and root planing (SRP) procedures for reduction of pocket depth in patients with adult periodontitis. ARESTIN® may be used as part of a periodontal maintenance program, which includes good oral hygiene and SRP.

IMPORTANT SAFETY INFORMATION

- ARESTIN® is contraindicated in any patient who has a known sensitivity to minocycline or tetracyclines. Hypersensitivity reactions have been reported with its use. Post-marketing cases of anaphylaxis and serious skin reactions such as Stevens Johnson syndrome and erythema multiforme have been reported with oral minocycline, as well as acute photosensitivity reactions.
- THE USE OF DRUGS OF THE TETRACYCLINE CLASS DURING TOOTH DEVELOPMENT MAY CAUSE PERMANENT DISCOLORATION OF THE TEETH, AND THEREFORE SHOULD NOT BE USED IN CHILDREN OR IN PREGNANT OR NURSING WOMEN.
- Tetracyclines, including oral minocycline, have been associated with development of autoimmune syndromes. In symptomatic patients, diagnostic tests should be performed and ARESTIN® treatment discontinued.
- The use of ARESTIN® in an acutely abscessed periodontal pocket or for use in the regeneration of alveolar bone has not been studied.
- The safety and effectiveness of ARESTIN® has not been established in immunocompromised patients or in those with coexistent oral candidiasis. Use with caution if there is a predisposition to oral candidiasis.
- In clinical trials, the most frequently reported nondental treatment-emergent adverse events were headache, infection, flu syndrome, and pain.

Please see Brief Summary of Prescribing Information on adjacent page.

Arestin® minocycline HCl 1mg
MICROSPHERES

*Single-blind, randomized, parallel-group study of 127 patients with moderate-to-severe periodontitis who had at least 5 teeth with >5 mm pocket depths. Mean RCB numbers at day 30 were reduced from 18.9×10^5 to 9.50×10^5 (50%) by ARESTIN + SRP ($p=0.002$) and from 19.3×10^5 to 14.2×10^5 (26%) by SRP alone ($p=0.002$).

‡In 2 multicenter, investigator-blind, parallel-design studies of 748 patients with generalized moderate to advanced adult periodontitis characterized by a mean probing depth of 5.90 and 5.81 mm, subjects received 1 of 3 treatments: (1) SRP, (2) SRP + vehicle, and (3) SRP + ARESTIN. Retreatment occurred at 3 and 6 months after initial treatment, and any new site with pocket depth ≥ 5 mm also received treatment. Patients treated with ARESTIN were found to have statistically significantly reduced probing pocket depth compared with those treated with SRP alone or SRP + vehicle at 9 months after initial treatment. ARESTIN vs SRP alone ($n=250$) $p<0.01$; ARESTIN vs vehicle + SRP ($n=249$) $p<0.001$; ARESTIN + SRP vs vehicle ($n=249$) $p<0.001$.

REFERENCES: 1. Goodson JM, Gunsolley JC, Grossi SG, et al. Minocycline HCl microspheres reduce red-complex bacteria in periodontal disease therapy. *J Periodontol*. 2007;78(8):1568-1579. 2. Doherty F, Lessem J, Hanlon A, Rose T. Efficacy of Arestin in perio maintenance patients. *J Clin Periodontol*. 2003;30(suppl 4):19-100. 3. Grossi SG, Goodson JM, Gunsolley JC, et al. Mechanical therapy with adjunctive minocycline microspheres reduces red-complex bacteria in smokers. *J Periodontol*. 2007;78(9):1741-1750. 4. Williams RC, Paquette DW, Offenbacher S, et al. Treatment of periodontitis by local administration of minocycline microspheres: a controlled trial. *J Periodontol*. 2001;72(11):1535-1544. 5. ARESTIN® (minocycline hydrochloride) Microspheres, 1 mg. Prescribing Information. OraPharma; 2015.

