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Rick Carr 877-466-7726 ext. 6602
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22 Increased Alveolar Crestal Bone Loss in Older HIV-infected Women
Retrospective chart review of panoramic oral radiographs revealed HIV status to be significant predictor of alveolar crestal height in older women, who also experienced greater tooth loss than uninfected women.

27 Case Report of Multiple Keratocystic Odontogenic Tumors Presenting as Nevoid Basal Cell Carcinoma Syndrome in Pediatric Patient
Nevoid basal cell carcinoma syndrome (Gorlin-Goltz syndrome) is autosomal-dominant, inherited genetic disorder with variable expressivity encompassing multiple jaw radiolucencies, palmar or plantar pits. Clinical features of NBCCS, treatment and future plans for case are described.

31 Multiple Miliary Osteoma Cutis of the Cheeks
Incidental Dental Radiographic Finding with Long-Term Follow-Up
John K. Brooks, D.D.S.
Case of MOC, rare dermatopathic disorder of heterotopic bone formation, often associated with acne and primarily involving cutaneous tissues of head and neck, is followed over 22 years to acquaint dental practitioners with features of rare disorder and associated comorbidities.

37 Delayed Diagnosis of Burkitt’s Lymphoma in HIV Patient after Third Molar Removal
Burkitt’s lymphoma, an aggressive neoplasm that progresses rapidly, necessitates prompt recognition, but its diagnosis, especially when its sole presentation is in the maxillofacial region, can be problematic. Case report is presented to encourage dental practitioners to add Burkitt’s lymphoma in the differential diagnosis when treating HIV-positive patients.

43 Lasers to Manage Tooth Hypersensitivity
Zahed Mohammadi, D.M.D., M.S.D.; Hamid Jafarzadeh, D.M.D., M.S.D.
There are several methods for managing dental hypersensitivity, among them, laser. A review is presented that updates applications of different types of laser to manage DH.
Practice Ownership and Management Key to Professional Autonomy

If dentists are unwilling to assume the costs and challenges of running a practice, they cannot truly be in control.

She signs the employment agreement and breathes a sigh of relief. Relief from the financial pressures of staggering dental school debt. Relief from the inability to purchase a private practice and from the daunting prospect of managing it. Finally, she can do what she supposedly went to dental school to do: practice dentistry. But, did she bargain for more?

Most college graduates select a career in dentistry to attain a high level of professional autonomy and control in their personal lives. However, we, as dentists, must be careful what we wish for when we seek apparent relief from the challenges inherent in providing oral healthcare, since such relief may be a catch-22 situation. The only way to earn the privileges of professional autonomy and control is to accept and embrace the very financial risks of ownership and challenges of management that many dentists now increasingly abdicate to large groups and service organizations.

The autonomy to define success for ourselves, then make it happen, stands as one of the central benefits available to private practitioners of dentistry. We can, if we so desire, attain the autonomy to control our career paths and, ultimately, transition into and out of active practice on our own terms. In addition, we have the resources available to control the clinical and management decision-making processes essential to ensure we practice in the best interests of our patients. However, these opportunities are privileges, not inalienable rights. As in any business or endeavor, it is the owners and managers who earn the privileges of career autonomy and control of the day-to-day decision-making processes. Unless we, as clinicians, assume the financial risks of practice ownership and the difficult task of practice management, we will not earn the authority to control our personal strategic transition plan, or draft and implement a practice mission statement consistent with our professional values.

Practice ownership requires the dentist, as entrepreneur, to create the vision and organize the clinical, business and management structures of the entity. Most importantly, to do so, the owner must take on greater than normal financial risk. Equity ownership empowers dentists with legal and financial control over practice succession, including the terms of how and when the owners and associates transition into and out of the practice. Importantly, equity owners can and do receive fair market value for the practice goodwill at the time of transition. This career autonomy allows us to define success for ourselves and to set and realize both our professional and personal goals. Employee dentists who, by definition, lack a financial stake in the practice entity, concomitantly earn little, if any, control over their own transition plans.

Ownership alone, however, without retaining accountability to manage, implement and enforce the practice vision and mission will not provide the
autonomy and control over our day-to-day practice. Certain dental service organization models involve agreements between dentists and non-dentist corporate managers, which result in the management organization providing, among other things, dental materials, human resource management, billing, marketing and information technology support. At some level, control of these critical components allows the management organizations to function as de facto practice owners.

