GP NEWS

The Publication for the General Practitioner

Volume 39, Number 3 September, 2015

AGD at the Nation's Capitol

CONTINUING TO REPRESENT THE GENERAL DENTIST

Dr. Myron J. "Mike" Bromberg, *Reseda*

Fifty some odd years ago a group of general dentists formed the Academy of General Dentistry (AGD) for the purpose of enabling general dentists to receive what heretofore was not available to them; high quality continuing education in various areas of expertise.

As time progressed, it became apparent that entities outside of the profession as well inside of the profession were advocating and promoting changes which would significantly limit the treatment and types of procedures general dentists would be capable of or allowed to be performing. It became clear that, in addition to providing upper level continuing education, it was necessary for the AGD to express and represent the needs, interests, concerns and issues of general dentists. That led to the creation of the advocacy arm of the AGD, which now consists of two fully-functioning councils and a fully qualified staff to monitor them. The Council on Legislation and Governmental Affairs and the Council on Dental Practice confront the issues on a daily basis that general dentists face, or will face in their practices.

To that end, throughout the year as necessary, AGD representatives descend on Washington, D.C. to discuss dental related issues. In addition, once a year, the AGD has a "Hill Day," where AGD members from around the country meet in our nation's capitol to discuss issues with legislators, regulators and lobbyists and attempt to influence the direction these issues have on our profession.

This year, as in many recent years, the issues were critical and significant. One of these issues had to do with supporting a new bill which would make it easier for poor people and people with limited access to a dentist to receive dentistry. This is important since there are numerous proposals to create a new type of provider with limited education to deliver certain dental procedures to people in this category. There has been a groundswell of movement in this direction and a few states have already adopted this new type of provider. Although this is essentially a state issue, there is a proposed study contained within the Affordable Care Act (Obamacare) to evaluate this so-called mid-level provider concept. The lack of necessity for this study was discussed as well as other possible solutions for those faced with access problems, for whatever reason.

Another proposal supported by the AGD representatives had to do with legislation introduced by Congressman Paul Gosar of Arizona, a dentist, to minimize if not eliminate the anti-trust protection dental and medical insurance carriers presently have.

Another proposal would also help the policyholders receive the full

(continued, page 4...see "Hill Day")

Dr. Bromberg with Mr. Luke Stone
(Office of Congressman Brad Sherman)

KNOW YOUR 2015 CAGD LEADERS

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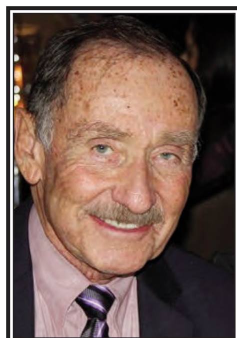
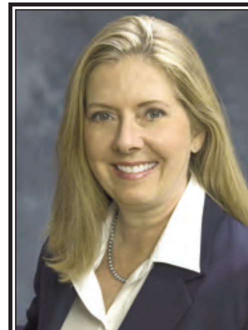
Dental Care Chairperson
DDS
West Hills

as well as FellowTrack and MasterTrack Coordinators



DR. MYRON BROMBERG
Legislative Chair, Dental Care Co-Chair, Nat'l AGD Advocacy Division Coordinator
DDS
Reseda

DR. JOHN BETTINGER
Advisor
DDS, FAGD
Santa Monica



LYNN PETERSON
Executive Director
CERTIFIED ASSOCIATION EXECUTIVE CAE
Oakley

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Advisor, "Watchdog Report"
DDS, MAGD
Fair Oaks

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Torrance

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Public Information Officer for CAGD
DMD
San Diego

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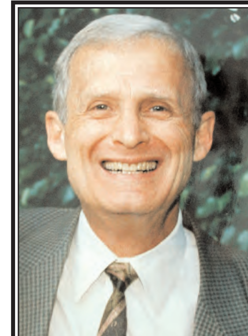
Advisor, AGD Nat'l PACE Committee Chairman
DDS, MAGD
Sacramento

DR. RALPH HOFFMAN
UCSF FellowTrack Coordinator
DMD, MAGD
San Francisco



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CALIFORNIA ACADEMY *of* GENERAL DENTISTRY

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"HILL DAY" *(continued from page 1)*

benefit of their dental insurance coverage.

The unfair and unjustified Medical Device Tax, a new 2.3% tax on medical and dental devices which helps fund Obamacare was also one of our targets.

A good deal of time was spent discussing student debt, which many studies show an average in the vicinity of $300,000. The attendees promoted measures that would help to bring down tuition costs, keeping federal student loans affordable and allowing the students or new dentists to refinance at more appropriate rates when feasible.

Efforts to expand the National Health Service Corps Loan Repayment Program was also discussed. This issue is particularly important since, given minimal employment opportunities in some regions, economic necessity as a result of this significant debt load can largely influence—and in fact jeopardize—the recent graduate's ability to choose a preferred career path.

This has significant ramifications for the entire profession.

Much emphasis was placed on efforts to support and expand Oral Health Literacy, which the AGD believes is a very important aspect, if not the most important aspect in the prevention of dental disease, particularly amongst low income groups.

The outreach and influence the Academy has increases each year. The AGD representatives were warmly received and welcomed by the legislators who heard our thoughtful, cogent opinions and suggestions on these issues.

It was clear that the AGD is a player in this legislative arena. ■

Dr. Bromberg is the Division Coordinator of the Advocacy and Representation Division of the Academy of General Dentistry. He is a Past President of the California AGD, a recipient of the AGD's Advocacy Award and is in private practice in Reseda.

The San Diego AGD introduces their

Practice Management Study Club

If you missed our last two seminars on Labor Law and Retirement Investing for Dentists —you won't want to miss what we have next!

◆ *Thursday, September 17, 2015 (6 p.m. till 9 p.m.)*

Contract Law for the Dentist

with Robert Robinson, Esq.

Discussion about lease renewals, tenant improvements, partnership agreements, contract negotiations . . . and more!

◆ *Thursday, November 19, 2015 (6 p.m. till 9 p.m.)*

TBA (topic will be geared toward the desires of the group)

Earn two CE seminar credits

Cost is $200 per seminar and includes dinner and valet parking

All meetings are hosted at the University Club atop Symphony Towers in San Diego

Network with outstanding dentists like yourself. Bring a colleague and learn from other dentists who experience the same struggles of everyday practice as you do and prepare your practice for the future.

To RSVP, contact Dr. Larry Pawl:

lrpawl@yahoo.com

and sign up today as seats are limited!

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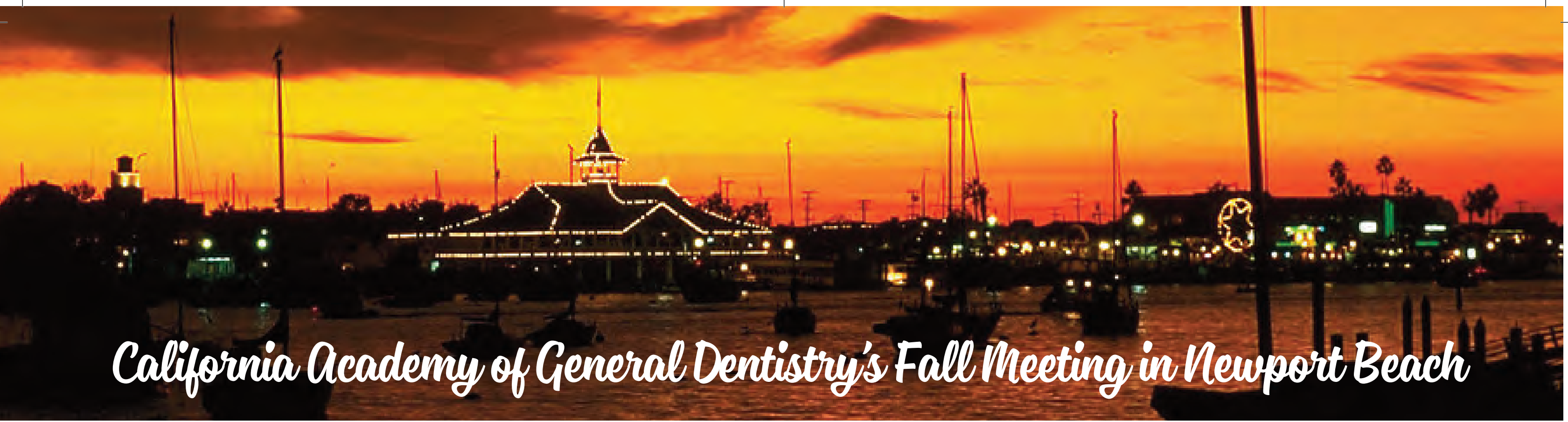


FUNDAMENTALS OF BONE GRAFTING AND RIDGE PRESERVATION

✳ **Mike Chen, DMD, DICOI**

✳ Saturday, **November 7,** 2015 (8:00 till 5:00)

✳ Newport Beach Fairmont
4500 MacArthur Boulevard, Newport Beach, California

There are numerous types of bone grafting materials to use. In this course, the practitioner will gain a better understanding of the different types of bone grafts, with a specific focus on synthetic bone and its application in clinical situations. An introduction to ridge preservation will also be presented.

After completion of this course, the practitioner should have a good understanding for socket and ridge preservation and fundamental clinical grafting protocol. Practitioners should also have an understanding of different types of ridge defects and bone regeneration techniques.