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Application period open for Dr. Ray Bowen Student Research Award

BY DAVID BURGER

Gaithersburg, Md. — The ADA Foundation is accepting applications for the Dr. Ray Bowen Student Research Award until Dec. 1. This award is open to dental students who wish to undertake novel research relevant to operative dentistry. The Foundation offers the award every other year in collaboration with the Academy of Operative Dentistry. The award provides

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\$6,000 to support the student’s proposed research and up to \$1,000 to cover the costs of his or her attendance at the AOD’s annual session, where the student will present a table clinic based on their award-winning research. The award honors Dr. Bowen, a former director of the ADA Foundation Paffenbarger



Dr. Bowen

Research Center (now the ADA Foundation Dr. Anthony Volpe Research Center) and still active as Distinguished Scientist at the research center on the campus of the National Institute of Standards and Technology. Dr. Bowen is the

BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION FOR ARESTIN (MINOCYCLINE HYDROCHLORIDE) MICROSPHERES, 1 MG

This Brief Summary does not include all the information needed to use ARESTIN safely and effectively. See full Prescribing Information.

ARESTIN® (minocycline hydrochloride) Microspheres, 1 mg

Rx only

INDICATIONS AND USE

ARESTIN® is indicated as an adjunct to scaling and root planing procedures for reduction of pocket depth in patients with adult periodontitis. ARESTIN® may be used as part of a periodontal maintenance program which includes good oral hygiene and scaling and root planing.

CONTRAINDICATIONS

ARESTIN® should not be used in any patient who has a known sensitivity to minocycline or tetracyclines.

WARNINGS

THE USE OF DRUGS OF THE TETRACYCLINE CLASS DURING TOOTH DEVELOPMENT (LAST HALF OF PREGNANCY, INFANCY, AND CHILDHOOD TO THE AGE OF 8 YEARS) MAY CAUSE PERMANENT DISCOLORATION OF THE TEETH (YELLOW-GRAY BROWN). This adverse reaction is more common during long-term use of the drugs, but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. TETRACYCLINE DRUGS, THEREFORE, SHOULD NOT BE USED IN THIS AGE GROUP, OR IN PREGNANT OR NURSING WOMEN, UNLESS THE POTENTIAL BENEFITS ARE CONSIDERED TO OUTWEIGH THE POTENTIAL RISKS. Results of animal studies indicate that tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Evidence of embryotoxicity has also been noted in animals treated early in pregnancy. If any tetracyclines are used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be advised that this reaction can occur with tetracycline drugs, and treatment should be discontinued at the first evidence of skin erythema.

PRECAUTIONS

Hypersensitivity Reactions

Hypersensitivity reactions that included, but were not limited to anaphylaxis, angioneurotic edema, urticaria, rash, swelling of the face, and pruritus have been reported with the use of ARESTIN®. Some of these reactions were serious. Post-marketing cases of anaphylaxis and serious skin reactions such as Stevens-Johnson syndrome and erythema multiforme have been reported with oral minocycline.

Autoimmune Syndromes

Tetracyclines, including oral minocycline, have been associated with the development of autoimmune syndromes including a Lupus-like syndrome manifested by arthralgia, myalgia, rash, and swelling. Sporadic cases of serum sickness have presented shortly after oral minocycline use, manifested by fever, rash, arthralgia, and malaise. In symptomatic patients, liver function tests, ANA, CBC, and other appropriate tests should be performed to evaluate the patients. No further treatment with ARESTIN® should be administered to the patient.

The use of ARESTIN® in an acutely abscessed periodontal pocket has not been studied and is not recommended. While no overgrowth by opportunistic microorganisms, such as yeast, were noted during clinical studies, as with other antimicrobials, the use of ARESTIN® may result in overgrowth of non-susceptible microorganisms including fungi. The effects of treatment for greater than 6 months has not been studied. ARESTIN® should be used with caution in patients having a history of predisposition to oral candidiasis. The safety and effectiveness of ARESTIN® has not been established for the treatment of periodontitis in patients with coexistent oral candidiasis. ARESTIN® has not been clinically tested in immunocompromised patients (such as those immunocompromised by diabetes, chemotherapy, radiation therapy, or infection with HIV). If superinfection is suspected, appropriate measures should be taken. ARESTIN® has not been clinically tested in pregnant women. ARESTIN® has not been clinically tested for use in the regeneration of alveolar bone, either in preparation for or in conjunction with the placement of endosseous (dental) implants or in the treatment of failing implants.

Information for Patients

After treatment, patients should avoid chewing hard, crunchy, or sticky foods (i.e., carrots, taffy, and gum) with the treated teeth for 1 week, as well as avoid touching treated areas. Patients should also postpone the use of interproximal cleaning devices around the treated sites for 10 days after administration of ARESTIN®. Patients should be advised that although some mild to moderate sensitivity is expected during the first week after SRP and administration of ARESTIN®, they should notify the dentist promptly if pain, swelling, or other problems occur. Patients should be notified to inform the dentist if itching, swelling, rash, papules, reddening, difficulty breathing, or other signs and symptoms of possible hypersensitivity occur.