As dentists abdicate increased responsibilities to corporate entities, these entities will begin to impose their own definition of success upon the dentists who work for or with them. This model creates a slippery slope that will, ultimately, give corporate stakeholders, in some cases non-dentists, increased influence on the practitioners’ clinical practice, including decisions regarding the type and quality of dentistry and acceptance of third party payer plans with reduced fee schedules. We relinquish control over our practice mission statements when we allow third parties to dictate our method of practice.

The future of dentists’ professional and personal autonomy rests with their desire and ability to own and manage their practices. The solution does not require dentists to ignore, to their detriment, the entrepreneurial, financial and management skills of corporate experts. We must recognize that it is not the expertise itself that impairs our autonomy, it is how we, as dentists, use and control it. Management organizations and large group practices can offer the autonomy a dentist may desire, but only if the dentist maintains controlling ownership and accountability for management. Dentists need to delegate, not abdicate, authority. While dentists have the absolute right to elect a life of employment without the control, for those of us who want professional autonomy, we must earn it.

D.D.S., J.D.
NYSDA achieved a good outcome from this year’s legislative session, achieving three major priorities. But the Association also saw a tort reform bill it has opposed for years passed.

For a long time, NYSDA has argued with insurance companies and government agency officials that it is illegal under New York’s anti-interdependent sales law—Section 4224(d)(1) of the New York State Insurance Law—for insurers to include discounts on totally uninsured dental services as part of dental insurance plans they market. While no government agency ever disagreed with NYSDA, out of fear it would be seen as advocating raising prices for consumers, neither would any agency choose a side in the debate with certain insurance companies. In fact, some insurers agreed with NYSDA and would not engage in this practice. But the stalemate was inconvenient and, although NYSDA warned it would litigate this issue if any insurer tried to sanction a member dentist for charging his or her usual fee for uninsured services, many members remained intimidated by the possibility of insurers dropping them from plans—even though NYSDA never received evidence this had happened in the seven years of this ongoing stalemate.

Finally, to put an end to this dilemma, in which it must be said New York State government officials were singularly useless resolving, NYSDA introduced a bill to have the State Legislature clarify and settle the conflict over interpreting the existing law. Ironically, the insurance industry fell all over itself in agreeing to the new law. The industry’s chief concern was making sure that dental services that were insured were not treated as being uninsured. Since this had never been an issue for NYSDA and was not part of the conflict over non-covered services, it was easy to convince legislators that they should pass NYSDA’s bill and end the uncertainty over the law. Thus, A.8141-A (Cymbrowitz)/S.6496-A (O’Mara) was passed unanimously in the Assembly and Senate and awaits delivery to the governor for his signature.

Since NYSDA and the insurance industry were in complete agreement on the bill, it is not expected that the governor will veto the bill, as it really just clarifies what had already been the law for a long time. Nevertheless, this is a major relief to many dentists, who worried they could not trust insurance plans to follow the law.

Membership and Infection Control

Another priority item NYSDA successfully passed unanimously in the Assembly and Senate was A.5984 (McDonald)/S.3516 (Croci), the bill that altered the NYSDA governing statute to allow the Association and its components to successfully adopt the American Dental Association’s Aptify unified membership computer system. Aptify was unable to process or track membership where an ADA member was treated differently for representation purposes as opposed to actual membership purposes. Aptify could only allocate members to the component dental societies where they were actual members. By eliminating NYSDA’s dual representation/membership system, which applied to a limited and dwindling number of members, NYSDA and component dental societies were able to adopt Aptify without any hitch. This bill also awaits the governor’s signature. He is not expected to veto this necessary housekeeping measure.
A bill that NYSDA initially opposed but had amended, thereby eliminating its reason for objecting, was A.6053-A (Nolan)/S.4971-A (Marcellino), which incorporated sepsis training into infection-control training. The final bill merely adds sepsis to a list that already included human immuno-deficiency virus (HIV) and hepatitis as items to be cognizant of in infection-control training. The original version of the bill, which NYSDA opposed, would have, illogically, included training in recognizing, diagnosing and treating sepsis as a disease state in patients as part of infection-control training. This mixed apples with oranges and would have changed the fundamental nature of infection-control training from a work environment and equipment sterility focus to a clinical disease/patient treatment focus.

While NYSDA no longer objects to this bill as revised, it is not certain the governor will sign it into law. There are still concerns from some that the goal of the bill for sepsis training as a disease state in patients is no longer apparent in the revised version and that it still makes no sense to graft sepsis training as a patient disease state onto an infection-control curriculum. The governor’s office has already asked questions about the bill that indicate skepticism.