Lecture course—8 CE lecture credits

Event Sponsors:

REGISTRATION *(submit a separate form for each attendee and print legibly). For online registration (credit cards only) go to* **www.caagd.org**

*First Name*________________________ *Last Name*________________________

*Address*________________________ *City*____________ *Zip*________ *Telephone*____________

E-mail address (NEEDED TO CONFIRM REGISTRATION. INFORMATION KEPT CONFIDENTIAL)________________________

Fees: ❑ ***Member AGD and Delta @ $109*** *AGD Membership No.*____________

❑ ***Dental Non-Member @ $209*** *Now is the time to join the AGD at* **www.AGD.org**

If you join between October 1 and December 31, 2015, you will enjoy the benefits of membership thru the end of 2016, plus $100 off of this course.

Payment Method:

❑ **CHECK** *I'm paying by check and it is enclosed and payable to the* ***CAGD*** *in the amount of $*____________

❑ **CREDIT CARD** *Card No.*________________________ *Expiration Date*____________

*Name of Cardholder*________________________ *Card Billing Address if not the same as above:*

*Address*________________________ *City*____________ *State*________ *Zip*________

*Security Code*________ *(the security code on Visa and Mc is a 3-digit number at the end of the signature panel on the back. On AMEX it's a 4-digit number above the account number on the front)*

Mail or fax this registration form to:
CAGD, 950 Glenn Drive, Suite 150, Folsom, California 95630 *Fax:* ***916-932-2209***

Cancellations can only be honored before October 30, 2015
Questions, call: 916-932-2245

THE PRESIDENT'S CORNER

DR. SIREESHA PENUMETCHA
Elk Grove

If you didn't attend the AGD Annual Meeting, you missed out.

We hope to see you at the next one!

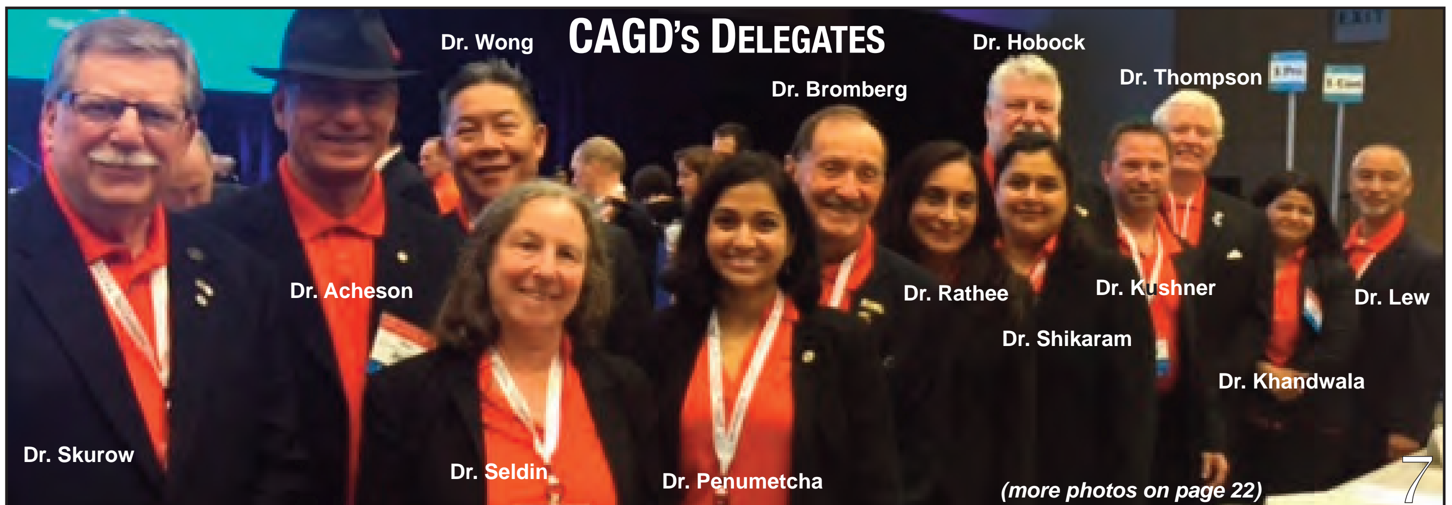
What an exciting year with our AGD Annual Meeting right here in San Francisco!

Several exciting highlights:

1. The weather has never been as perfect as during the meeting. *Everyone enjoyed it.*
2. Contested elections for several national executive positions were held between highly-competitive and capable leaders. *This made it very electric.*
3. During our California Caucus meeting, some CAGD Board delegates had to leave for Sacramento to attend the CDA special House of Delegates as they are also California Dental Association delegates. The date for both meetings clashed. *Talk about timing!*
4. All awardees from California *(Mastership, Fellowship and Lifelong Learning and Service Recognition)* were invited to a reception and a reunion sponsored by the CAGD the night before the convocation. Live music, dancing and delicious food was enjoyed by all. *MasterTrack is a four-year program offered by the CAGD to any AGD member interested in pursuing Mastership in the AGD.*
5. The House of Delegates meeting went well and adjourned on time without the need for an afternoon session.
6. The convocation ceremony was well attended. Many Californians made us proud by attaining Fellowship, Mastership and Lifelong Learning and Service Awards.
7. The continuing education offered had some interesting, live-patient experiences. *Live patients was a first.* There were many interesting lectures and hands-on courses.
8. Last, but not the least, if you didn't attend the annual meeting, you missed out. We hope to see you at the next one!

More updates soon to follow. ■

Dr. Sireesha Penumetcha



(more photos on page 22)

Dead End Tunnel Bone Augmentation

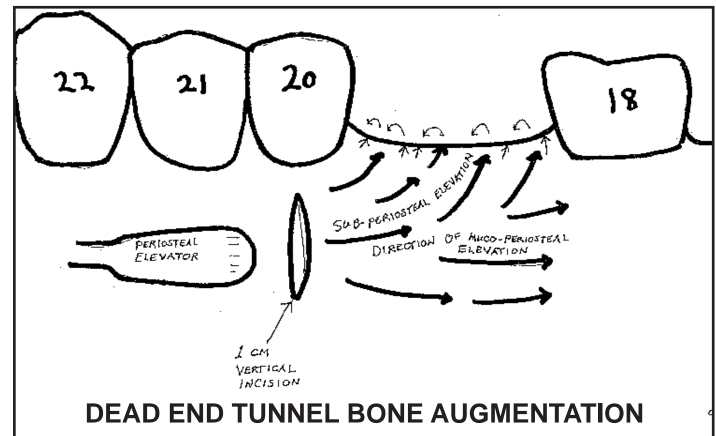
ADD FACIAL-LINGUAL BONE TO RESORBED ALVEOLAR RIDGES FOR IMPLANT PLACEMENT

Robert Garfield, DDS, *SCAGD Executive Director, Los Angeles*

Dental implants survive and maintain cervico-crestal bone integrity best when there is at least 2 mm of cervical bone width on the facial and on the lingual of the implants. Less bone volume in these vulnerable areas can result in resorption due to a lack of adequate blood supply to the bone. After tooth extractions alveolar ridges can resorb and lose two-thirds or more of their width. Traditional bone augmentation methods, using a variety of very costly materials, may be phasing-out in favor of simpler methods that stimulate the body's own osteoblasts to produce more bone where needed. *Example:* A DET augmentation on a horizontally resorbed edentulous area #19 *(it could be anywhere in the mouth).*

1. Make a 1 cm vertical incision down to the bone at the mid root position of #20. Start the incision about 4 mm apical to the gingival margin and terminate it in the vestibule. This is the only incision we will make. The "tunnel" has a dead-end at the mid-root area of tooth #18.
2. Carefully detach the periosteum with a thin, blunt elevator shaped to the task at hand. Keep the elevator firmly against the bony surface to avoid tearing the periosteum. Fan out to include a wide area and be sure to elevate slightly over the alveolar ridge crest just barely onto the lingual surface, since the bone height may be correctable to the height of the CEJs of the adjacent teeth. Make sure that there are no snags or adhesions to the bone surface left in this pouch/pocket.
3. Decorticate the bone surface with a bone scraper or slow #8 HP bur, entering through the vertical incision. Protect the elevated periosteum from the bur with a large cement spatula that has been given a 45 degree bend, or use a proper tissue protective retracting instrument.
4. Pack the pouch/pocket with body warmth setting mineralized bone matrix material. Alternatives such as beta-tri-calcium phosphate, calcium sulfate, hydroxyapetite and systemic blood cells or stem cells aspirated from the arm or anterior iliac crest can be used. Shape with external finger palpation and suture the incision. No membranes are needed unless periosteal laceration has occurred. An intact periosteum is the best barrier membrane. All of these materials, including the hip and arm aspiration syringes and Flagyl, an antibiotic effective against anaerobic bacteria, are available as commercial products.
5. You can treat almost any sized defect that you can confine the matrix material into. Of course access becomes limited the larger the tunnel. More vertical access incisions could be necessary.

Elevating maxillary sinuses can be done in a similar manner working through the drilled osteotomy channel, and pushing the sinus membrane and cortical bone superiorly using an osteotome with a series of light mallet blows, then placing the patient's own bone chips or matrix material in the channel and using the implant to act as a "tenting" pole. This procedure, known as the "Robert Summers Sinus Lift" has been used for over twenty years and requires at least 4 mm of existing bone between the oral cavity and the maxillary sinus to provide stabilization of the implant. This sinus augmentation takes only three to five minutes and may use no additional bone nutrient matrix materials at all.



