ADA Foundation funds initiatives to help prevent early childhood tooth decay

Infants and children from 10 U.S. communities will benefit from grants awarded this year by the ADA Foundation’s Samuel Harris Fund to help prevent early childhood caries (ECC), which affects more than 25 percent of U.S. infants and children aged 1 to 6 years.

Sometimes referred to as “baby bottle” tooth decay, early childhood caries is a rampant form of acute decay made worse in infants and toddlers by prolonged contact with almost any liquid other than water. This can happen by putting an infant to bed with a bottle of formula, milk, juice or any beverage containing sugar, or allowing them to suck on a bottle or breastfeed for longer than a single mealtime, either when awake or asleep.

Left untreated, this decay can cause pain and impact a child’s ability to chew and speak properly.

This year’s Harris Fund winners designed programs that focus on preventing ECC, including an educational component for pregnant and parenting mothers and caregivers.

The following organizations received grants, sharing $50,000:

- Colorado Area Health Education Center of Aurora, Colo.
- La Clinica de La Raza of Oakland, Calif.
- Primary Health Care of Urbandale, Iowa.
- St. Vincent Healthcare Foundation of Billings, Mont.
- Youth & Family Services of Rapid City, S.D.
- Children’s Dental Services of Minneapolis.

Dental museum devotes day to animal teeth

By Fred Michmershuizen, Online Editor

The National Museum of Dentistry, located in Baltimore, plans to hold a special event — called “Jaws and Paws” — dedicated to teaching members of the general public about animal teeth.

The family festival will be held Saturday, June 26, from 10 a.m. to 4 p.m. The purpose of the event, according to museum officials, is to better educate people about their own teeth.

“The variety of teeth in the animal kingdom shows us how different animals use their teeth for different jobs,” said National Museum of Dentistry Executive Director Jonathan Landers. “It also teaches us how important it is to preserve our own teeth.”

According to the museum, just as human teeth adapted through time to tear off a chunk of food and chew it, the teeth of elephants, beavers, snakes and lions evolved to perform specialized tasks.
Platelet-rich plasma helps after extractions

The use of platelet-rich plasma (PRP) following tooth removal appears to speed healing and bone formation, according to a recent article in the Journal of Oral Implantology, the official publication of the American Academy of Implant Dentistry and the American Academy of Implant Prosthodontics.

When a tooth is removed, poor healing can lead to excessive bone loss in the jaw that can delay tooth replacement or even be impossible to fix, according to the article, “Platelet Rich Plasma to Facilitate Wound Healing Following Tooth Extraction” (available at www2.allenpress.com/pdf/OMI136.FNL.pdf).

“Patients and clinicians could benefit from a cost-effective, simple technique that were available that decreased bone-healing time and increased the predictability of favorable results,” the article states.

For the study, radiography techniques were used with patients to detect bone changes after surgery to remove molars specifically, the bilateral mandibular third molar. For each patient, one extraction site was treated with PRP and the site on the other side of the mouth was not, serving as the control. Three patients received PRP on the right side and three on the left.

The patients returned after the operation for evaluations. Observers checked visually to evaluate tissue opening, bleeding, inflammation, facial edema and pain. The early radiographs found a significant increase in bone density in the PRP-treated sites.

“The PRP treatment had a positive effect on bone density immediately following tooth extraction,” the article states.

Patients did not report significant differences in their perception of pain, bleeding, numbness, facial edema or temperature between the different sites, according to the study.

Faster bone formation could benefit patients who need immediate prostheses or dental implants, according to the article, because the current four- to six-month wait for these could be reduced to two to four months if PRP is used.

Overall, the article states, PRP increases the rate of bone formation and decreases the healing time during the initial two weeks after surgery, helping patients return to “full function” sooner.

(Source: American Academy of Implant Dentistry)

Many with facial paralysis are socially adjusted

A recent study reported in The Cleft Palate-Craniofacial Journal, the publication of the American Cleft Palate-Craniofacial Association, quantitatively examined social competence, anxiety, and depression associated with Moebius syndrome, a rare congenital condition causing facial paralysis.

The article states that the condition robbed people of the ability to smile, frown or even raise an eyebrow. However, contrary to previous studies, it does not appear to increase anxiety and depression or lower a person’s satisfaction with life.

Thirty-seven adults with Moebius syndrome and an equal number of subjects in a gender-matched control group participated in the study, which is described in the article “Living With Moebius Syndrome: Adjustment, Social Competence, and Satisfaction With Life” (available at www2.allenpress.com/pdf/PCF147.FNL.pdf).

Moebius syndrome is a progresive disease that occurs early in prenatal life. It is typically characterized by complete bilateral facial paralysis, but also can include limb or hand malformations and hypoglossia — weakness or malformation of the tongue. Speech difficulties, which can be mostly resolved with therapy, are also frequently part of this condition. The cause of Moebius syndrome is unknown.

“Many people with the condition live professionally and personally successful lives,” the article states.

(Source: American Cleft Palate-Craniofacial Association)

H1N1 epidemic offers lesson for dentists

The H1N1 flu epidemic has lessons to offer health-care providers, even dentists, according to a recent editorial in Anesthesiology, the official publication of the American Society of Anesthesiology.

The limited amount of vaccine available initially left pregnant women, small children with medical conditions and other high-risk populations waiting in long lines.

The problems encountered in reaching certain segments of the population apply to the provision of dental care as well as other disciplines, according to the article by Joel M. Weaver, DDS, PhD, titled “What Can We Learn From the H1N1 Flu Epidemic?” (available online at www2.allenpress.com/pdf/anpr57.FNL.pdf).