**Battle of the Budget**

It seems every year we mention that we preserved dental Medicaid for both adults and children in New York State without any reductions in services or funding. Our continued success makes it seem as if it is no big deal and would have happened anyway. The same often appears to be true of the repeated failure by trial lawyers to pass any of their pro-plaintiff tort reforms, about which we warn every year. But these successes and warnings are not routine by any means. This year, the trial lawyers did pass their bill to change the medical and dental malpractice statute of limitations to a date of discovery rule instead of a fixed two-and-one-half-year rule. This year, the trial lawyers did pass their bill to change the medical and dental malpractice statute of limitations to a date of discovery rule instead of a fixed two-and-one-half-year rule. These successes and warnings are not routine by any means.

**Council on Awards**

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<tr>
<th>Chairperson</th>
<th>Address</th>
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<tr>
<td>Chad P. Gehani</td>
<td>35-40 Blvd St., Jackson Heights, NY 11372</td>
</tr>
<tr>
<td>James A. Hoddick</td>
<td>402 Delaware St., Saratoga Springs, NY 12145</td>
</tr>
<tr>
<td>Terrence J. Thines</td>
<td>Upstate Medical Center, 250 East Adams St., Syracuse, NY 13210</td>
</tr>
<tr>
<td>Patrick L. Anders</td>
<td>47 Lafayette Blvd., Buffalo 14221</td>
</tr>
<tr>
<td>Scott R. Firestone</td>
<td>42 Mark Dr., Smithtown, NY 11787</td>
</tr>
<tr>
<td>Samuel D. Carocci</td>
<td>35-40 Blvd St., Jackson Heights, NY 11372</td>
</tr>
<tr>
<td>John C. Comisi</td>
<td>2333 N. 2nd Avenue, #304, Yakima, WA 14505</td>
</tr>
<tr>
<td>Renuka R. Bijoor</td>
<td>325 S. Highland Ave., Braniff Manor, NY 10510</td>
</tr>
<tr>
<td>Richard F. Andolina</td>
<td>Crossroads Professional Building, 74 Main St., Hornell, NY 14843</td>
</tr>
<tr>
<td>Joseph R. Giovannone</td>
<td>286 Genesee St., Utica, NY 13502</td>
</tr>
<tr>
<td>Wayne S. Harrison</td>
<td>8 Medical Arts Ln., Saratoga Springs, NY 12866</td>
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**Office**

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<td>602 20 Corporate Woods Blvd., Albany, NY 12211</td>
<td>(518) 465-0044 (800) 255-2100</td>
</tr>
<tr>
<td>Mark J. Feldman</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Lance R. Plunkett</td>
<td>General Counsel</td>
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<tr>
<td>Beth M. Wanek</td>
<td>Associate Executive Director</td>
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<tr>
<td>Michael J. Herrmann</td>
<td>Assistant Executive Director Finance-Administration</td>
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<tr>
<td>Judith L. Shub</td>
<td>Assistant Executive Director Health Affairs</td>
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<tr>
<td>Grazia A. Yaeger</td>
<td>Assistant Executive Director Marketing and Communications</td>
</tr>
<tr>
<td>Laura B. Leon</td>
<td>Assistant Executive Director</td>
</tr>
<tr>
<td>Mary Grates Stoll</td>
<td>Managing Editor</td>
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</table>
year rule. Known colloquially as Lavern’s Law (for a patient who tragically died after a physician missed a diagnosis of cancer, but who could not sue because she discovered the missed diagnosis too late), the bill had major momentum towards the end of the legislative session in June, helped by a barrage of media attention in favor of its sympathetic genesis. However, unlike previous versions, the bill that passed this year—A.8516 (Weinstein)/S.6800 (DeFrancisco)—was scaled back to apply only to failures to diagnose cancer or malignant tumors. All other bases for malpractice lawsuits remain under the current fixed two and one-half years from the date the patient was last seen for the issue being complained about.

Thus, while it was not possible to stop this law this time around, it was significantly altered to have a more limited impact. It should be noted that the much worse version of the bill—A.3339 (Weinstein)/S.4080 (DeFrancisco)—was being pushed at the same time as the one that passed, so the battle to prevent that worse version from passing was intense. The governor has previously said he will sign this bill into law when it reaches his desk, although it has not yet been sent to him.