DEAD END TUNNEL BONE AUGMENTATION

Every implant-placing dentist has his/her favorite bone regeneration recipe. However, as we know, the underside layer of the periosteum contains an osteo-genic layer of cells. If the periosteum is carefully elevated off of the bone surface, and tearing and scratching of it are minimized, and the space thus created can be held away from the bone by a matrix that will not resorb for about four or five months, then bone will grow into this mass from both the osteogenic layer of the periosteum and the decorticated bleeding surface of the bone that releases osteoblasts into the matrix.

Dr. Bob Garfield
Los Angeles

The more bleeding walls at the defect, the more predictable will be the graft. ■

Bone graft matrix materials:

DirectGen *(thermo-stiffening)*
Bioresorb *(Implant Direct Sybron)*

Questions? *Dr. Garfield can be reached at:*
drrobertgarfield@aol.com

Lifelong Learning and Service Recognition Awarded To CAGD Masters

Lifelong Learning and Service Recognition (LLSR) acknowledges the continued achievements of AGD Mastership recipients who recognize the need for continuous learning and to stay active in organized dentistry and their communities.

This year, the California AGD has four of its members *(pictured to the right)* who have achieved this recognition. ■

SIREESHA PENUMETCHA, DDS, MAGD
Elk Grove

LILLIANA L. STOJIC, DDS, MAGD
Sacramento

KIRK M. HOBOCK, DDS, MAGD
San Juan Capistrano

ROGER L. GARRETT, DDS, MAGD
Calabasas

Look for this logo when you sign up for continuing education courses

Academy
of General Dentistry™

PACE
Program Approval for
Continuing Education

Congratulations To New Masters

ACHIEVING MASTERSHIP STATUS

The practitioners pictured on this page and the pages that follow qualified for and received the Academy of General Dentistry's prestigious Mastership award in San Francisco at the AGD's Annual Meeting. They successfully completed a rigorous curriculum outlined by the national Academy of General Dentistry.

Mastership is the highest award available in the AGD. It is one of the most respected and recognizable designations in the dental profession. Less than one percent of the general practitioner population in the United States have achieved this lofty goal. California has 174 actively practicing Masters out of a population of over 21,500 general dentists.

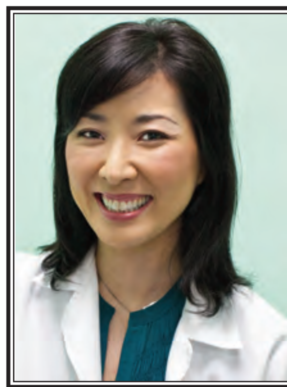
To achieve Mastership, a dentist must complete a minimum of 1,100 hours of approved continuing dental education. Most who have reached this level of continuing education have many, many more hours than the previously stated minimum number. At least 400 hours must be accrued in participation, hands-on courses in sixteen different subject codes.

Students are involved in the demonstration of a particular skill or technique under the direct supervision of highly skilled experts. ■

Masters are trained by the best to be the best!

DR. UPENDRA J. PATEL
Sacramento

DR. SHANTHI MADIREDDI
Saratoga

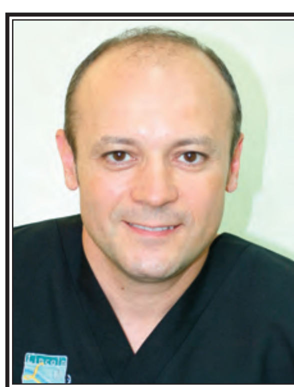


DR. SUSIE SHIN
San Francisco

DR. DARRYL TKACHYK
Edmonton, Alberta, Canada

DR. ASHKAN ALIZADEH
Sacramento

DR. SHITAL KAZI
San Lorenzo



DR. BASILE MUNTEAN
Orange

DR. ROGER SOHN
Loma Linda

New Masters in California *(continued from the previous page)*

DR. TITUS TANG
Daly City

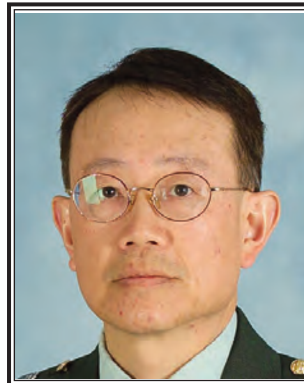
DR. WILLIAM BLACK
Sacramento

DR. A. KEYLA SPRINGE
Paso Robles

DR. ANTHONY CHING
Bakersfield

DR. ERIC LEWIS
San Diego

DR. JASON BALLOU
Rancho Santa Margarita


DR. JOHN GEE
San Ramon

DR. ADINA MANOLESCU
San Diego

DR. WALLACE WOO
San Francisco

DR. BENJAMIN SEATON
Los Banos

DR. REED PUELICHER
Yuba City

DR. BRUCE BOSLER
Vacaville

DR. PHILLIP FLETCHER
Palo Alto

DR. FRANK NG
San Bruno

DR. BIJAN MODJTAHEDI
Fountain Valley

DR. RONALD MILLER
Tracy

New Masters in California *(continued from the previous page)*

DR. EVAN FARR
North Hollywood

DR. MEHRDAD AMANI
Emeryville

DR. KINNARI JAYESH GHIA
San Jose

DR. SAMIR AYOUB
Bellflower

DR. DARRELL CHUN
Elk Grove

DR. NANCY NEHAWANDIAN
Los Gatos

DR. NAMITA DUTTA
San Diego

Awardees Not Pictured

DR. CRAIG PETTENGILL
San Jose

DR. R. MYAING-MISFELDT
Lemoore

DR. HENRY PHILLIPS
Marina del Rey

DR. PETER S. YOUNG
Arcadia

DR. STEPHEN HENRY
Foster City

2015 Mastership, Fellowship and Lifelong Learning and Service Recognition Awardees

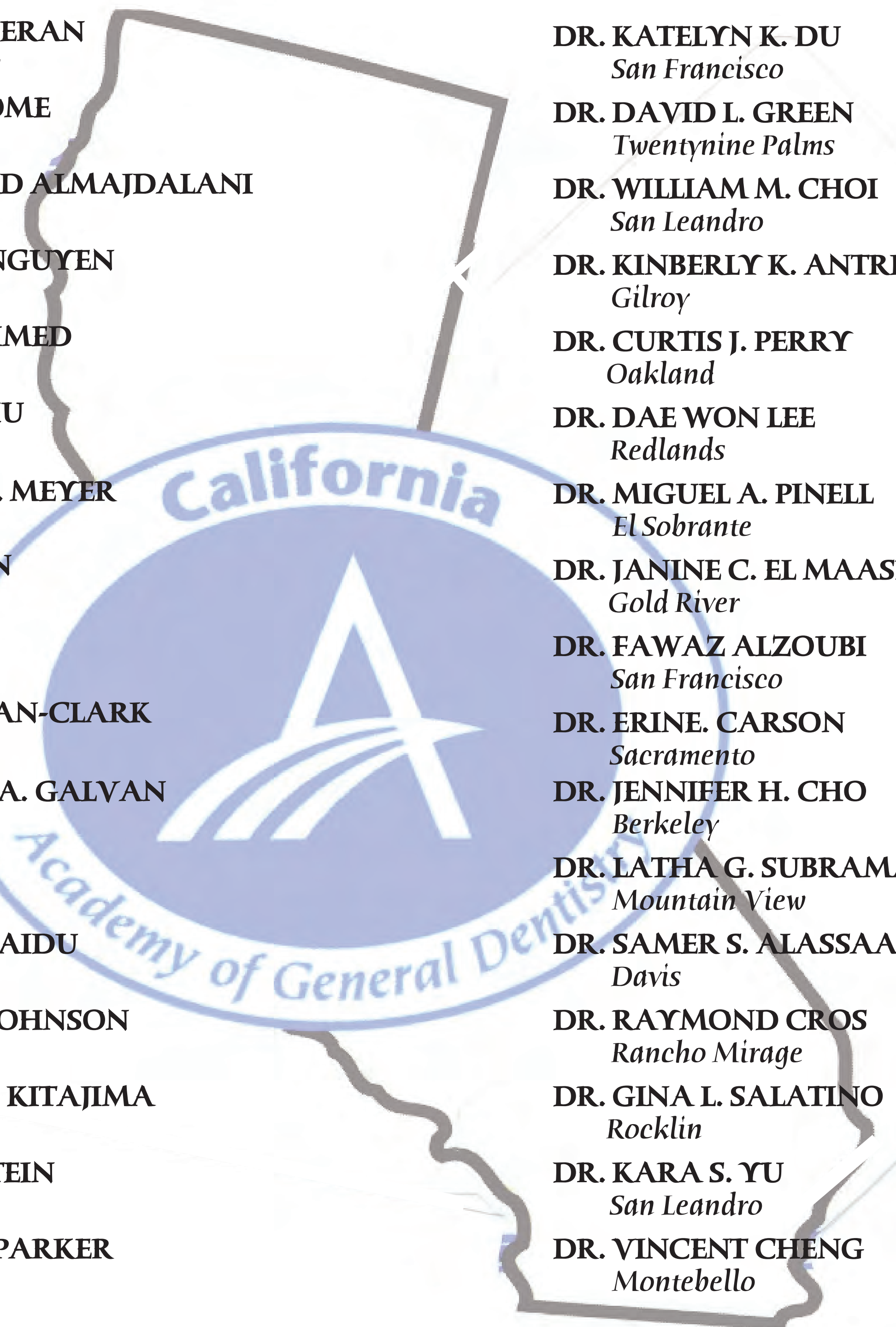
*(Not all awardees made it into this photo. For more on Fellowship awardees, see the page that follows.
For more on CAGD's LLSR awardees, see page page 25)*

New California AGD Fellows

ACHIEVING FELLOWSHIP STATUS

Candidates for Fellowship in the Academy of General Dentistry must have been members for at least three years prior to becoming a Fellow. They have completed a minimum of 500 hours of continuing education. After that, they must pass a comprehensive 400-question written examination.