Weaver says special-needs populations are too often overlooked by dentists because of a lack of experience in managing these patients in the dental office.

“The addition of a highly skilled mobile ambulatory general anesthesia practitioner can transform a dentist’s office into a fully monitored mini operating room,” Weaver says.

This would allow dentists to provide safe, high-quality care to people who otherwise cooperate with treatment, he says.

Weaver also notes positive changes in the health-care community and beyond because of the H1N1 flu epidemic. Much as the impact of the HIV/AIDS virus spawned the wearing of gloves and other protective equipment by dental professionals, this epidemic is also bringing about transformations.

These include a better awareness of hygiene and improved measures, such as hand washing, that will decrease the spread of illness.

(Source: American Dental Society of Anesthesiology)
For example, elephants use their tusks — incisors that can weigh up to 150 pounds — as weapons. Beavers use their teeth to cut down trees to make lodges. The fangs of some snakes inject poison into their victims. Lions use their teeth to transport their young, defend themselves, and catch and tear apart food.

The special event will feature experts from the Maryland Zoo. Visitors will be able to see a prehistoric shark’s tooth as big as a baseball glove, and they can explore a special exhibit on the narwhal, an Arctic whale with a six-foot-long tooth.

Also on view at the museum are George Washington’s teeth, vintage toothpaste commercials and hands-on exhibitions about the power of a healthy smile.

The museum is located at 31 South Greene St., a short walk from the Inner Harbor. Admission is $7 for adults, $5 for seniors and students with ID, $3 for children ages 3 to 19; and free for ages 2 and younger. The museum is closed Mondays, Tuesdays and major holidays.

More information is available at (410) 706-0600 or online, at www.smile-experience.org.

(Left) A prehistoric shark’s tooth, foreground, is part of ‘Jaws and Paws’ at the National Museum of Dentistry. (Photo/National Museum of Dentistry)
Copenhagen once again led the way to a symposium of practical, educational and informative dentistry. Dr. Kim Sperly, the renowned Danish dentist who is the head of the European Society of Cosmetic Dentistry, led this non-political, educationally oriented organization.

Presenters gave unbiased, informative and practical information on techniques to improve predictability, diagnostic choices, esthetics and maintainability.

Supported by Dentanet, the participants were constantly pampered with accoutrements of sophisticated snacks and drinks. These treats were definitely appreciated by presenters and attendants (especially those special Danish brownies on the last day).

The commercial booths were productive and busy, equipped with knowledgeable personnel who uplifted the professional atmosphere of the symposium. The participants appreciated the honest straightforward, yet exciting, informative Danish style.

The international presenters were certainly varied. Dr. Elliot Mechanic, from Montreal, Canada, spoke on “The Artistic Smile Design: Building the Esthetic Practice.” He emphasized the importance of well-made temporary restorations to influence a lab as a blueprint, as well as the key to an esthetic restoration.

Coming from England were three diverse practitioners with the same directive: their use of the Inmann Aligner. They emphasized the lower anteriors where there is crowding, with a conservative tooth-saving esthetic result. Presenters from the UK were Dr. Tif Quershi, Dr. Tim Bradstock-Smith and Dr. James Russell.

Headlining the symposium, from the United States, was Prof. David L. Hoexter from New York City. His subject of "Regeneration of Esthetics and Smiles Utilizing Implants and Cosmetic Periodontal Surgery" covered every possible implant, implant modality, bone graft and all esthetic periodontal possibilities with their techniques made predictable.

This was an ideal symposium in that it was well organized and provided informative education, and its attendees appreciated this.
Whether an associate dentist is considered an employee or independent contractor could have certain tax and non-tax consequences for the owner of a dental practice.

From a tax standpoint, an employer is required to withhold certain taxes. From a non-tax standpoint, the major issue is vicarious liability, whereby an employer may be liable for the negligent acts of an employee.

For tax and liability reasons, the status of an associate dentist must be clearly defined as either an employee or independent contractor.

The following treasury regulations, §§31.3121(d)-1(c), 31.3306(i)-1(b) and 31.3401(c)-1(b), state that, generally, an employer/employee relationship exists when the person for whom services are being performed has the right to control and direct the individual who performs the services.

Internal Revenue Ruling 87-41 provides 20 key factors to consider whether an employer/employee relationship exists.

No. 1: Instructions
A worker who is required to comply with other persons’ instructions about when, where and how he or she is to work is ordinarily an employee.

This control factor is present if the person or persons for whom the services are performed has the right to require compliance with instructions.

No. 2: Training
Training a worker by requiring an experienced employee to work with the worker, by corresponding with the worker, by requiring the worker to attend meetings or by using other methods, indicates that the person or persons for whom the services are performed want the services performed in a particular method or manner.

No. 3: Integration
Integration of the worker’s services into the business operation generally shows that the worker is subject to direction and control.

No. 4: Services rendered personally
If the services must be rendered personally, presumably the person or persons for whom the services are performed are interested in the methods used to accomplish the work as well as in the results.

No. 5: Hiring, supervising and paying assistants
If the person or persons for whom the services are performed hire, supervise, and pay assistants, that factor generally shows control over the workers on the job.

No. 6: Continuing relationship
A continuing relationship between the worker and the person or persons for whom the services are performed indicates that an employer-employee relationship exists.

No. 7: Set hours of work
The establishment of set hours of work by the person or persons for whom the services are performed is a factor indicating control.

No. 8: Full time required
If the worker must devote substantially full time to the business of the person or persons for whom the services are performed, such person or persons have control
over the amount of time the worker spends working, and impliedly restricts the worker from doing other gainful work. An independent contractor, on the other hand, is free to work when and for whom he or she chooses.