On the positive side of the legislative equation, the New York State Budget was again very favorable to NYSDA, with continued funding for our grant program to serve underserved communities, continued funding for community water fluoridation, and continued funding for adult and children’s Medicaid services without reductions. These items were not achieved without crucial negotiating, but they were passed as part of the state budget in a year that saw many cuts to the spending plan and ongoing worries over federal funds drying up, especially for Medicaid. However, NYSDA fought hard to keep dental priorities funded, and the governor was supportive of these budget initiatives in a year where he issued a significant number of line item vetoes of funding items.

**Healthcare Delivery and Billing**

Finally, NYSDA saw two lesser noticed items passed, one that it supported and one it had monitored. The one we supported was a bill to extend the antitrust exemption known as certificates of public advantage (COPA), issued by the Department of Health to certain accountable care organizations (ACOs) as a new form of healthcare delivery system—A.7748 (Gottfried)/S.5342 (Hannon)—already signed into law by the governor as Chapter 80 of the Laws of 2017. The COPA allows healthcare professionals to collaborate on negotiations in order to permit the ACO to achieve efficiencies and cost savings. While this is not a broad antitrust
exemption for collective negotiating by healthcare professionals, it is a step in that direction that is helpful at least in the ACO context. ACOs may become a more common healthcare delivery system in the future, but only time will tell whether they really make a difference in improving the delivery of healthcare services.

The second item, which NYSDA just monitored, was A. 7866 (Gottfried)/S.6012 (Seward), a bill that allows school-based health centers to continue to be paid on a fee-for-service basis in Medicaid rather than on a managed care basis. NYSDA took no position on this bill, and it is not known if the governor favors signing into law any carve-out from the plans to transition all of Medicaid to a managed care system. While the bill does include dental services provided at school-based health centers and will increase funding for such centers, it is a mixed blessing for other Medicaid providers. Because the bill effectively continues the system already in place, NYSDA weighed its pros and cons and decided to remain neutral. The Association monitors many bills this way, some of which there are tendencies to support and some to oppose. When one of those tendencies particularly outweighs the other, NYSDA will take a definite position. But there are times when competing interests or the public relations aspects of a bill make the politics of choosing a position unwise.

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**Not Done Yet**

Generally, it was another good legislative session for NYSDA. Certain items we lobbied for did not advance, particularly student debt relief programs, although we saw some progress on this front, particularly making legislators more aware of the problem. Neither did changes to dental scope of practice advance beyond where they were last session. But those issues will not be going away.

Sometimes, things move quickly in the Legislature, but most of the time, issues are handled over many sessions. A lot depends on the nature of the issue and potential opposition to it. Items requiring funding are never easy sells, nor are items with strong opponents. At times, even the intrinsic merits of such items are not enough to overcome concerns. But the one constant is that NYSDA tries every year to advance critical dental priorities, not just for the benefit of the profession, but also for the good of the public and the patients dentistry serves. 

The material contained in this column is informational only and does not constitute legal advice. For specific questions, dentists should contact their own attorney. An archive of previously published legal articles can be accessed in the members-only area of the NYSDA website, www.nysdental.org.
RISK MANAGEMENT COURSES

There are just two remaining Risk Management courses scheduled before the end of the year. They are Nov. 1, hosted by the Suffolk County Dental Society, and Dec. 8, hosted by the Nassau County Dental Society. Both courses will meet from 9 a.m. to 1 p.m. For information and to register, call SCDS at (631) 244-0722, or NCDS at (516) 227-1112.

The NYSDA Risk Management course is accepted by most malpractice insurance carriers. An exception is CNA Insurance Co., which accepts only its own course. Members are encouraged to check with their carriers before registering for a class. Carriers who accept the course will extend a discount on liability premiums to dentists completing the course.

RISK MANAGEMENT COURSE ONLINE

The NYSDA Risk Management course is offered online. Dental professionals who choose to take the course online will be charged a small fee, but will have up to six months to complete the course. Upon completion of the course, they will receive a 10% discount on their malpractice insurance for three years, four continuing education credits, automatic recording of their credits with the NYSDA Continuing Education Registry and a certificate of completion.

The course is available at www.nysdentalfoundation.org. Fees are as follows: $40/NYSDA & ADA members & auxiliary staff; $80/others.