Carcinogenicity, Mutagenicity, Impairment of Fertility

Dietary administration of minocycline in long-term tumorigenicity studies in rats resulted in evidence of thyroid tumor production. Minocycline has also been found to produce thyroid hyperplasia in rats and dogs. In addition, there has been evidence of oncogenic activity in rats in

studies with a related antibiotic, oxytetracycline (i.e., adrenal and pituitary tumors). Minocycline demonstrated no potential to cause genetic toxicity in a battery of assays which included a bacterial reverse mutation assay (Ames test), an *in vitro* mammalian cell gene mutation test (L5178Y/TK+/- mouse lymphoma assay), an *in vitro* mammalian chromosome aberration test, and an *in vivo* micronucleus assay conducted in ICR mice. Fertility and general reproduction studies have provided evidence that minocycline impairs fertility in male rats.

Teratogenic Effects

Pregnancy Category D. (See **WARNINGS**.)

Labor and Delivery

The effects of tetracyclines on labor and delivery are unknown.

Nursing Mothers

Tetracyclines are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from the tetracyclines, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother. (See **WARNINGS**.)

Pediatric Use

Since adult periodontitis does not affect children, the safety and effectiveness of ARESTIN® in pediatric patients cannot be established.

ADVERSE REACTIONS

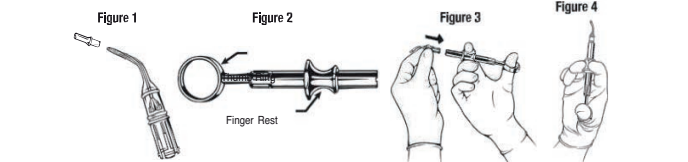
The most frequently reported nondental treatment-emergent adverse events in the 3 multicenter US trials were headache, infection, flu syndrome, and pain.

Table 5: Adverse Events (AEs) Reported in ≥3% of the Combined Clinical Trial Population of 3 Multicenter US Trials by Treatment Group			
	SRP Alone N=250	SRP + Vehicle N=249	SRP + ARESTIN® N=423
Number (%) of Patients			
Treatment-emergent AEs	62.4%	71.9%	68.1%
Total Number of AEs	543	589	987
Periodontitis	25.6%	28.1%	16.3%
Tooth Disorder	12.0%	13.7%	12.3%
Tooth Caries	9.2%	11.2%	9.9%
Dental Pain	8.8%	8.8%	9.9%
Gingivitis	7.2%	8.8%	9.2%
Headache	7.2%	11.6%	9.0%
Infection	8.0%	9.6%	7.6%
Stomatitis	8.4%	6.8%	6.4%
Mouth Ulceration	1.6%	3.2%	5.0%
Flu Syndrome	3.2%	6.4%	5.0%
Pharyngitis	3.2%	1.6%	4.3%
Pain	4.0%	1.2%	4.3%
Dyspepsia	2.0%	0	4.0%
Infection Dental	4.0%	3.6%	3.8%
Mucous Membrane Disorder	2.4%	0.8%	3.3%

The change in clinical attachment levels was similar across all study arms, suggesting that neither the vehicle nor ARESTIN® compromise clinical attachment.

DOSAGE AND ADMINISTRATION

ARESTIN® is provided as a dry powder, packaged in a unit dose cartridge with a deformable tip (see Figure 1), which is inserted into a spring-loaded cartridge handle mechanism (see Figure 2) to administer the product. The oral health care professional removes the disposable cartridge from its pouch and connects the cartridge to the handle mechanism (see Figures 3-4). ARESTIN® is a variable dose product, dependent on the size, shape, and number of pockets being treated. In US clinical trials, up to 122 unit dose cartridges were used in a single visit and up to 3 treatments, at 3-month intervals, were administered in pockets with pocket depth of 5 mm or greater.



The administration of ARESTIN® does not require local anesthesia. Professional subgingival administration is accomplished by inserting the unit-dose cartridge to the base of the periodontal pocket and then pressing the thumb ring in the handle mechanism to expel the powder while gradually withdrawing the tip from the base of the pocket. The handle mechanism should be sterilized between patients. ARESTIN® does not have to be removed, as it is bioresorbable, nor is an adhesive or dressing required.