No. 9: Doing work on employer’s premises
If the work is performed on the premises of the person or persons for whom the services are performed, that factor suggests control over the worker, especially if the work could be done elsewhere.

No 10: Order of sequence set
If a worker must perform services in the order or sequence set by the person or persons for whom the services are performed, that factor shows that the worker is not free to follow the worker’s own pattern of work but must follow the established routines and schedules of the person or persons for whom the services are performed.

No. 11: Oral or written reports
A requirement that the worker submit regular or written reports to the person or persons for whom the services are performed indicates a degree of control.

No. 12: Payment by hour, week, month
Payment by the hour, week or month generally points to an employer-employee relationship. Conversely, payment made by the job or on a straight commission generally indicates that the worker is an independent contractor.

No. 13: Payment of business and/or traveling expenses
If the person or persons for whom the services are performed ordinarily pay the worker’s business and/or traveling expenses, the worker is ordinarily an employee.

No. 14: Furnishing of tools and materials
The fact that the person or persons for whom the services are performed furnish significant tools, materials and other equipment tends to show the existence of an employer/employee relationship.

No. 15: Significant investment
If the worker invests in facilities that are used by the worker in performing services and are not (typically maintained by employees (such as the maintenance of an office rented at fair value from an unrelated party), that factor tends to indicate that the worker is an independent contractor.

No. 16: Realization of profit or loss
A worker who can realize a profit or suffer a loss as a result of the worker’s services (in addition to the profit or loss ordinarily realized by employees) is generally an independent contractor, but the worker who cannot is an employee.

No. 17: Working for more than one firm at a time
If a worker performs services for more than one person, that factor generally indicates that the worker is an independent contractor.

No. 18: Making services available to general public
If a worker performs services for a multiple of unrelated persons or firms at the same time, that factor generally indicates that the worker is an independent contractor.

No. 19: Right to discharge
A worker who can be fired so long as the independent contractor produces a result that meets the contract specifications.

No. 20: Right to terminate
If the worker has the right to end his or her relationship with the person for whom the services are performed at any time he or she wishes without incurring liability, that factor indicates an employer/employee relationship.

‘An associate dentist should have an employment contract that specifically states whether he/she is an employee or independent contractor.’

Protecting your practice
In the past few years, the IRS has taken an active role in the dental profession in order to determine whether an associate dentist is an employee of an independent contractor.

The reclassification or determination that an associate dentist is actually an employee instead of an independent contractor could have substantial tax and liability consequences for the owner of the dental practice.

Therefore, in order to protect the owner of a dental practice, an associate dentist should have an employment contract that specifically states whether the associate dentist is an employee or independent contractor. How a worker performs services for more than one person may be an employee of each person, especially where such persons are part of the same service arrangement.

An employer exercises control through the threat of dismissal, which causes the worker to obey the employer’s instructions.

An independent contractor, on the other hand, cannot be fired so long as the independent contractor produces a result that meets the contract specifications.

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One day I was chatting with Dr. Lorin Berland, the editor in chief of Cosmetic Tribune, and he mentioned how much outsourcing his human resources has saved him. At first I was not aware a dentist could do, I decided to get the full story from Berland’s Dental Practice Special and I gather the best employees, committing them properly, providing competitive employee benefits, offering training and development, and monitoring and measuring employees’ performance.

Over time, these are the activities that make a good dental practice a great dental practice.

Our program enhances top- and bottom-line organizational performance by strengthening a practice’s most important asset — employees’ performance.

Does Odyssey OneSource have programs expressly for dental practices?

Yes, as part of our commitment to providing his HR outsourcing. So Odyssey OneSource has created an outsourced solution that goes a step further by assuming many of the employer liabilities that clinicians shoulder today.

As the employer of record with government agencies, Odyssey assumes the liability for payroll, payroll taxes, unemployment claims, EEOC claims, fiduciary obligations and more.

Like larger organizations, dentists can benefit from strategic HR practices. Strategic HR focuses on recruiting and retaining the best employees, compensating them properly, providing competitive employee benefits, offering training and development, and monitoring and measuring employees’ performance.

Over time, these are the activities that make a good dental practice a great dental practice.

Our program enhances top- and bottom-line organizational performance by strengthening a practice’s most important asset — employees’ performance.

Would you like to upgrade your employee benefits?

Odyssey provides health, dental, life and vision insurance options that are vastly more comprehensive than a typical dental practice can afford on its own. We have several options available in order to suit the needs of different practices.

One popular option lets the practice enjoy the benefits of top-rated PPOs at very attractive rates by incorporating health savings accounts, or HSAs. HSAs are triple-tax-advantaged. Contributions go into the accounts on a tax-free basis, earnings on HSA balances accumulate tax-free and distributions are tax-free — provided that they are for qualified medical expenses. Participants enjoy the convenience of a debit card to pay for qualified medical expenses.

Our HSA pays annual exam/wellness benefits at 100 percent with no deductible required. HSA contributions may be paid by the employee, a family member of the employee, the employer or a combination of all three. Account balances roll over without limitation from year to year. The accounts are completely portable so when individuals terminate employment, they take their HSAs with them.

Is your employee timekeeping process automated and integrated with payroll?

Most dental practices use a cumbersome and antiquated timecard system to record hours worked. Odyssey offers an automated system that electronically maintains your time clock data and is fully integrated with our payroll system. One simple command confirms your time clock data is ready for processing. We take care of payroll processing, direct deposits, tax deposits, tax filings, garnishment administration and payroll account reconciliation.

Are you, or someone on your staff, adequately trained to avoid costly IRS penalties?