That exam is administered by the AGD each year at their annual meeting. Study courses are available at every annual meeting to any AGD members desiring to avail themselves of this. In addition, study guides are available by contacting the AGD at: **www.AGD.org** ■



DR. ARMEN TERTERAN
Woodland Hills

DR. DANNY E. ROME
San Mateo

DR. MOUHANNAD ALMAJDALANI
Daly City

DR. ANDREW T. NGUYEN
Menifee

DR. ZAHID H. AHMED
Sunnyvale

DR. GIANG H. CHU
Morgan Hill

DR. MATTHEW A. MEYER
Monterey

DR. ERIC S. KWON
Palo Alto

DR. MINA LEVI
San Francisco

DR. LYNDA T. TRAN-CLARK
Santa Cruz

DR. ALEXANDER A. GALVAN
Ontario

DR. OLIVER B. VU
Elk Grove

DR. ARCHANA NAIDU
Alamo

DR. MICHAEL L. JOHNSON
Bonita

DR. NICHOLAS K. KITAJIMA
Danville

DR. JEFFREY H. STEIN
Lancaster

DR. LAVEDITA L. PARKER
Visalia

DR. KATELYN K. DU
San Francisco

DR. DAVID L. GREEN
Twentynine Palms

DR. WILLIAM M. CHOI
San Leandro

DR. KINBERLY K. ANTRIM
Gilroy

DR. CURTIS J. PERRY
Oakland

DR. DAE WON LEE
Redlands

DR. MIGUEL A. PINELL
El Sobrante

DR. JANINE C. EL MAASRI
Gold River

DR. FAWAZ ALZOUBI
San Francisco

DR. ERINE. CARSON
Sacramento

DR. JENNIFER H. CHO
Berkeley

DR. LATHA G. SUBRAMANIAN
Mountain View

DR. SAMER S. ALASSAAD
Davis

DR. RAYMOND CROS
Rancho Mirage

DR. GINA L. SALATINO
Rocklin

DR. KARA S. YU
San Leandro

DR. VINCENT CHENG
Montebello

A *Grand Canyon* TRIP TO REMEMBER!

Sand, sand, sand everywhere...! *Worth placing on your bucket list.*

Guy Acheson, DDS, MAGD, *Fair Oaks*

***Editor's Note:** Dr. Guy Acheson, Past President and author of the "WatchDog Report," really makes an effort to extract all he can out of life. Here, he takes on the Grand Canyon and the rapids of the Colorado River. He is also an avid and accomplished glider pilot.*

"Horseshoe Bend"

Day 1, Pondering What's Ahead

The first time I saw the Grand Canyon was when moving from Wisconsin to California. I was eleven years old and still remember being awe-struck by the depth and breadth of this giant hole in the earth. The colors; the endless shades of red in the dirt, the rocks, and the morning and evening sky. And way, way, way down in the bottom of that hole was a tiny sliver of green…the tool that crafted this wonder…the Colorado River. From the moment I saw it, going down that canyon and exploring was on my bucket list. In fact, it was very likely the very first entry in my bucket list.

I was offered the opportunity to live my dream this spring and without pausing for one second, said "YES!" My wife, my office, and my patients were not going to stop this adventure.

There are many ways to experience the Grand Canyon. Standing on the rim as I had done many times. You can hike down to Phantom Ranch (or ride mules) to spend the night and look up to the rim. You can take a helicopter ride. You can sit on the decks of the largest inflatable pontoon boats you have ever seen and driven down the river by noisy outboard motors. Or, you can do it the old fashioned way and paddle or row the 242 miles. My trip was eighteen days of paddling, kayaking, and floating with hikes into side canyons and curiosities every day.

This was a commercial trip that is done only twice a year. It was all paddle with hiking every day. The story of the Grand Canyon is not just the geologic history of earth, it is also about man's relationship with nature, good and bad. The explorers from Spain who first saw it. The adventurers who first went down the river with all the rapids and isolation. The native people who lived in the canyon. The politicians and engineers who wanted to dam the whole length of the canyon and the nature lovers who fought to keep it free. If you read the book, "The Emerald Mile," you will get a good overview of all these issues and an appreciation of the special people who make these Grand Canyon trips possible, the river guides.

Sand. Sand everywhere! Very fine, almost like talcum powder, it is brought into the air by the lightest breeze. It is in EVERYTHING; your hair, under your fingernails, your belly button, your sleeping bag, your coffee. You become one with the sand.

No sense of time or date. I took my watch off on the second day. By day four, I didn't know what day of the week it was and I didn't care. Every day had a rhythm. You hear the jet engine-like propane water heater fire up at dawn. The sound of the conch shell horn announces the coffee is ready and I crawl out of my sleeping bag to get my coffee cup. I rinse out the sand and enjoy it while standing on the bank of the river watching the water slide by. Watch the walls of vertical stone transform from a muted grey to all the glorious shades of pink, red, and orange as the sun begins to leak down into the depths of the canyon. Watch the cliff swallows swoop and dive while catching insects. Listen to the deafening silence of the canyon or the roar of a nearby rapids. Stretch, eat breakfast, get dressed for the day, pack everything into a single waterproof bag. Then join the others for a conga line to move everything from shore to the boats, passing things hand to hand. Then on the boats and like Huckleberry Finn, you push off and join the river's current for another day of adventure.

(continued on page 15)

Scouting the Rapids

Not really a cakewalk (or ride)...!

RIVER RAFTING *(continued from page 14)*

This was an all human-powered adventure. No motorboats. Our armada consisted of four large oar boats, a six-person paddle boat, and two inflatable kayaks we called, "duckies." The oar boats are the Mack trucks that carry all the food, equipment, tents, and personal bags. Each is piloted by one oarsman who sits high on top of all the gear and moves the craft with two seventeen-foot oars. There is a small area in the nose and tail where two people can ride along like Egyptian royalty.

Nature's Erosive Artwork Everywhere

The six-person paddle boat is the Ferrari. With six strong people on board it can drag race down the river, turn on a dime, and blast its way thru the biggest waves and whirlpools the river can throw at us. The duckies are pure fun. Tippy and squirrelly, they allow the paddler independent freedom to explore the river's shores. Sitting down so low in the water the waves and holes in the rapids look twice as large and you are virtually guaranteed to flip over in the rapids and go swimming. I rotated thru all the boats and luxuriated in sleeping on the deck of an oar boat after an exhausting day on a duckie.

The canyon is an area of extremes. The extreme verticality of the towering walls. The extreme quiet and tranquility of the side canyons and lazy stretches of the river. The brute physical power of the rapids whose noise level is so high that you have to scream at your neighbor to be heard. The sharp contrast of the ninety to 100 degree air temperature and the fifty degree water which takes your breath away when your duckie flips over and you are dumped into the freezing fluid. How small and vulnerable I feel when standing by myself and just looking at my surroundings.

The food was amazing. Each oar boat had an ice chest the size of your home refrigerator. We had fresh fruit and vegies every one of our eighteen days. The guides had perfected their menus over decades of practice. I actually gained three pounds on the trip. Of course, that was all muscle from paddling, hiking, and swimming every day.

Rafting in Style

The rapids are high energy, high anxiety events. Each is unique in its conformation; the way the water flows, the rocks both hidden and exposed, the size and verticality of the waves, the unsettling holes and whirlpools that look like the doors to the *(continued on the following page)*

Red Nose Day

Tranquility before the Approaching Rapids

Paddle Boat

Oars Woman

ADVERTISEMENT

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RIVER RAFTING *(continued from page 15)*

underworld. There is a typical pattern. The top of each rapid is a flat, broad, smooth expanse of water because it is essentially a lake held back by the dam of rocks that form the rapids. Usually you can't see the rapids because this pool of water is like an infinity pool. As you get closer you hear the roar of the upcoming rapids which keeps increasing in volume as you drift through this lake of tranquility. As you come upon the rapids the river flow starts increasing and gets concentrated into a constantly narrowing river within the river that pours out over the lip and injects you into the noise and froth and mountains and valleys of water that are the rapids. Our guides have done this many times and exhibit almost statesman-like calm as they skillfully guide the high oarboats thru the chaos with surprisingly few pulls on the oars. Still, when these large boats hit a tall wave the boat momentarily disappears under water as it punches its way through the watery barriers. Everyone gets completely soaked with freezing cold water.

Rituals of celebration exist for many events. Crossing the equator typically involves bizarre activities involving King Neptune. A first solo flight in a glider ends with the pilots getting soaked with a bucket of ice water and having the back of their shirt cut off to be posted in the hanger. The biggest, meanest rapids in the Grand Canyon is Lava Falls. It was one of only a few where we pulled ashore above the falls and hiked down the river to look at it before entering. The rocks that form part of the rapids areconstantly moving so the safe pathways are constantly shifting. It was BIG. A thirteen-foot drop focuses the mind when your boat is tipping over the edge and you are looking at a wall of churning water that completely fills your field of view. Our fleet bashes its way through and no one went swimming! YEAH...!