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inventor of resin composites and dentin adhesives and an internationally recognized authority on composite materials.

Dr. Bowen, who began his research career experimenting with resin composites on his back porch, said he was honored to have the award named after him. “It’s very pleasing and I appreciate it,” he said. He encouraged younger people that had the aptitude and curiosity to pursue research. “It’s a good endeavor if they have enough interest and objectives in mind.”

The most recent winner of the award is Andres Alvarez, a dental student at the University of Florida College of Dentistry. His research centered on a new arginine-based bonding agent with long-lasting anticaries activity, and he presented the findings of his research at the AOD’s annual session in February in Chicago after spending 2005 conducting his research.

Complete information on how to apply is located at ADAFoundation.org/en/how-to-apply/research. ■

Register for Management Conference

BY KIMBER SOLANA

Local, state and national dental society executives seeking to connect and collaborate with their peers can register for the 2016 Management Conference from June 1 to July 9.

Management Conference Week, held at ADA Headquarters, begins July 18 with workshops and meetings geared to special groups of state and local executives. A welcome reception is scheduled for July 19, followed by the conference July 20-21.

Attending the ADA Management Conference is one of the few opportunities dental society executives have to interact with dental society executives from other states, said Drew Eason, executive director of the Florida Dental Association.

“Often the challenges we face have been faced already by an executive in another state — the opportunity to talk through those problems and learn from others how they overcame them is invaluable — making that alone worth the cost of going,” he said.

Along with networking and various sessions, the keynote speaker is Andrew Miller, author of the business book, “Redefining Operation Excellence,” will discuss the topic of “Boosting Results Through Operational Excellence.”

“I’ve never missed an ADA Management Conference,” said Mike Koonce, executive director of San Diego County Dental Society. “It’s the best professional development meeting I attend all year. It provides an executive director with a great overview of what’s going on in association management and specific tools to improve our local or state associations in every area from governance to marketing.”

Registration is \$330 for the primary attendee; \$265 for additional attendees. Rates increase \$50 for onsite/day of registration. Hotel discounts are available, with hotel reservation deadline set for June 16.

For more information on the 2016 Management Conference, visit ADA.org and search “management conference” or contact Leadership Team Services director Joe Martin at martinj@ada.org. ■

Online course covers dentistry, diabetes

BY MICHELLE MANCHIR

When Dr. Cesar Sabates noticed a patient was slow to heal after a routine extraction, he wanted to find out more about him.

"After asking him several questions, I suspected that he may have diabetes and referred him for testing," said Dr. Sabates, a Florida dentist and the chair of the ADA Council on Access, Prevention and Interprofessional Relations. "The patient was very grateful for my referral and concern and it did indeed turn out that he had diabetes."

To help other dentists understand the signs, symptoms, risk factors and systematic complications of diabetes, CAPIR has developed an online course, "Diabetes Mellitus and the Dental Professional." It is available at ADAonline.org by searching for the course title.

With an estimated 29.1 million people in the U.S. — or 9.3 percent of the population — living with diabetes, it is likely dentists are regularly treating patients with the disease.

"Many patients visit the dentist more often than they visit their primary health provider. It is often the dentist that identifies early signs and symptoms of diabetes and makes the appropriate referral to a health care provider," Dr. Sabates said.

The course will summarize the evidence-based relationship between periodontal disease and diabetes and will note special considerations involved in treating these patients, in addition to other topics.

By treating and controlling periodontal diseases, dentists play a critical role in a collaborative medical team approach in the care and management of diabetics, said Dr. Tim Fagan, chair of CAPIR's interprofessional relations subcommittee.

"All health care providers can play a role in diabetes primary prevention and diabetes

management," Dr. Fagan said. "Research has shown that people with diabetes may be at increased risk of gingivitis and periodontitis, that periodontal disease may affect blood glucose levels, and that treatment of chronic periodontal disease may help improve glycemic control."

Dr. Jerry Brown, a retired clinical dentist who is the first health professional with a dental degree to earn board certification as a Certified Diabetes Educator from the National Certification Board for Diabetes Educators, is

an author of the CE course.

The second section of the video features Jordan Ashton, D.O., a Wisconsin-based physician who focuses on preventive medicine; and Dr. Srinivas Challa, a dentist who works with Dr. Ashton on a bidirectional referral project for patients with diabetes.