The IRS reports that one out of every three employers has been assessed a penalty for a payroll tax mistake, with total penalties totaling billions of dollars.

In addition, given the ever-changing nature of tax regulations, it’s easy to make an error that can
Is your practice in compliance with all state and federal labor regulations? An essential element of human resources is reducing an employer’s liability. From written policies to dispute resolution, dentists depend on Odyssey OneSource to anticipate and avoid potential HR nightmares.

Odyssey provides a thorough HR assessment at the onset of our arrangement in order to identify specific areas of concern. We reduce a clinician’s exposure to employee claims and suits by customizing practice-specific training and providing employment practices liability insurance, or EPLI, that covers the clinician in the event of a claim.

Dental-specific safety training is also available. This allows the dentist to refocus his or her internal compliance efforts to patient-related risk mitigation.

Does your practice maximize retirement savings opportunities for the clinician and his or her employees? One of Odyssey’s key benefits is our executive deferred compensation plan, which offers highly compensated professionals the opportunity to defer up to $100,000 in annual earnings using a 409a plan. This allows the clinician to defer income until a later date, helping the dentist to accumulate wealth by placing him or her into a lower tax bracket. The tax savings alone often exceeds the entire cost of our service.

The practice’s employees can also benefit from a 401(k) plan that we administer. We have investment advisors to assist employees with their investment decisions. The practitioner can decide whether or not to match employee contributions and can even offer a profit-sharing option if desired.

More information ...

Odyssey OneSource’s HR outsourcing arrangement also provides the following benefits:

• Competitive employee benefits, including health, dental, life and vision insurance, retirement plans and voluntary benefits that help clinicians attract, engage and retain the best employees.
• A deferred compensation plan that allows a practice to save up to $100,000 annually on a tax-deferred basis.
• A full-featured 401(k) plan that offers employees a bona-fide retirement option with no required contribution or administration on the clinician’s part.
• Immediate access to Odyssey’s experts, processes and systems, which are all designed to promote HR best practices.
• An integrated approach that eliminates the need for the dentist to coordinate the activities of multiple vendors, or even worse, attempt to perform these complex functions himself/herself.
• Elimination of significant employer liabilities including payroll tax, unemployment claims, workers’ compensation claims and more.
• Avoidance of costly employment-related lawsuits, such as wrongful terminations, sexual harassment, discrimination and more.
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How plaque biofilm can be managed

By Fred Michmershuizen, Online Editor

Dental Tribune spoke with Dr. Fotinos Panagakos about his upcoming webinar.

You have an upcoming course on the management of biofilm and gingival management. Would you please tell our readers why this topic is important?

Periodontal diseases are a set of poly-microbial diseases characterized as dental-plaque/biofilm-induced gingival inflammation that without treatment can result in the loss of periodontal support tissues, bone loss and, ultimately, tooth loss. For the past several decades, significant clinical and basic research has established the complex microbiology and pathology of periodontal diseases, and, specifically, that they involve a combination of bacterial infection, host immune reaction and bone metabolism, as well as genetic and environmental risk factors.

The importance of bacterial plaque to the onset and progression of periodontal diseases is well accepted. While more than 400 species of bacteria can be detected in the oral cavity, only selective pathogenic species produce products harmful to gingival tissues.

Microbial products of specific pathogens, such as lipopolysaccharide (LPS) and proteolytic enzymes, directly or indirectly trigger a host tissue response by inducing inflammatory protein (cytokine) production, increasing the levels of inflammatory mediators, which leads to inflammation and tissue destruction.

Without intervention or treatment, supporting tissues will be destroyed, clinical pockets will form, bone resorption will occur and, ultimately, the tooth will be lost.

How does plaque biofilm affect the surrounding soft tissue?

The plaque biofilm, if not removed, will trigger a chronic inflammatory disease of the gingiva and periodontium. This will result in the destruction of gingival connective tissue, periodontal ligament and alveolar bone. The periodontium responds to the tooth-borne biofilm by the process of inflammation.

The dental biofilm is composed of numerous bacteria, which tenaciously adhere to the tooth surface. Scientists are now beginning to understand the complex molecular interactions that occur, for example, between the bacteria and salivary pellicle that coats the tooth, and between gram-positive cocci of early plaque and gram-negative filamentous bacteria that populate the tooth as plaque matures.

Recent work has identified a set of complex signaling pathways — referred to as quorum sensing — between bacteria, mediated by soluble chemicals produced by the bacteria.

Clinically, inflammation is seen as redness, swelling and bleeding upon probing. However, at molecular and cellular levels, the inflammatory process is defined by cellular infiltrates and the release of a variety of cytokines.

The main provoking factor that induces inflammation of gingival tissue is the presence of bacterial biofilm on the teeth/gingival interfaces. The products of biofilm bacteria are known to initiate a chain of reactions in the tissue leading to host response as well as the destructive process.

How can patients better manage plaque biofilm at home? Are there certain techniques and/or over-the-counter products that are especially beneficial?

Control of the biofilm/plaque begins with daily oral hygiene. Mechanical cleaning of the teeth and associated gingival tissues removes the bulk of biofilm that has developed in the time since the last oral hygiene session. Within a few hours of meticulous tooth cleaning, bacteria colonize the tooth surface primarily around the gingival margin and inter-dental spaces.

The developing biofilm releases a variety of biologically active products.
ucts, including lipopolysaccharides [endotoxins], chemotactic peptides, protein toxins and organic acids. These molecules diffuse into the gingival epithelium to initiate the host response that eventually results in gingivitis and, in some circumstances, inflammatory periodontal diseases. Clinically, gingivitis is characterized by a change in color — from normal pink to red — with swelling and, often, sensitivity and tenderness.