Important Reminder for Dentists Taking MCE Courses

IN ORDER TO RECEIVE CREDIT for New York State mandatory continuing education, you must make sure that the entity sponsoring a continuing education course is approved to provide MCE credit by NYSDA, NYSED, ADA CERP or AGD PACE. NYSDA approves only its 13 component dental societies and the New York State Dental Foundation.

Information regarding sponsors approved by NYSED is available from the New York State Education Department, State Board for Dentistry, 89 Washington Ave., Albany, NY, 12234-1000; (518) 474-3817, ext. 550; fax (518) 473-0567. If you are unsure whether a sponsor offering a continuing education program is approved, contact the Dental Board or by e-mail at dentbd@nysed.gov.

ADA Salutes Dental Volunteers

THE ADA BOARD OF TRUSTEES has recognized six NYSDA members for their volunteer service outside of the United States. Each was commended for having relieved “the pain and suffering of people in disadvantaged countries,” having exemplified, through their volunteer contributions, “a selfless and giving nature that is needed in the world now more than ever” and for elevating the profession of dentistry.

Receiving certificates for International Volunteer Service and designation as ambassadors of goodwill and friendship among nations are:

Raya Bu-Zahara, Nassau County; David Klebanow, Nassau County; Laurence Wynn, Suffolk County; Sheldon Kupper, New York County; Steven Esposito, Fourth District; Alla Fishman, Suffolk County.

DATES TO REMEMBER

For more information about NYSDA-sponsored events, call the State Association at (800) 255-2100.

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<tr>
<th>Event</th>
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<tr>
<td>Council Governmental Affairs</td>
<td>September 29</td>
<td>Conference Call</td>
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<tr>
<td>Buffalo Niagara Dental Meeting</td>
<td>October 4-6</td>
<td>Buffalo Niagara Convention Center, Buffalo, NY (716) 829-2061</td>
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<td>NYSDA Board of Trustees</td>
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<td>Greater Capital District Dental Symposium</td>
<td>October 5-6</td>
<td>Albany Marriott, Albany, NY (518) 782-1428</td>
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<td>NYSDF Board of Trustees</td>
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In Memoriam

NEW YORK COUNTY
George Argerakis
Georgetown University ‘65
115 E 61st Street, #6A
New York, NY 10021
May 2, 2015

Frederick Curro
Tufts University ‘72
3 Powell Road
Emerson, NJ 07630
March 31, 2017

Bert Gaster
New York University ‘50
2 Tudor City Place, #10GN
New York, NY 10017
May 11, 2017

Steven Karr
New York University ‘45
225 George Sickle Road
Saugerties, NY 12477
December 10, 2015

Robert Sloane
New York University ‘41
30 Central Park South, Fl 9
New York, NY 10019
May 10, 2016

Meyer Tendler
New York University ‘45
2 Peter Cooper Road
New York, NY 10010
July 8, 2017

SECOND DISTRICT
Manuel Hirschfield
New York University ‘47
3335 Aruba Way, #44
Coconut Creek, FL 33066
April 26, 2015

Irving Shuman
University of Pennsylvania ‘57
295 NW 99th Way, #226
Coral Springs, FL 33065
July 23, 2017

THIRD DISTRICT
Leonard Faust
Virginia Commonwealth University ‘45
12455 Crystal Pointe Drive
Boynton Beach, FL 33437
May 18, 2015

Bruce Hotum
New York University ‘85
138 Pine Street
Kingston, NY 12401
July 21, 2017

Henry Jacobs
University at Buffalo ’63
8985 Shaol Creek Lane
Boynton Beach, FL 33437
August 25, 2015

John Kotin
Temple University ’62
PO Box 30
Monticello, NY 12701
April 23, 2016

SEVENTH DISTRICT
Raymond Brandte
205 E Side Drive
Concord, NH 03301
June 26, 2017

EIGHTH DISTRICT
Robert Balcerak
University at Buffalo ’62
7 Spring Way
Lancaster, NY 14086
January 25, 2017

Leo Crowley Jr
University at Buffalo ’54
48 The Village Green
Williamsville, NY 14221
February 14, 2017

Roger Czarnecki
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5861 Goodrich Drive, #11C
Clarence Ctr, NY 14032
October 2, 2016

Florian Dzimian
University at Buffalo ’42
6053-2 Quaker Hollow Road
Orchard Park, NY 14127
October 10, 2015

Donald De Rose
University at Buffalo ’56
522 Franklin Street
Buffalo, NY 14202
October 24, 2016