That evening before dinner the guides brought out bags of bizarre clothing for all of us to wear during our "Survived Lava Falls" party. Great fun after fifteen days in the canyon.

The Anasazi were the native peoples who lived throughout the southwest and deep in the Grand Canyon. The remains of several villages on the river banks was a highlight to explore. Lots of building foundations, broken pottery with unique designs, and grinding stones. All the villages were in places where you would want to have a vacation home. We also climbed high up the steep canyon walls to inspect grain storage areas built into ledges and small caves. Impressive construction.

A trip down the Grand Canyon is a truly American adventure that should be on your bucket list. The beauty, the solitude, the power and noise of the rapids where the river is squeezed between the soaring canyon walls is truly awesome.

Jump on board and be amazed...! ■

(there are a few more photos on page 24...see RAFTING)

WatchDog REPORT

Guy Acheson, DDS, MAGD, *Rancho Cordova*

DR. GUY ACHESON

"THANK YOU to the California Dental Association for their work on this issue."

A great big THANK YOU to all the CAGD members who responded to our call to send letters to the key people involved with changing B&P726 so that it will no longer be a crime of sexual misconduct to treat your spouse or domestic partner. Using the AGD CapWiz system, HUNDREDS of letters were sent and AB179 (Bonilla) now has this as the first paragraph in the Legislative Counsel's Digest of the bill:

1. ***Under existing law, the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer is unprofessional conduct, except that it is not unprofessional conduct when sexual contact is between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship, as specified. This bill would expand the exception by providing that it would not be unprofessional conduct when consensual sexual contact is between a licensee and his or her spouse or person in an equivalent domestic relationship, as specified.***

This bill has cleared the Assembly and is working its way through the Senate. The CAGD provided testimony on this topic at several Dental Board of California (DBC) meetings. Your letters to the key legislators very much made a difference. Especially hundreds of letters. A big, THANK YOU to the California Dental Association for their work on this issue.

Another interesting piece of proposed legislation involving dentistry is AB880 (Ridley-Thomas) which proposes allowing senior dental students to provide direct patient care at charity dental events like CDA Cares. This is proposed as another way to address access to care issues and the proponents claim that dental students who are involved in such events are more likely to continue to participate after they graduate and are licensed. The DBC's primary mission is ensuring the safety of the public. When this item came before the DBC, the President of the board (a public member) cautioned taking a very balanced approach to this legislation by expressing that the efforts to address the access to care issue does not justify increasing risk to the public. I liked her call for a detailed look at this proposal.

I have been attending and writing about the work of our Dental Board of California (DBC) for over three years now. I want to acknowledge that our DBC is a hard working group and want to say THANK YOU on behalf of the California Academy of General Dentistry to all the hardworking board members and the support staff. We all read occasional stories about various state boards and agencies that do little or have little purpose, but our DBC is not in that camp. Our DBC is the leader in many cutting edge issues that other states just don't know exist. Licensure by portfolio and approval of foreign dental schools are just two examples of issues that our DBC has faced head on and is the first in the nation to tackle.

Since my last report, licensure by portfolio has gone live and already several students have qualified for a California dental license using this alternative to the free-standing clinical examination that all of us suffered through. California has the largest number of pathways to licensure of all the states: clinical examination by WREB, residency, working in a dentally underserved area, transfer from another state, portfolio and graduates of approved foreign dental schools. The DBC continues to look for additional pathways and they are now investigating allowing clinical examinations run by the American Board of Dental Examiners (ADEX) to be used for California licensure. Also, let us not forget that the DBC has received an application by a second foreign dental school, this one in Moldova, for their graduates to be qualified to apply for a California license.

The legislative process has been compared to the process of making sausages. All kinds of raw materials (proposed legislation, letters, testimony, speeches, articles, meetings) go into the hopper and what comes out the other end many times has little relationship to the initial ideas. There are bills working their way thru the system related to expanding scope for dental hygienists, funding The Virtual Dental Home system, on-line tracking of prescriptions for controlled substances (CURES), and changing the practical examination system for Registered Dental Assistants. My column in the next GP News will report what comes out the legislative sausage-making system.

Immediate IMPLANT POSITIONING *in the* ESTHETIC AREA

John DiPonziano, DDS, MAGD, DICOI

DR. JOHN DiPONZIANO
Pleasanton

The proper positioning of a maxillary anterior implant, after the immediate extraction of a tooth, can be one of the more challenging procedures in implantology.

If the implant is placed too far facially, the health of the facial plate of bone can be compromised. This can lead to facial bone loss, thread exposure, and generally an overall poor esthetic result.

One of the most common mistakes leading to this facial malposition is placing the implant in the same space as the missing tooth root. ***Figure 1***

Properly positioned, the implant should engage the palatal wall—3 to 4 mm from the apex of the root. In addition, it should be angled to provide approximately 2 mm of space from the implant facial surface to the inner aspect of the facial plate of bone. For a cemented restoration, the center of the implant should be in line with, or slightly lingual to, the incisal edge of the tooth. ***Figure 2***

The following illustrations outline the individual steps needed to achieve this proper implant positioning after the extraction of the tooth:

Figure 3—#6 round surgical carbide is positioned at the socket apex and then slid down the palatal wall, 3 to 4 mm. The bur is then run at 1300 to 1500 RPM to pierce the palatal cortical wall of the socket.

Figure 4—A sidecutting drill is used to advance the osteotomy to proper length and angulation, keeping in mind the goal of centering the implant at, or lingual to, the incisal edge of final restoration.

Figure 5—Twist drill further defines the osteotomy.

Figure 6—Guide pin placed into osteotomy and visually checked for proper distance from facial plate. A radiograph is taken to verify mesial/distal position.

If positioning is incorrect, the sidecutting drill is used to re-direct the osteotomy.

Figure 7—Final sizing drill taken to depth.

Figure 8—Implant in proper position after integration showing its relation to facial plate and incisal edge of restoration. ■