Gentle probing of the gingival margin typically elicits bleeding when gingivitis is present. Because gingivitis is often not painful, it may remain untreated for many years. Lack of management at this stage may result in disease progression. This is why periodontal disease is often depicted as a spectrum of severity.

Given the complexity of periodontal diseases and the importance of oral health, one of the critical questions is how to best prevent and treat periodontal infection. Clinical procedures such as scaling and root planing provide immediate and universal benefits, whereas effective routine oral care can help maintain a healthy oral environment and decrease the occurrence of oral disease.

It is interesting to speculate that a therapeutic agent that combines both antibacterial and anti-inflammatory efficacy may provide a unique and beneficial approach to the prevention and treatment of periodontal diseases via daily oral-care procedures, not only for high-risk individuals, but also for the general population. The current therapeutic strategy to control periodontal infections involves mechanical removal of deposits, both supra- and subgingival. This also could involve the use of topical and systemic antimicrobial agents.

Can topical antimicrobials applied via an oral delivery system, such as toothpaste, rinse, or gel, help with the management of dental biofilm?

A unique triclosan/copolymer/fluoride dentifrice technology, found in Colgate® Total®, has been developed and clinically proven to enhance conventional oral care procedures. This technology uses a patented system consisting of a broad-spectrum antibacterial agent, triclosan and a polyvinylmethylether/maleic acid (PVM/MA) copolymer to deliver sustained antibacterial activity in the oral cavity, thereby controlling dental plaque and preventing and treating gingival inflammation.

Triclosan is a broad-spectrum antibacterial agent that has been shown to kill oral pathogens, and clinically effective concentrations of triclosan are present up to 12 hours post-brushing, providing an anti-bacterial benefit between brushings. In practice, this triclosan/copolymer/fluoride dentifrice has been proven to deliver statistically significant and clinically relevant benefits in the prevention of caries, the reduction of dental calculus buildup and oral malodor, as well as the control of dental plaque and treatment of gingivitis.

Such a multi-benefit oral-care technology can significantly enhance routine oral care procedures and help to maintain a healthy oral environment.

Control of the plaque biofilm through effective oral hygiene procedures, in combination with the use of a product such as Colgate Total, can provide most patients with an effective regimen to maintain good oral health between dental visits.

References

* For a longer version of this interview please visit www.dental-tribune.com/articles/content/scope/specialties/section/general_dentistry/id/2294.
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Vegas for the non-gambler

Gambling isn't the only thing Las Vegas has to offer its visitors. There are quite a few things to do in the City of Lights that won't cost you a dime.

Free things to do
- **Bellagio fountain show:** On weekdays, the show is every 50 minutes from 5–8 p.m., and then every 15 minutes until the clock strikes midnight. On weekends, the schedule is the same, except it begins at high noon. The best time to view this show is after dark though, and every show is different.
- **Mirage volcano fountain:** Wait until nighttime when you can watch the volcano erupt every fifteen minutes until midnight.
- **Epic battle at Caesars Forum Shops:** Taking place in the fourth rotunda, a 50,000-gallon, saltwater aquarium is the backdrop for an epic battle complete with smoke and fire. Who's fighting to rule Atlantis? Well, Alia, Atlas and Gadrius of course! The show is daily and takes place from 10 a.m. to 11 p.m.
- **Bacchus statues at Caesars Forum Shops:** Held in the first rotunda, this is a special effects show. Bacchus — the god of wine and merriment — awakens from his slumber and promptly decides that what he and shoppers at the Forum need is a little party (a seven-minutes-long party to be exact). Other gods, such as Apollo, Plutus and Venus, join in the revelry. This show is also daily and takes place from 10 a.m. to 11 p.m.
- **World's largest permanent circus:** Visit the Circus Circus hotel for acrobats, aerialists, high wire acts, jugglers and magicians. Daily shows begin at 11 a.m. and last until midnight.
- **Venetian “streetmosphere”:** A variety of street performers, from actors to opera singers, will liven up your experience as you window shop through the Grand Canal Shoppes on the cobblestone streets. There are performances at various locations throughout the day, and keep your eyes peeled for “living statues” in St. Mark's Square and near the Ann Taylor store. At night, you can enjoy music from the Venetian Trio at St. Mark's Square.
- **Rio Hotel and Casino Show in the Sky:** Costumes, dancing and a different show three times a day all take place above the casino floor. The shows begin at 7 p.m. and occur every hour until midnight from Thursday to Sunday. If it’s a Wednesday night, you can enjoy Latin tunes with a strong Brazilian influence by Michito Sanchez & Bahia.
- **Bacchus’ 1.5-inch of glass separates you from the lions as they feed, groom, play and sleep. Visitors can also learn interesting lion facts from the plaques that are part of the exhibit (i.e., lions sleep 18 to 20 hours a day on average). The lions live on a ranch that is 12 miles away from the hotel and are rotated through the exhibit in blocks of six hours per day. While there are 31 lions in total, only a few will be in the habitat at any given time.
- **Hawaiian Marketplace:** Visit this casino for a 27-foot tall chocolate fountain with 2,100 pounds of melted chocolate flowing through it. Some 25 handcrafted glass vessels catch the cascading chocolate. The chocolate is kept at 120 degrees Fahrenheit and it takes six pumps to circulate it all. It took two years to design, plan and engineer the fountain, which contains more than 900 feet of steel piping. Michel Mailhot of Canada designed the fountain. Open daily from 7 a.m. to 11 p.m.
- **Las Vegas sign:** You’ve seen it in movies and photos, but why not snap your very own picture of this famous sign? The sign is near the Mandalay Bay Casino, which is the southern end of the strip.