Gordon Kauderer
University at Buffalo ’58
8181 Oak Leaf Lane
Williamsville, NY 14221
March 18, 2017

Conrad Kubinec
University at Buffalo ’61
12 Hickory Lane
Cazenovia, NY 13035
March 18, 2017

Frank Nappo
University at Buffalo ’59
228 Golden Pond Estate
Akron, NY 14001
January 15, 2017

Renzo Nylander
University at Buffalo ’73
524 N Forest Road
Williamsville, NY 14221
January 29, 2017

Harold Ortman
University at Buffalo ’41
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Buffalo, NY 14226
October 14, 2016

Edwin Patricola
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Clarence Center, NY 14032
September 5, 2016

Barry Wood
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March 14, 2017

NINTH DISTRICT
George Jackrel
New York University ’72
73 Hillis Terrace
Poughkeepsie, NY 12603
February 22, 2017

Sanford Kirsch
Washington University ’46
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Chappaqua, NY 10514
August 31, 2016

Jefferson Weishaar Jr.
Harvard University ‘42
114 Old Mountain Road N
Nyack, NY 10960
June 14, 2017

NASSAU COUNTY
Harry Newman
New York University ‘48
901 Roosevelt Way
Westbury, NY 11590
March 1, 2017

J. Paul Rosenbaum
University of Pennsylvania ‘48
1251 Wesley Avenue
Pasadena, CA 91104
March 1, 2017

Howard Scherer
Virginia Commonwealth University ‘45
356 N Wyoming Avenue
N Massapequa, NY 11758
No Date Available

QUEENS COUNTY
Charles Stagg Jr.
Baltimore College of Dental Surgery ‘44
1543 Florence Road
Clarence Center, NY 14032
April 30, 2017
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Andrew G. Vorrasi, D.D.S., whose behind-the-scenes efforts to bolster organized dentistry have earned him the respect of his colleagues and helped to strengthen the profession, is the 2017 recipient of the Pierre Fauchard Academy Distinguished Service Award, presented by the New York Section of the academy.

The presentation to Dr. Vorrasi was made June 2 during the NYSDA Annual Meeting at Turning Stone Resort Casino in Verona. The PFA gathering witnessed as well the induction of 12 dentists as fellows of the academy.

Dr. Vorrasi, a general dentist, lives and practiced in Rochester. He is a past president of the Seventh District Dental Society, was an ADA Delegate for 11 years, a NYSDA Governor or Trustee for 12 years and a member of numerous local, state and national committees. He is generally recognized for initiating the Combined Dental Venture, which brought Rochester-area dental institutions and organized dentistry together to streamline credentialing so that practitioners could more quickly and efficiently treat Medicaid recipients and volunteer at regional hospitals. And he was previously honored by the Seventh District, which presented him with its highest honor, the George Greenwood Award.

The PFA award winner is a member of the American College of Dentists, for which he chaired the Western New York section; the International College of Dentists, serving as a District 2 Regent; the Pierre Fauchard Academy; the Misch Implant Institute; and the Academy of Dentistry International. He is a 1980 graduate of the University at Buffalo School of Dental Medicine. He earned a master’s degree in chemistry from UB also.

New Members Inducted

The Pierre Fauchard Academy seeks to educate dental professionals about the latest techniques in dentistry and to foster a sharing of ideas to improve the profession. Amarilis Jacobo, Bronx County, is section chair. Edward Feinberg, Ninth District, is section vice chair. This year’s inductees include the following:

- Renuke Bijoor, Ninth District
- Maurice Edwards, New York County
- Gary Goldstein, Third District
- Eric Huang, Ninth District
- James Jacobs, New York County
- Adrienne Korkosz, Third District
- Amrita Patel, Ninth District
- David Ramjattansingh, Seventh District
- Duraid Sahawneh, Ninth District
- Jacqueline Winter, New York County
- Boris Zats, Second District
- William Zugner, Seventh District.

Fauchard Academy Honors Andrew Vorrasi

Inducts 12 New Members

Amarilis Jacobo and Edward Feinberg, chair and vice chair of New York Section, Pierre Fauchard Academy, who announced selection of New York chapter to receive PFA 2016 Model Section Award.

PFA Distinguished Service Award winner Andrew Vorrasi with family. From left: wife, Susan; son, John Vorrasi, D.M.D.; daughter, Mary Reiser.