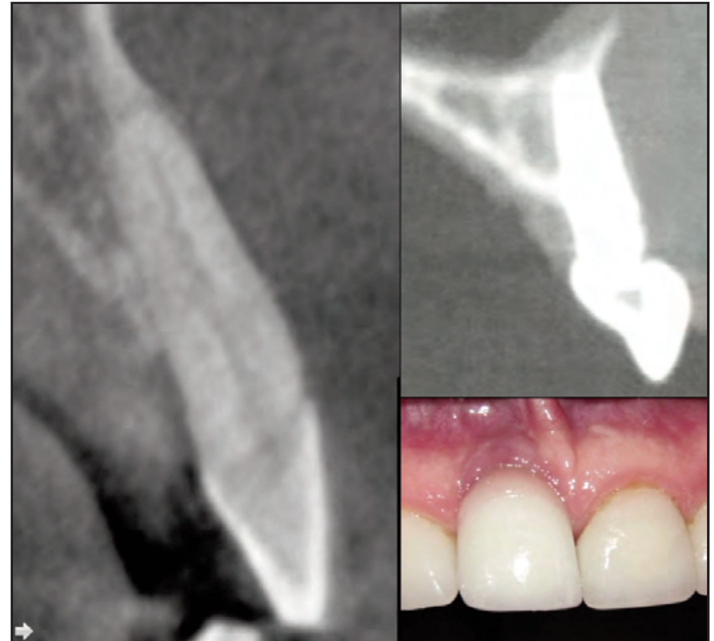


Figure 1

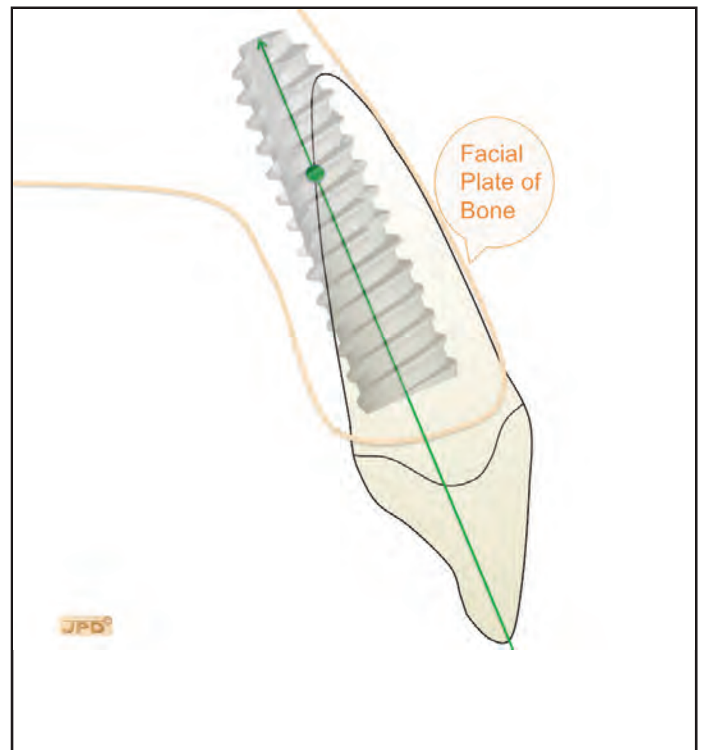


Figure 2

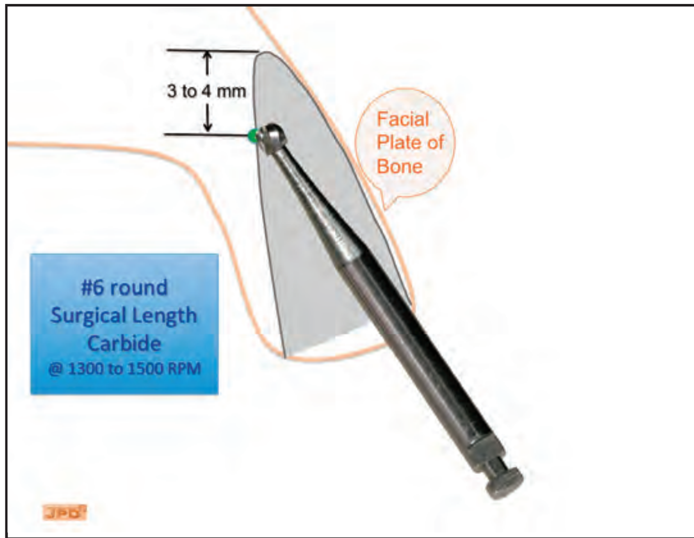


Figure 3

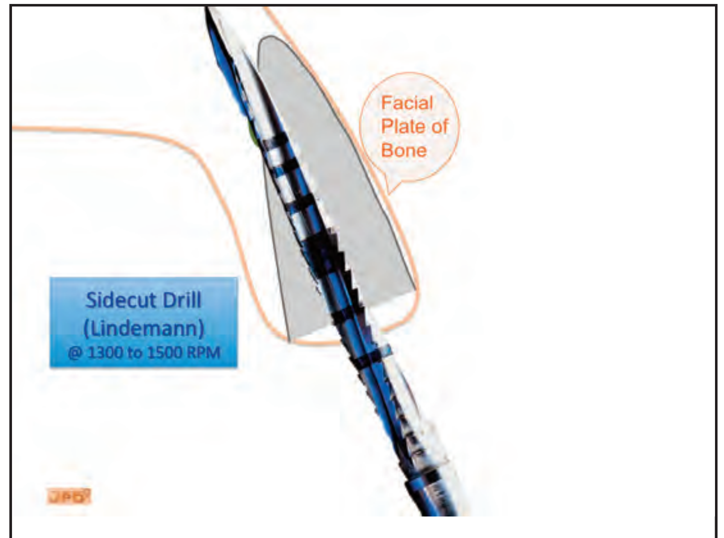


Figure 4

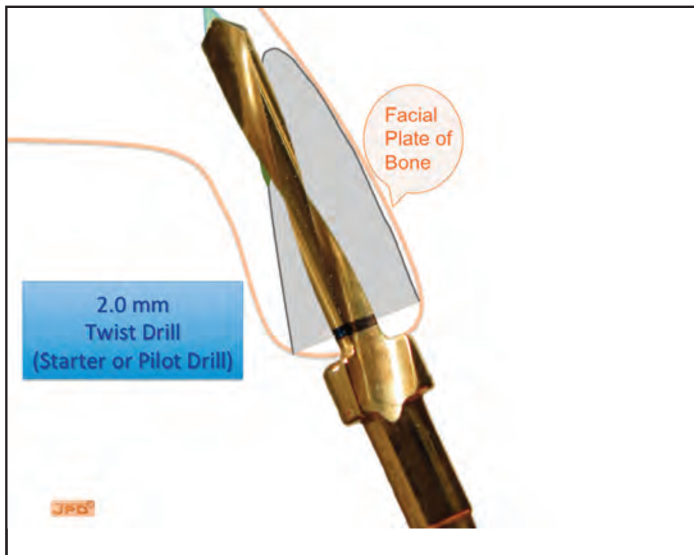


Figure 5

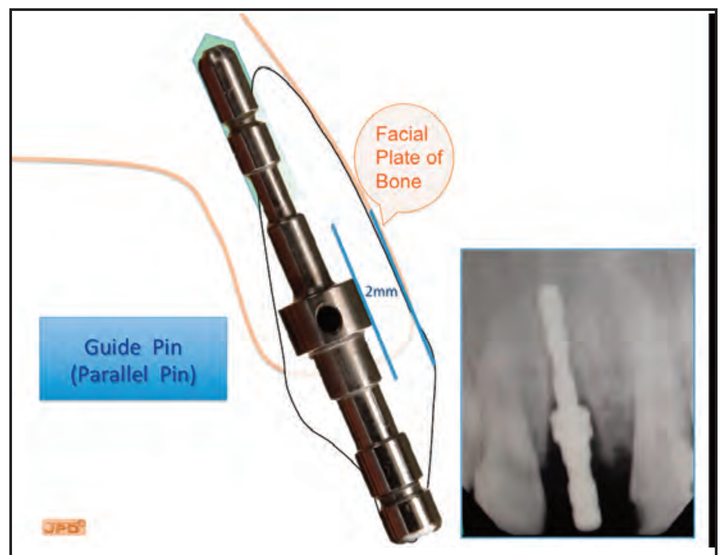


Figure 6

Figure 7

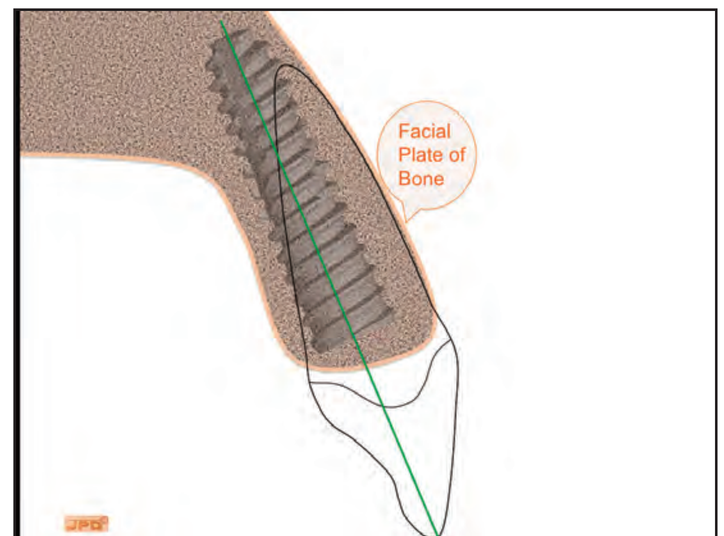


Figure 8

Platlet-Rich Plasma (PRP) in Tissue Regeneration

Muna Soltan, DDS, DICOI, FAGD

DR. MUNA SOLTAN
Napa

Introduction:

Within the circulatory system, cells exist in a liquid suspension and are not bound in solid tissue. This whole blood contains plasma, hematopoietic cellular components, circulating primitive mesenchymal cells, stem cells and their progeny. All combine to engage the biologic process of tissue repair and regeneration.

Tissue injury and/or surgical trauma trigger the body's natural healing response to release mast cells, monocytes, and other nucleated granulation cells. The immediate reaction to tissue injury such as incision, reflection of the mucoperiosteal flap, or bone graft, is the influx of neutrophils and migration of macrophages to the site of injury. This cellular interaction stimulates circulating stem cells to proliferate, differentiate, and to secrete cytokines designed to activate other cells to migrate to the site of injury.

The reparative potential of the cells collected from the peripheral blood depends on a number of factors, including:

Patient Age: With increasing age, the number of multipotent mesenchymal stem cells (MSCs) decrease. The presence of such cells is higher during adolescent growth spurt, which is associated with a marked stimulation of bone formation than in the adulthood.

Systemic Health: Systemic disease such as diabetes, HIV, or metabolic disorders can hinder the process of healing and bone regeneration.

Medications: Medications such as steroids, immunosup pressant drugs, or bisphosphonates can decrease the number of stem cells, and their functional competence to heal, repair and regenerate.

Patient Habits: Smoking and drug abuse, such as cocaine, decreases the body's ability to heal and resist infections and can compromise the vascular supply necessary for repair and regeneration.

The potential for combining an allograft, xenograft or alloplast graft material, with centrifuged peripheral blood, results in increased success, when compared to autogenous bone or other graft matrices not combined with blood. These recommendations are derived from an understanding of the biology of bone growth and repair. The collected cells include, and are not limited to monocytes, lymphocytes, megakaryocytes, mesenchymal precursor cells, and hematopoietic precursor cells, all present in circulating blood. These cells not only provide cells for angiogenesis and vasculogenesis, a source of bone-forming cells, but growth factors that induce regeneration.

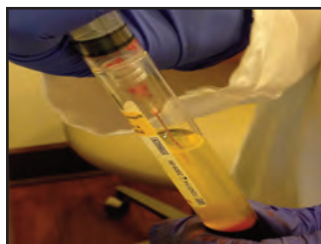
Repair and regeneration follows a series of well organized cell-cell and cell-macromolecular interaction. Bone and tissue regeneration depend on at least three components working together: a resorbable extracellular matrix, signaling molecules, and undifferentiated mesenchymal, hematopoietic and angiogenic precursor cells. In the body the mesenchymal cell can multiply indefinitely, as long as bone formation is needed. However, it is the circulating and local signaling regulators and growth factors that interact and influence this process.

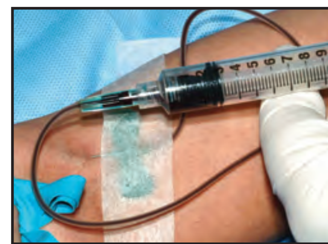
PRP Collection Technique:

Using the following protocol, cells were concentrated from peripheral blood. Approximately 10 mL of blood was drawn from the antecubital fossa into a yellow top tube containing ACD (Anticoagulant Citrate Dextrose) Solution.