(Photos/www.stockxchng.com)

You've seen it in

CBCT technology: Informed dentists make informed decisions

Imagine a technology that brings the most detailed knowledge of the patient’s dental anatomy and greater treatment predictability right into the dental office. A good imagination is no longer necessary to achieve that goal. That technology, CBCT imaging, is not just a dental dream but also a reality every day in many dental offices nationally and internationally.

Before and after investing in CBCT, many professionals take advantage of educational opportunities to grow their knowledge of this imaging method. On June 25 and 26, in La Jolla, Calif., Imaging Sciences International and Gendex Dental Systems will be hosting the fourth International Congress on 3-D Dental Imaging. There, dental professionals will hear about 3-D’s past, its present uses and successes, and future implications. The two-day symposium offers insights into field-of-view options for various specialties, detailed clinical application and hands-on training with 3-D planning software programs, and discussions of legal issues.

Three-dimensional technology is already redefining dental outcomes across a broad spectrum of treatment options, including implants, bone grafting, oral surgery, orthodontics and endodontics. The ability to capture a 3-D image of the mouth and to view it from all angles, together with the capability of rotating that 3-D mode and zooming in on details, can only result in more effective dental treatment.

With cone beam, all of the information can be coordinated for integration with other applications, such as guided implant placement software or CAD/CAM. The recent integration of E4D and i-CAT®/GXCB-500™ allows clinicians to combine high-resolution three-dimensional cone-beam scan data and digital impression scan data so that they can simultaneously plan implants and restorations together in one cohesive system (Fig. 1). Software navigates the clinician through this process and ultimately reduces the risk of poorly placed implants. For immediate-load implant cases, pairing these two technologies offers chairside milling of surgical guides so that the patient can be completely treated from implant placement to the seating of the restoration in one visit.

Dentists who have already implemented 3-D technology are seeing results, from more proficient diagnosis to more defined treatment planning and increased case acceptance. Speakers at the conference, such as i-CAT-owner Dr. Steven Guttenberg and GXCB-500 HD-owner Dr. John Flucke, will share their experiences on how CBCT is helping to change the face of dentistry across a wide range of procedures.

**How is dental imaging broadening the scope of dental procedures for the general dentist as well as specialties?**

Dr. Steven Guttenberg: With 5-D imaging, the dental profession is experiencing a real paradigm shift. Dental radiography has come a long way from the first X-ray taken by Wilhelm Roentgen of his wife’s hand in December of 1895. However, even with a panoramic radiograph, we are getting a 2-D representation and making diagnostic and treatment decisions for a three-dimensional object.

CBCT imaging gives dentists the opportunity to diagnose and plan treatment more efficiently. While I thought that I would use my i-CAT...
primarily just for implant procedures, I now use it for everything — taking out a tooth that is close to the nerve, exposing a tooth for orthodontics, for implants, TMJ treatment and trauma. Three-dimensional imaging touches all aspects of dentistry, from endodontics looking at teeth cross-sectionally, to orthodontics for non-surgical treatment or for integration for SureSmile robotic archwire technology.

When I think about the many ways that scans can be viewed and the scope of information that each scan provides (Fig. 2), the list of procedures that can benefit from this technology just keeps getting longer — I use it for extraction, pathology, orthognathic surgery, airway studies, dento-maxillofacial trauma, implants, bone grafts and evaluation of the paranasal sinuses.

**What type of dentist really needs 3-D imaging?**

**Guttenberg:** Being at the congress last year was an eye-opening experience. I witnessed how doctors of different specialties and general dentists use this innovation. For any practice to expand and improve, a dentist must embrace change. Physicist Thomas Kuhn, who first coined the term paradigm shift in 1962, noted that scientific advancement is not evolutionary, but is rather “a series of peaceful interludes punctuated by intellectually violent revolutions. In those revolutions one conceptual world is replaced by another.”

Cone beam, to me, represents a revolutionary concept in imaging. Six or seven years ago, it was just being looked upon with curiosity, but now it is becoming the standard of care for dental radiography. Education in the possibilities that 3-D imaging brings to the practice is invaluable.

While 2-D still has its place in the dental practice, many patients need more for optimal care. Change is not easy, but it is necessary to change to move forward and to provide patient care in a better manner.

Three-dimensional imaging is definitely a paradigm shift, letting dental professionals see the same information in an entirely different way. Nothing else really describes what is going on here.

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**Can you share a case from your own practice?**

**Flucke:** There are so many cases, but this case in particular was very satisfying. A new patient arrived at my practice eight months after seeing her previous dentist, who she had seen for the past 10 years. The patient had always been diligent, almost fanatical, about her dental health, but was two months overdue for a cleaning.

We took a CBCT scan and found an undetected cyst growing in the mandible almost to the point of causing a fracture of the mandible (Fig. 3). When we pointed this out, the patient responded, “Maybe that is why my lip goes numb sometimes, and I get these shooting pains in my jaw.”

While the patient wondered why, even throughout her regular visits to the dentist this condition went undiagnosed, I recognized that the previous dentist was not really at fault. The dentist had been taking 2-D films for the past 10 years, and the patient had been diligent, almost fanatical, about her dental health, but was two months overdue for a cleaning.

Four different outcomes were possible for this condition, and two could have either been life-altering or life-threatening. Fortunately, the situation turned out to be benign, necessitating some extractions and bone grafting. Afterward, the patient asked, “Why did I go somewhere else for 10 years, and the dentist never saw this, when you found this after 10 minutes?” It was all thanks to CBCT.
What is your main message to dentists contemplating implementation of CBCT?