Dr. Brown, who has Type 1 diabetes and is outspoken about educating dentists on the topic, spoke with the members of CAPIR at their January meeting. Dr. Sabates said developing this course is one of the

ways the council moves toward its goal of addressing issues that help both ADA members and "the overall health care of our nation."

Two CE credits are available for the course.

For more information about this and other ADA CE courses, visit ADA.org/CE. The ADA Science Institute has compiled a list of resources regarding diabetes and oral health. Visit ADA.org/en/member-center/oral-health-topics/diabetes. ■

—manchirm@ada.org



Dr. Sabates



Dr. Brown

Durbin

Continued from Page 1

prescription pain medications from becoming a source of harm in our communities," they concluded. "For our part, the ADA will continue raising professional awareness about prescription opioid abuse, encouraging dentists to complete CERP-recognized training in model opioid prescribing, and urging every dentist to register with his or her state prescription drug monitoring program."

For more information about prescription opioid use in dentistry, visit ADA.org/opioids. ■

—garvinj@ada.org

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PrecisionDentalEstheticLab	Los Angeles, CA 323-399-7270		InternationalDentalArts	Tulsa, OK 800-741-0002	
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Get ADA technical reports at no cost

BY MICHELLE MANCHIR

Internet security, digital imaging and electronic health records are all subjects of ADA technical reports, and are available for download at no cost to members.

"Don't let the moniker 'technical report' scare you off," said Dr. Terry O'Toole, vice chair of the ADA Council on Dental Practice. "Technical reports, frequently referred to as TRs, are written to describe and explain a particular topic for both the nontechnical as well as the technically inclined reader."

Previously available for download for a fee, the technical reports offer up-to-date information on new materials, technologies or software; or are tutorial in nature, helping members specify and select new hardware, software and devices of all types.

Technical reports are developed and vetted by ADA experts. Dentists, academicians, dental product manufacturers and other interested subject experts collaborate to develop the reports and consider comments from the public about them. Next, affiliated ADA council and standards committees review them for final approval.

"The goal of the technical report is to provide information that is useful to members in support of their practice," said Dr. Gregory Zeller, ADA Standards Committee on Dental Informatics chair. "The focus of each report is to offer solutions to real-world issues that dentists face."

ADA members can access technical reports at the ADA catalog, ebusiness.ADA.org and search for "technical reports." ■

Survey shows more pregnant women in U.S. visiting a dentist

BY MICHELLE MANCHIR

Oak Brook, Ill. — The number of pregnant women in the U.S. going to the dentist has increased 5.5 percent over the last year, according to survey data released in May from Delta Dental Plans Association.

In 2015, 57.5 percent of mothers in the United States reported they visited the dentist during their pregnancy, Delta Dental Plans Association said. The 2016 survey results show that number has increased to 63 percent.

"This is positive news and we're glad expectant mothers are increasingly visiting the dentist. Oral health issues have a heightened risk of occurring during pregnancy, so being aware and on top of these is crucial," said Dr. Bill Kohn, Delta Dental Plans Association's vice president of dental science and policy, in a news release.

Most women who reported seeing a dentist during pregnancy — 37 percent — said it was a routine checkup, while 13 percent said they wanted to address a particular oral health issue and six percent said they wanted to discuss what to expect when it came to oral health while pregnant.

The survey was conducted between Dec. 16, 2015, and Jan. 14, 2016, among a nationally representative group of 1,607 parents of children 12 and under.

Dental professionals can use ADA's consumer website, MouthHealthy.org, to help inform patients about what's safe and healthy for them during pregnancy. For more information, visit MouthHealthy.org/pregnancy.

In 2015, The Journal of the American Dental Association published research that showed it's safe for pregnant women to undergo dental treatment with local anesthetics.

The researchers compared the pregnancy outcomes between a group of women exposed to dental treatment with anesthetics and a control group that did not have treatment. The study showed that exposure to dental care and local anesthetics during pregnancy is not associated with increased risk for major medical problems in newborns.

To see that article, visit jada.ADA.org and search for the article title, "Pregnancy Outcome After In Utero Exposure to Local Anesthetics as Part of Dental Treatment." ■

Case Western

Continued from Page 1

schools and the profession over the past several decades. In 2014, 47.7 percent of first-year dental students were women, according to the ADA Health Policy Institute. That's up from 1.1 percent in 1968.