For optimum specimen quality, the tube is gently inverted five times after collection to mix anticoagulant with blood. This mixture was centrifuged for ten minutes.

Centrifuging separates the blood sample into three layers: The top yellowish clear layer is the platelet poor plasma that contains only the plasma, the second layer is a whitish thin layer called the myeloid-erythroid layer that contains the platelets and all the white cells, and progenitor cells. The third layer is the hematocrit layer that contains the red blood cells.



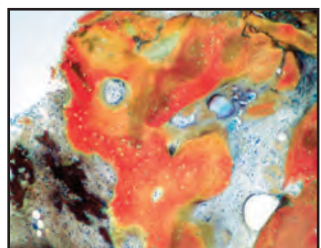


With care not to agitate the layers, a pipette or syringe is used to remove the plasma layer from the top of the test tube. This top layer is discarded.

The middle myeloid-erythroid layer of about 1 ml is suctioned and mixed with the desired bone graft material.

The bottom hematocrit layer is discarded.

The centrifuging process facilitates collection of the nucleated and granulated cells. The concentrated cells enhance osteogenesis, hematogenesis, angiogenesis and vasculargenesis.



A histological slide taken at three months healing showing new bone formation. The bone matrix was an alloplastic material mixed with the centrifuged collected blood cells. New blood vessel formation surrounded with new bone formation. ■

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San Diego Component

SAN DIEGO AGD ANNUAL MEETING

EXODONTIA, BONE GRAFTING, IMPLANT SURGERY… *all hands-on!*

Election of Officers

Friday, October 23, 2015
8:00 a.m. till 4:00 p.m.
Lecture: 8:00 a.m. till noon — Hands-on: 1:00 p.m. till 4:00 p.m.

Dr. Charles Zahedi

UCLA Periodontics part-time faculty member. Previously, full-time Associate Professor, Department of Advanced Periodontics and Implant Surgery, School of Dentistry, Loma Linda University

Course objectives:

- How to extract with minimal trauma
- Preserving the socket during extraction
- Grafting the site (proper instruments and supplies)
- Choosing the appropriate implant system
- Advanced treatment planning
- When to refer
- Which pitfalls to avoid
- What to do when problems are encountered
- Case selection with participant cases

Patterson Education Center

4030 Sorrento Valley Boulevard, San Diego 92121

Register at:

www.sdagd.org

or fax to: **760-736-8261**

or ***U.S. Mail*** *to:*

Dr. Thanh Tran
9936 Scripps Westview Way (Suite 256)

Tuition:

$245 AGD Members *($299 after October 9, 2015)*
$299 Non-Members *($349 after October 9, 2015)*
$99 Staff and Military *($125 after October 9, 2015)*

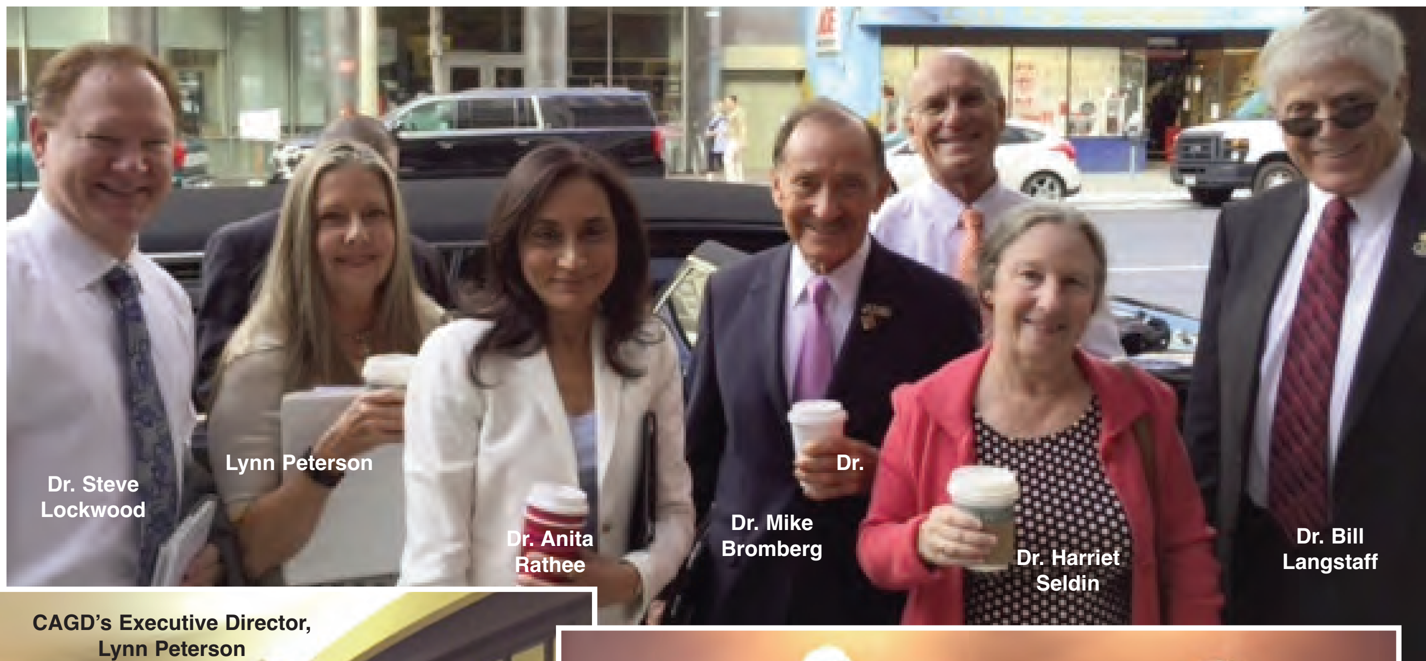
Seating is limited, so register soon!

Questions? E-mail to:
sandiegoagd@gmail.com

Participants are encouraged to e-mail their cases so the group can discuss, troubleshoot and treatment plan.
E-mail to: **sandiegoagd@gmail.com** *(participants can bring FMX, panos, CBCT, models – bring your challenging cases)*

IN SAN FRANCISO REPRESENTING CALIFORNIA'S GENERAL PRACTITIONERS

California's Delegation at the AGD National Meeting



Dr. Steve Lockwood

Lynn Peterson

Dr. Anita Rathee

Dr. Mike Bromberg

Dr.

Dr. Harriet Seldin

Dr. Bill Langstaff

CAGD's Executive Director, Lynn Peterson

Dr. Steve Lockwood

Dr. Bob Davis from Texas

Dr. Bill Langstaff

ENTERTAINMENT AT THE OPENING SESSION PRIOR TO THE AWARD CONVOCATION CEREMONY

University of California at Los Angeles

Spring Quarter Summary

Allyson Taylor, *President Elect, UCLA FellowTrack*

ALLYSON TAYLOR

The AGD student chapter at UCLA focused on learning events during this past Spring quarter. We held two "Lunch and Learn" sessions, where we were treated to a tasty lunch while faculty lectured on topics of interest to the students.

In April, Dr. Saeid Razi, a faculty member of the UCLA AEGD program for the past 17 years, lectured on "Excellence in Posterior Composites." This lecture provided students with an introduction to when and how composite restorations can be used on posterior teeth. Dr. Razi discussed the latest in bonding systems, how to produce consistent interproximal contacts, and how to avoid post-operative sensitivity, among other things. Students were engaged by his upbeat and energetic lecture style and came away with a better understanding of new concepts and principles of minimally invasive tooth preparation.

In June, the UCLA AGD hosted Dr. Adrienne Fang, one of the clinical faculty at UCLA.

Dr. Fang gave a presentation discussing the practicalities of making provisional restorations and let students in on her tips and tricks for success. She spoke about different methods of making immediate bridge temporaries and gave suggestions for tackling those *"What do I do now?"* moments that students often face in the clinic. Dr. Fang took time to answer several student questions. Students were interested in which methods of creating provisional restorations are least prone to distortion, and also asked how to enhance the strength of provisional restorations.

Overall, the UCLA AGD had a great Spring quarter. Turnout for our "Lunch and Learn" events was excellent, and we look forward to hosting more events in the Summer quarter. ■

Mark Your Calendar

CAGD ANNUAL MEETING IN NEWPORT BEACH

January 30, 2016

A SATURDAY

DETAILS WILL FOLLOW SHORTLY

FellowTrack North

University *of* California *at* San Francisco

Ryan Tuinstra, *AGD President, UCSF FellowTrack*

It has been a fairly quiet last quarter for the UCSF AGD FellowTrack. As we got ready to send off our fourth-year students, we were fortunate to have Dr. Ward Noble present a fantastic Lunch and Learn in April. Over forty students attended his lecture on Interdisciplinary Management of Complex Restorative Care.

In the hour course, we received an interactive lecture of case-based presentations. Topics included considerations of Vertical Dimension of Occlusion, new restorative materials, complicated fixed prosthodontics, and the use of implants. The presentation by Dr. Noble addressed many advanced topics not addressed in our curriculum. It is exciting to see complicated full-mouth rehabilitation cases completed by general practitioners.