Flucke: I’m a general dentist. I use and believe in this technology. I have seen so many scans that have changed the course of treatment or provided the missing information for difficult diagnoses. By being a speaker at the conference, this is what I want people to know: Don’t be afraid to use 3-D imaging. Use it because it is the smart and the best thing to do. The end game is making the lives of our patients better and cone-beam 3-D imaging is the best way to do that.

Dr. Guttenberg offers a parting thought from George Bernard Shaw to encourage colleagues to educate themselves on 3-D technology to better understand its benefits to the dental practice.

“Progress is impossible without change, and those who cannot change their minds cannot change anything.”
For a full list of the topics and speakers that will be featured at the fourth International Congress on 3-D Dental Imaging and registration information, visit www.i-CAT3D.com.

### About the interviewees

Dr. John Flucke practices in Lee’s Summit, Mo.; he is a well-recognized expert and educator in dental technology.

Dr. Steven Guttenberg is an oral and maxillofacial surgeon, practicing in Washington, D.C., where he is director of the Washington Institute for Mouth, Face and Jaw Surgery.

### Attend the fourth International Congress on 3-D Dental Imaging online

Don’t miss the opportunity to learn from the industry’s leading experts on 3-D imaging, planning and treatment. Learn how to incorporate, afford and use the technology in your practice today.

On June 25 and 26, the fourth International Congress on 3-D Dental Imaging hosted by Imaging Sciences and Gendex Dental Systems will be broadcast live online to provide those who cannot make it to La Jolla, Calif., an opportunity to learn about the benefits of 3-D imaging technology. Please see program details at www.i-cat3d.com.

Online participants will receive ADA-CERP C.E. credits. Registration for the two-day, live online broadcast is $149 and provides access to the archived recording for 30 days, to review at your convenience. Attendees require an online computer with audio capabilities. Please register at www.DTStudyClub.com under Online Courses. See you online!

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Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerselfexam.com. This website shows patients how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations.

Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?
Bacterial contaminants on patient napkin holders

The primary purpose of The Dental Advisor study was to evaluate the presence and composition of bacterial contaminants on patient napkin holders (i.e., bib chains) before and after patient care appointments. Experiments were also performed to investigate the effectiveness of cleaning procedures on reusable bib chains.

As expected, control, unused metal and plastic napkin holders were found to harbor very few contaminant bacteria. Metal and coiled plastic napkin holders that were quickly wiped between use on patients with an EPA-approved, intermediate level disinfectant showed more bacterial contamination compared to unused controls.

The highest levels of bacterial contamination were found on metal napkin holders, which was reused on eight patients without any cleaning procedure between uses. Microbial contamination was found on both metal and coiled plastic napkin holders after use during patient care. The highest concentrations of isolated bacteria were observed on bib chains where a cleaning procedure was not performed between patient uses.

Although cleaning chains with a disinfectant wipe between patient appointments lessened the microbial load, resultant bacterial levels were still higher than those noted for new unused patient napkin holders.

Of additional interest, culture of re-used and wiped plastic napkin holders yielded a mean colony count that was almost two times greater than that found for the metal chains (41.3 vs. 21.9 cfu/mL). This increased microbial load may have occurred because of the more complex, coiled structure of the former type of napkin holder.

Thorough cleaning of this type of chain could require a greater effort on the part of dental personnel in order to reach less accessible areas. For the present study, personnel were asked to only perform a quick wiping motion over the chain with the moist towelette.

Contamination of chains could have occurred by a few different mechanisms:

1) prolonged contact of the bib chain with the patient’s neck, there-by contacting normal epithelial bacterial flora;
2) exposure of the chain to microbe-containing aerosols and spatter generated during treatment and
3) handling of the napkin holders with gloves contaminated during patient care.

Microbial contamination was found on both metal and coiled plastic napkin holders after use during patient care. The highest concentrations of isolated bacteria were observed on bib chains where a cleaning procedure was not performed between patient uses.
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- Dr. Jay Gerber
Director of Orthodontics
A patient who is happy with his or her smile will ultimately be a more compliant patient. One of the easiest and most significant methods to achieving an esthetically pleasing smile is to bleach the teeth.

There are reports of teeth whitening dating back more than 1,000 years, and today people are now more than ever wanting this cosmetic procedure. Surveys show that more than 80 percent of patients want whiter teeth, but only 15 percent have ever used a bleaching product. That leaves 65 percent of patients eligible to be approached about bleaching.

Proper patient evaluation and a good approach can bring a large increase in case acceptance for bleaching.

Thoughtful consideration of the patient’s age, habits and current restorations should be used when determining which bleaching product should be matched to the patient.

Dental offices should have several product options available as not every patient has the same bleaching needs.

### Bleaching options

With so many bleaching products on the market, it is easy to be confused about what is safe and effective to recommend to patients. Many dental offices already provide the service of take-home bleaching trays to patients.

The trend of in-office bleaching is gaining popularity as techniques and equipment become more cost effective and easy to administer.

There are two types of take-home bleaching gels available to patients. Carbamide peroxide and hydrogen peroxide.

- Carbamide peroxide gel is a slow-release gel with about one-third the strength of hydrogen peroxide. It usually works with a two- to four-hour release time, making it ideal for patients who want to wear trays while they sleep.
- Hydrogen peroxide gels are fast-acting, releasing the peroxide between 50 and 60 minutes, and will usually come in concentrations from 5 to 30 percent. Some manufacturers also now offer 35 to 40 percent carbamide peroxide gels for home use, which only require a 25- to 30-minute application.