"At Case Western Reserve University School of Dental Medicine, anyone who applies to our school is treated fairly and equally, regardless of gender or race or any other factors," said Dr. Kenneth Chance, dean. "That says it all to me, and we're proud of that." ■

—solanak@ada.org



History: Dr. Carol Gomez Summerhays, ADA president, gave a commencement speech May 15 at Case Western Reserve University School of Dental Medicine, as Dr. Kenneth B. Chance, dental school dean, and Dr. Kristin Z. Victoroff, associate dean for education, look on. In her speech, Dr. Summerhays highlighted that 42 of the 66 graduates were women, making the class of 2016 the first majority female graduating class in school history. The dental school was founded in 1892.

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References: 1. GSK DOF RH02006. 2. Shellis RP et al. J Dent 2005; 33(4): 313-324. 3. Schemehorn BR et al. J Clin Dent 2011; 22(1): 11-18. 4. Hughes N et al. J Clin Dent 2009; 20(7): 218-222. 5. GSK DOF - 2860473. 6. GSK DOF - Z2860435.

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Infection control courses available from CMS

Three new courses from the Centers for Medicare and Medicaid Services aim to teach health care professionals about infection control and injection safety.

Infection Control: Environmental Safety, Infection Control: Injection Safety and Infection Control: Hand Hygiene are web-based training courses offered on the Medicare Learning Network website at learner.mlnlms.com/Default.aspx. Continuing education credit is available for participating.

In the environmental safety course, dentists can learn about proper cleaning practices in health care facilities; categories of environmental surfaces; and turnover cleaning versus terminal cleaning. The injection safety course will discuss safe injection practices; single dose/single use versus multi-dose medications; and injection safety scenarios.

Dentists can also learn about hand hygiene in patient care zones and nearby administrative areas; appropriate methods for maintaining good hand hygiene; and how to recognize opportunities for hand hygiene in a health care setting.

A login and password is required to access these courses. ■

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Communities favor water fluoridation

Dentists play a role in educating the public on its safety, efficacy

BY MICHELLE MANCHIR

Marin County, Calif. — An initiative aimed at removing supplemental fluoride from the water here failed, in part, local leaders say, because people listened to their dentists.

“We heard that, towards the end, the group (gathering signatures for the anti-fluoridation ballot issue) was having a very difficult time getting people to sign and a very common reason was ‘because my dentist told me not to,’” said Dr. Rita Lanphier, Marin County Dental Society president, and Dr. Alan Cascio, Marin County Dental Society trustee, in a May letter to supporters.

Those opposing fluoridation in the county of about 260,000 residents had until May 9 to collect 11,000 signatures that would have required the local water district to stop using fluoride in water until the water district provided to its customers a list of all chemicals in the water and “a written statement verifying the fluoridating chemical’s safety for ingestion, once introduced into the water supply.”

The fluoridation opponents were about 2,500 signatures short, according to the Marin County Dental Society.

Marin Municipal Water District has fluoridated its water for more than 30 years, according to the district website, after a majority of voters approved it in 1972 and again in 1978.

Collier County, Florida

Thanks in part to local dentists and physicians sharing the value of fluoridation with the public, commissioners here voted 4-1 in May to maintain community water fluoridation.

The question of whether to remove fluoridation came after a citizen petitioned the commissioners to stop the practice, launching a months-long discussion among county leaders, dental and medical professionals and residents.

“I’ve spent my life promoting health and well-being,” said Dr. Scott Tomar. “Why would I, or any of these groups whose mission is about public health, endorse community water fluoridation if it wasn’t safe and effective?”

Dr. Scott Tomar, professor at the University of Florida College of Dentistry, was among those who shared with commissioners and the public information about the benefits and safety of community water fluoridation.

“What I tried to convey is I’ve spent my life as a dentist and as a public health worker. If there were any doubt in my mind about the safety of community water fluoridation, I would not be advocating it. I would not have raised my own two kids drinking it,” Dr. Tomar said. “I’ve spent my life promot-

ing health and well-being. Why would I, or any of these groups whose mission is about public health, endorse community water fluoridation if it wasn’t safe and effective?”

The county’s water system has about 160,000 customers, according to the county website.

Downingtown, Pennsylvania

The Downingtown Municipal Water Authority board voted in May to continue water fluoridation for this borough.

The water authority, which serves about 3,500 customers, had notified the public in March that it intended to cease fluoridation. After Dr. Karin Brian, a Downingtown dentist, notified the Dental Society of Chester County and Delaware County about the notice, “a member awareness campaign ensued,” Dr. Brian said.