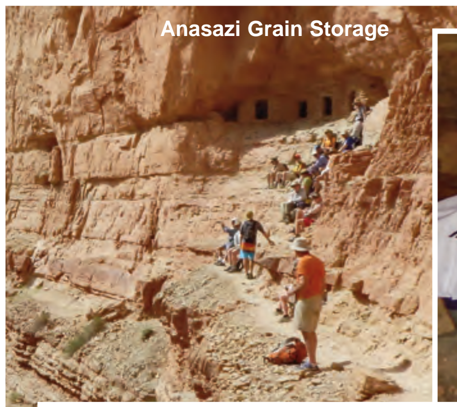
These presentations provide motivation for expanding our scope of practice following dental school. Quality courses such as Dr. Noble's fuel a student's commitment to quality CE.

This upcoming Fall we look forward to attending the 2015 FellowTrack Leadership Conference in Southern California. In the past, this meeting has proven to be a valuable avenue for the leadership of the Fellow- Track chapters to exchange ideas and strategies for grooming the next leaders of the profession.

Our past president, Danielle Niren, did a fantastic job setting up the chapter for success this upcoming school year. In collaboration with the UoP FellowTrack Chapter, we will again host our largest event of the year—New Dentist Day.

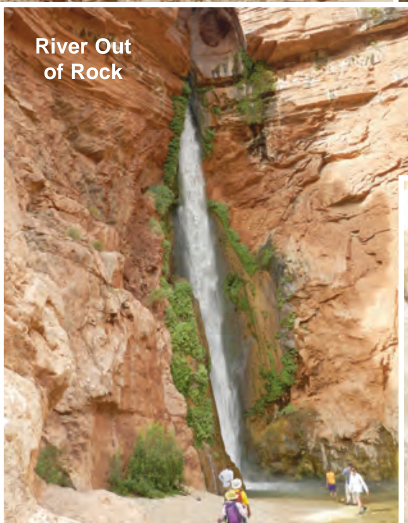
We look forward to a strong year at UCSF! ■

RAFTING *(continued from page 16)*



Anasazi Grain Storage

End of Another Strenuous Day



River Out of Rock

Group Hike

University of Southern California

Catherine Tan, *Herman Ostrow School of Dentistry of USC*

The Academy of General Dentistry FellowTrack Student Program at the Herman Ostrow School of Dentistry is always seeking new opportunities to educate our members on dental and oral health related topics and issues for the future general dentist. A couple of recent events included a continuing education course on forensic dentistry with Dr. Michael Bowers and a hands-on course focused on implant procedures and grafting training with Dr. Joel Henriod.

Dr. Bowers' Presentation:

Dr. Michael Bowers is a forensic dentist who works with the Ventura County Coroner's Office. He visited our school to teach our students about human identification from teeth and bitemarks, managing dental aspects of mass disasters, and dentistry and law. Dr. Bowers spoke about his experiences, including solving a missing persons case by identifying remains from an amalgam restoration. Dr. Bowers stressed the importance of understanding that cases investigated through the coroner's office is a collaborative endeavor, with teams of experts from multiple disciplines working together to collect information and analyze findings. Dr. Bowers also encouraged students to pursue their interest in forensic dentistry by learning more about the field through organizations such as the American Board of Forensic Odontology (ABFO) and the American Academy of Forensic Sciences (AAFS).

Dr. Henroid's Presentation:

Dr. Joel Henriod is a periodontist who practices in-Pasadena. During the course held at the Olympic Collection in Los Angeles, Dr. Henriod thoroughly reviewed implant and grafting procedures. He covered concepts including anatomical considerations, how to interpret bone density from cone beam CT scans, as well as best practices and com- mon pitfalls when placing implants and completing grafting procedures. The lecture was infused with case studies as well as videos from Dr. Henriod's series titled, Enamel Pearls. The videos, which are available online, are a fun and quirky way to review the important basics for implant procedures. There were also opportunities throughout the course to use the Zimmer system to place implants and to practice grafting and suturing techniques on typodont and mandible models. This course was also a great opportunity for us to network with our student colleagues from the other Southern California dental schools who also attended the course.

We have recently transitioned leadership positions for the new 2015-2016 school year. The new leadership team consists of Valerie Velasco, Alex Lee, Dennis Sourvanos, Janet Myung, and myself. We are really excited to plan events including Lunch and Learn lectures, networking events, and continuing education courses for our members. We are also really excited for the upcoming AGD Student FellowTrack Conference in October. We hope that this trimester we will be able to increase membership and provide more opportunities for our fellow Trojans to advance their dental education. ■

Fight On!

FellowTrack South

Western University of Health Sciences, College of Dental Medicine

THE INFECTIOUS POTENTIAL OF UNUSED NITRILE

An Examination of Examination Gloves

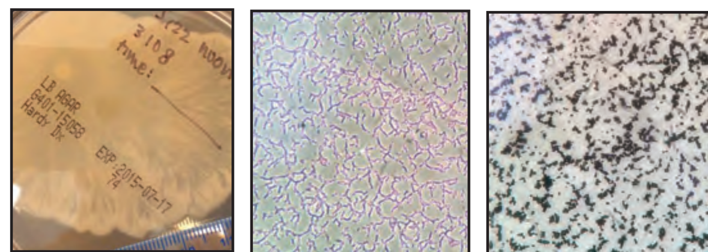
The following six authors contributed equally to this project:

Ho-Hyun (Brian) Sun **Melissa Ven Dange** **Fue Yang** **Long Cao** **Sally Sun** **Jeffrey Turchi, DDS**

Since the "AIDs scare" of the 1980s, examination gloves have been an integral part of the dental clinics in the United States. Their use is typically associated with cleanliness, infection control, and professional appearance. However, our cursory survey of fifty health professions students from dentistry, medicine, pharmacy, and podiatry reveal the students' perception that the examination gloves are primarily for the protection of the care provider, not the patient. This unfortunate perception seems to be fueled largely by the unsterilized nature of most gloves used in practice and the lack of measures taken to sanitize gloves and/or their surfaces. Unlike the other surfaces of a typical operatory, opened glove boxes are rarely cleaned using antimicrobial wipes.

In our personal experiences, most opened examination glove boxes were placed in readily visible locations within easy reach of the dental provider. These surfaces are often contaminated via aerosolized particles from the patients' mouths, especially subsequent to treatments using high speed and ultrasonic hand pieces.[1,2] Physician researchers have identified specifies of Enterococcus, Klebsiella, and methicillin susceptible Staphylococcus in the general healthcare setting.[3] Furthermore, dental researchers also found that opportunistic organisms of the genera Pseudonomas, Cornyebacteria, and Streptococcus were commonly detected in the aerosol particulates of dental offices.[4] This is especially concerning with the recently documented transmission of pneumonic plague and SARS via airborne droplets and dentists' increased risk of exposure to M. tuberculosis compared to the general public.[5,6]

As newcomers to the dental profession, we were surprised at the apparent lack of publications with keywords "glove bacteria," "glove microbes," and "glove contamination" in dental literature of the MEDLINE database. To investigate this matter, we collected data over the period of one week during which nitrile gloves from evenly distributed sections of a modern school-based clinic were tested for the presence of microorganisms. Although the gloves were sampled during non-clinic hours, the clinic was in use by dental students prior to sample collection. Gloves were collected using a sterile forcep and allowed to rest on a plain-agar plate for five seconds. All plates and gloves were placed beneath an active flame to induce an upward airflow and prevent unwanted deposition of airborne particles. The plates were then incubated at 37 degrees Celsius and 5% CO_2 for 48 hours to monitor the degree of microbial growth. Finally, colonies were measured for size and gram stained for visualization under a microscope.



Regardless of when the samples were collected, microscopy of almost every selected colony showed extensive presence of gram-positive cocci arranged in short chains *(center photo)* or grape-like clusters *(right photo)* reminiscent of Streptococcus and Staphylococcus species, respectively. Multiple samples also exhibited growth of poorly-branched, non-sporulating, and partially gram-positive organ-isms *(left photo)* indicative of a fungal species. Interestingly, colonies of both the bacterial and fungus-like species were much more prev- alent from glove samples taken from areas with active air circulation and frequent high speed hand piece utilization while unopened boxes of gloves did not contain noticeable numbers of colonies, suggesting a correlation between aerosolization and microbial growth. The overall results of our investigation corresponded well with the notion that opened boxes of unused examination gloves are common final resting locations for many of the aerosolized microbes.

In light of our and previous investigations, we propose that simple measures to eliminate unused glove contamination is a worthwhile venture especially considering the rising rates of immunosuppressive diseases such as diabetes mellitus. Sawhney and colleagues have found that the pre-procedural use of antimicrobial mouth rinses and regular utilization of high-volume suction apparatus limits the spread of microorganisms via dental aerosols.[7] Moreover, a prospective study in glove-reuse demonstrated that sanitizing gloved hands via washing with water and soap or an alcohol solution may reduce microbial content by 300 fold or more.[8] The glove boxes may be further protected from aerosol contamination by placing them in low airflow areas such as drawers or enclosed containers.

As healthcare professionals who have taken the oath to "first do no harm," it may very well be a part of our duty to first take the low cost considerations to limit the maleficence that may come of our patients. While further research is required to examine the exact protocol and degree of effect these measures may have, their overall impact in reducing microbial transfer is sound and well-documented.

This project was made possible with guidance from our principal investigator Dr. Jeffrey Turchi, scientific consultation from Dr. Bradley Henson and Mr. Carlos Guerra, and sponsorship by the WesternU Dental Student Research Group (DSRG). ■

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