This gel concentration is perfect for patients who do not have much time to whiten, want fast results and are not prone to sensitivity.

In-office bleaching gels usually are 25 to 30 percent hydrogen peroxide and need to be used only with supervision of a professional to ensure the gel is properly applied and will not harm the soft tissues.

### Sensitivity

Several dental manufacturers recognize that sensitivity can limit a patient’s whitening potential, and now there are several bleaching gels that contain fluoride, amorphous calcium phosphate (ACP) or a combination of the two.

Patients with dentinal hypersensitivity can often pose a big challenge to teeth bleaching, but this can be easily remedied with proper pre-treatment protocol.

For 10 days to two weeks prior to beginning the bleaching process, a sodium fluoride or product containing ACP should be used once or twice a day and then again as needed during the course of treatment.

If performing chairside bleaching, care should be taken to cover exposed root surfaces and worn incisal edges with a protective dam or bonding agent.

### Special circumstances

Patients receiving cosmetic restorations after bleaching will benefit from waiting two weeks for the oxygen and hydration in the tooth to return to normal levels. At this time, the final shade will have stabilized and the teeth will achieve the strongest bonding strength.

Patients with white-spot lesions, or fluorosis, will want to bleach the teeth to an ideal shade and then follow up with an air-abrasion appointment to smooth and even out the appearance and texture of the enamel.

For patients with translucent incisal edges, a very thin layer of composite can be placed on the lingual surface of the teeth after bleaching as long as it does not interfere with the bite, so the teeth will not appear to have a bluish, see-through appearance.

Patients with bruxing habits will often have noticeably thicker and darker teeth because of more calcified dentin. These patients will most likely achieve the best results by first using an in-office system and then a high concentration take-home gel for touch-ups.

For parents who are concerned about a child’s yellow or mottled enamel, adult-supervised take-home bleaching kits may be used with the option of chairside bleaching, as it may be performed on anyone with all permanent dentition.

Usually, a low-concentration hydrogen peroxide gel works well for children and teens because they don’t have issues with staining habits or thick, calcified dentin.

Tetracycline stain is the most challenging to remove, but excellent results can be achieved if a
Dear Reader,

Recently I have been hearing a commercial on the radio regarding things in our world that alert us before something potentially bad or inconvenient happens to us. The commercial talks about the low fuel light in cars and how it would not be very beneficial if the light came on after the gas had run out. The ad also mentions how a child would feel if he or she was called to dinner after all the food was gone.

There are many things taken for granted when it comes to warning us about impending dangers. Think about smoke detectors. Hopefulness is granted when it comes to warning us about impending dangers. Think about how we are not utilizing such technology, we are not treating patients the way they should be treated. What if all the warnings we take for granted were taken away? Maybe then we would realize the importance of such mundane luxuries.

Best Regards,

Angie Stone, RDHI, BS

Give Kids A Smile grant recipients honored at annual gala

Five grant recipients of the Give Kids A Smile Program Growth Fund were honored at the third American Dental Association Foundation Give Kids A Smile Awards Gala at the Decatur House on Lafayette Square in Washington, D.C. For the third year in a row, CareCredit donated $100,000 to the fund. The CareCredit donation has enabled five key programs to expand services and access to care for children in underserved communities.

The Hispanic Dental Association, National Dental Association, and Oral Health America were selected to receive 2010 grants to continue to expand the availability of dental care to underserved children.

The Hispanic Dental Association is using the funding for outreach programs that identify disadvantaged children and provide preventive services in Los Angeles, Dallas and Boston.

The National Dental Association is enhancing the Deamonte Driver Dental Project, which provides oral health education through local health fairs and connects vulnerable children with a network of volunteer dentists.

Oral Health America’s grant will support local Smiles Across America programs in California, Minnesota and Nevada, expanding children’s access to dental care through local schools.

Additionally, two $15,000 Program Champion grants were awarded to established national oral health programs.

The first, America’s Dentists Care Foundation (Missions of Mercy), has helped more than 100,000 patients and has provided more than $50 million in free dental services since its inception in 2000.

The second, TeamSmile, uses the popularity and power of professional and collegiate sports partnerships to bring patients in need together with dental professionals and volunteers.

In every community across the country, there are children who have limited or no access to dental care. These children have oral infections that may be impacting their ability to sleep, eat and learn.

“The 2010 grant recipients are established programs that have been proven to positively affect access to care of children in need,” said Cindy Hearns, Give Kids A Smile Advisory Board member and senior vice president of marketing at CareCredit.

The National Dental Association is awarded a $15,000 grant from the ADA Foundation Give Kids A Smile Fund during a recent awards gala. Pictured from left are Robert Henderson, PhD, ADA Foundation Board of Directors; Dr. Darrell Clark, NDA; Dr. Edward Chappelle, NDA; Steve Koss, ADA GRAS National Advisory Board chair; Dr. Hazel Harper, NDA; Dr. Belinda Garver-Taylor, NDA; Dr. Walter Owens, NDA; and ADA Executive Director Robert S. Johns. (Photo/Provided by ADA News)

Today, CareCredit is offered by more than 85,000 dental teams. CareCredit is exclusively selected for their members by most state and national dental associations, including ADA Business Resources, AGD, AADOM and AAP, and is also recommended by leading practice management consultants.

The awards gala was held April 15.
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Please send stories to Group Editor Robin Goodman at r.goodman@dental-tribune.com.

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About the author

Julie Seager, RDH, BS, is currently practicing dental hygiene in Northern California and is a former RDH Practice Adviser for Discus Dental. Her website is www.hygienescene.com. You may e-mail her at julieseager@yahoo.com.
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