The society encouraged local dentists to contact the water authority and share facts about the safety and benefits of community water fluoridation. Dr. Brian, other dentists and dental team members also attended water authority meetings.

“I believe water authority board members considered the letters and emails that were received, which were more in favor of keeping the fluoride in versus removal,” Dr. Brian said. “The board of directors realized the benefit of water fluoridation to the community, despite the cost to residents to maintain and upgrade the system.”

Albuquerque, New Mexico

The water utility authority here voted 4-2 in May to remove proposed funding for supplemental drinking water fluoridation, according to the water authority website.

About \$250,000 had been budgeted (out of a \$212 million total budget) for the installation of fluoridation equipment with another \$250,000 slated for annual operations and maintenance.

“We are disappointed that the Albuquerque Bernalillo County Water Utility Authority staff unilaterally discontinued the 40-year practice of supplement fluoridation,” said New Mexico Dental Association President Michael Law. “By ignoring the public health benefits supplemental water fluoridation provides, the ABCWUA has put the oral health of our most vulnerable populations, the young and the underprivileged, at risk.”

Newport, Oregon

Most voters in Newport said “no” – 2,335 to 1,315 – to a resolution in May asking whether the local water authority should resume a fluoridation program.

The city had been fluoridated until 2005, when it was suspended in part because of physical limitations in the city’s chemical room, according to city documents. Before that, the city had been fluoridated after residents voted to support it in 1962.

The ADA endorses community water fluoridation. For more information, resources and testimonials about the safety and benefit of fluoridation, go to the website ADA.org/fluoride. ■

—manchirm@ada.org

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Philippines

Continued from Page 1

Foundation, he finished building a full-service dental clinic in the province of Northern Samar and turned it over to the Sisters of the Order of St. Benedictine, who are running the clinic.

The clinic served more than 400 people in the first two days of its opening. "Many of the patients, particularly the very young and those in their early teens, had never seen a dentist before," he said. "One rather elderly lady even confessed to us that she has never visited a dentist in her entire life. And she was in her 60s."

Dr. de la Vega's success with that first clinic has spurred him to build another clinic in the Philippines, designed to help the indigenous Ati people in the Capiz province, in the central part of the country.

"For years, I wanted to do something to give back and make a difference," Dr. de la Vega said. "But I could not do much as I had four kids to send to college. Now that my personal responsibilities at home are done, and I am in the twilight of my dental practice, I have more time to do my humanitarian work, much like my father did many years before me."

Dr. de la Vega's late father was a dentist in the Philippines. "Occasionally I would accompany him to rural areas in the country to do dental missions for the poorest of the poor," Dr. de la Vega said. "Seeing the results of his work for the poor inspired me to do the same. It was then that I decided to follow his footsteps and went to dental school."

After earning a D.M.D. degree from the University of the Philippines College of Dentistry and completing an internship in general dentistry in Montreal, Dr. de la Vega learned upon moving to the U.S. in 1968 that he wouldn't be able to receive a dental license. He then enrolled and graduated from the University of Southern California School of Dentistry (now the Herman Ostrow School of Dentistry of USC).

"Going to USC for another dental degree and the privilege to take the licensing exams in California or any state in the country opened my eyes to what dentistry is all about," he said. "It made me the dentist I am today."

Being a dentist meant giving back, and over the years, he traveled to his homeland to attend Philippine Dental Association conventions (as well as to visit his mother's gravesite). "I met many dentists from different corners

of the country and heard stories about their struggles to provide dentistry," Dr. de la Vega said. After many years of limited-time humanitarian missions, "I spoke to many friends in the Philippines and got ideas and advice as to how I can be most effective."

"That is when I found out that a religious order involved in health care and education on the island of Samar in the central Philippines was looking for help," he continued. "I decided to help them since they recently built a small 25-bed hospital. More importantly, they were willing to provide a space for a dental clinic and were willing to manage the clinic. All they asked for was for me to build and equip the clinic."

Construction of the clinic began in November,

and after multiple visits from Dr. de la Vega and foundation volunteers, the clinic was completed, blessed and opened in April. A young dentist from the area and visiting dentists from the local Group A Dental Associates will staff the clinic, which will be open at least three days a week and features a digital dental X-ray system.

"The gleam in their eyes and the shy smiles on their faces after their problem is resolved speaks volumes," Dr. de la Vega said. "It's the best 'thank you' ever that I have received from anyone I have treated in my over 50 years of doing dentistry."

Dr. de la Vega's latest endeavor impressed one of his friends, Dr. Mary Satuio, assistant clinical professor at the Herman Ostrow

School of Dentistry of USC. "Building the office to serve the indigent population of that province is a very big deal," she said. "He's a man of integrity. He looks out for people who need help, and he never gets tired of helping people. He gives so much of his time and resources — it's amazing."

Learn more about the Dentistry For Every Village Foundation at dentistryforeveryvillagefoundation.com.

To learn about volunteer opportunities with other nonprofit organizations providing dental care to people in need around the world, visit the ADA Foundation's International Volunteer website: internationalvolunteer.ADA.org. ■

— burgerd@ada.org

Affordable Care Act Information Returns webinar available online

Washington — The Internal Revenue Service has posted a webinar for health care providers and employers about the process for identifying and reporting errors on Affordable Care Act Information Returns.

The webinar defines a corrected information return and also explains how to identify and correct errors on information forms. The webinar may be viewed on the IRS Video Portal at irsvideos.gov. ■

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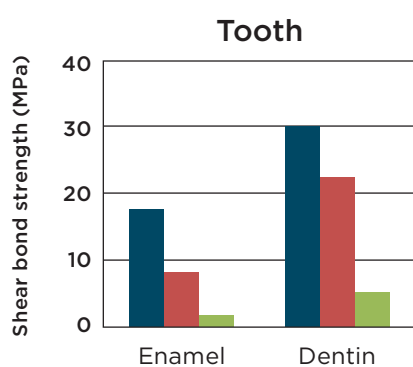
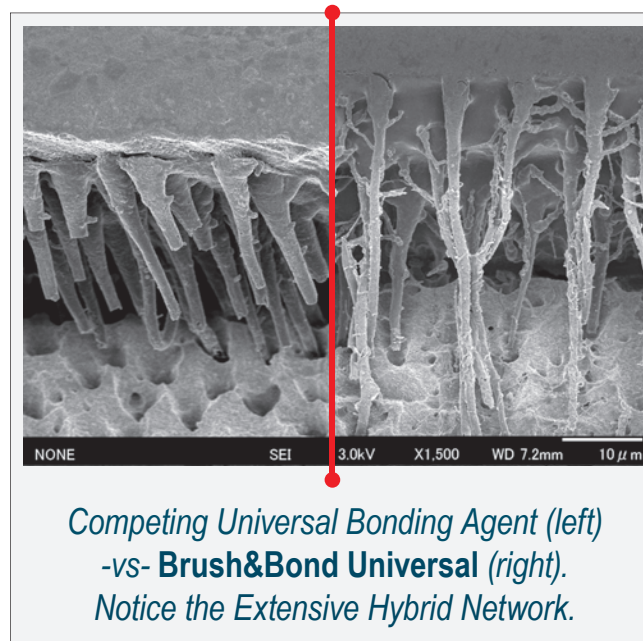
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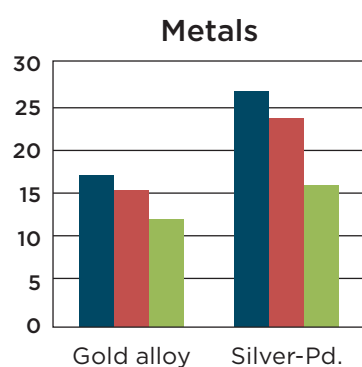
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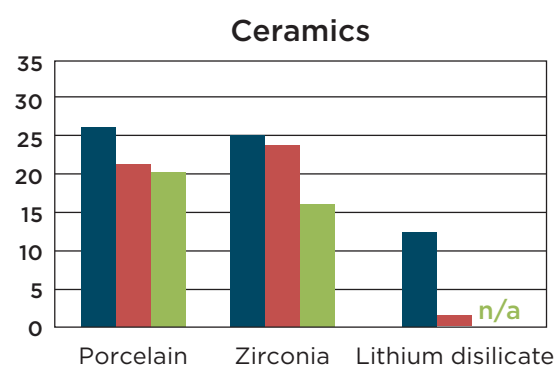
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* Metals & ceramics were pretreated as per manufacturer's recommendations prior to application of appropriate primers. Studies conducted In-House.