This year’s new Pierre Fauchard fellows include Adrienne Korkosz and Gary Goldstein, both of Third District.
The mood was enthusiastic and festive when NYSDA members and guests gathered Saturday, June 3, a sunny, early spring evening, to honor Richard F. Andolina, whose term as president of the Association was coming to an end. The President’s Dinner Dance is the social highlight of the House of Delegates Annual Session, held this year at Turning Stone Resort and Casino in the Central New York town of Verona.

President Richard Andolina and wife, Molly, gather with family as they prepare to greet well-wishers at President’s Dinner Dance, highlight of Annual House Meeting. They are, from left: son Mitch and Katlyn Richardson; Rick’s sister, Pam Favro, of Henrietta; Molly and Rick; son Richard Jr. and Emily Mahoney; son Nick.

NYSDA Trustee Frank Barnashuk, Eighth District, and wife, Debbie.

2015-2016 President David Miller and wife, Patrice, enjoy company of Nassau County colleagues, from left: NCDS President Fabiola Milord; Sanford Klein, 1986 NYSDA President; the Millers; House delegates James Fitzgerald and Frank Palmaccio.

John Liang, 2014-2015 NYSDA President, and wife, Sharon.

NYSDA Speaker and past president Steven Gaunardes (2007) and wife, Dianne, with Scott Firestone, Suffolk County Alternate Delegate, and SCDs Executive Director Paul Markowitz.
Lawrence Busino and wife, Kyle, prepare to celebrate Dr. Busino’s installation the following day as NYSDA President for 2017-2018.

Fourth District Trustee James Galati and wife, Kelli.

Kevin Henner, at right, prior to his installation as Suffolk County Trustee, with Paul Leary, attending last House meeting as trustee, and Paul’s wife, Deborah.

Michael Grassi, left, and Bradley Davidson, co-chairs of Annual Meeting, with Lori Bowerman, executive director, Seventh District, which hosted the 2017 meeting.

Lawrence Busino and wife, Kyle, prepare to celebrate Dr. Busino’s installation the following day as NYSDA President for 2017-2018.

Attending from Ninth District are, from left, Delegate Paul Patella, Alternate Delegate Bhagwati Mistry, Alternate Delegate Renuka Bijoor, Delegate and Ninth District President Mary Ellen Lukaswitz.
New York State Dental Association

ANNUAL SESSION

President-Elect Brendan Dowd and wife, Colleen, with Robert Buhite, attending last meeting as Seventh District Trustee.

Traveling from Western New York are, from left: Lawrence Volland, NYSDA President, 2005, and wife, Judith; Mary Kay Calnon; Debbie Barnashuk.

From left: Maria Maranga, delegate, Suffolk County; Nassau County Dental Society President and Delegate Fabiola Milord; Claudia Mahon-Vazquez, Suffolk County.

Trustee David Shipper, New York County, left, with Gary Scharoff, delegate, Ninth District.

New York State Dental Journal Editor Chester Gary, right, with Delegate Robert Shpuntoff, Queens County.
2017  

Turning Stone Resort, Verona

NYSDA Vice President Payam Goudarzi, left, is greeted warmly by Suffolk County Treasurer and Delegate Jeffrey Seiver.

Incoming NYSDA President Lawrence Busino, center, and Third District Trustee David Delaney, right, welcome Pennsylvania Dental Society President Bruce Terry to meeting.

NYSDA past presidents Chad Gehani (2011-2012), left, and Michael Breault (2009-2010) with their wives, Rekha and Linda. Dr. Gehani is ADA Trustee. Dr. Breault is 2017 Distinguished Service Award winner.

UB classmates ('90) reconnect at reception. From left, Third District President Michael Maloney, Michael Keating, Seventh District President Theresa Casper-Klock, Fifth District President Kevin Sorge.

Bronx County Trustee Rob Margolin, second from left, and husband, Dan Barbour, with Elizabeth Sandoval, delegate, Bronx County, and Rudy Parra.
NYSDA thanks the following sponsors for their participation in the 2017 House of Delegates Meeting

NYSDA past president (2013-2014) and EDPAC Chair Joel Friedman, far right, and wife, Marian Faytell, with Timothy Calnon and Alternate Delegate Lauren Vitkus, Seventh District.

From left: Viren Jhaveri, delegate, Queens County; Trustee Prabha Krishnan, Queens County; NYSDA past president P. Deborah Weisfuse (2012-2013) and husband, Robert Lipner.

NYSDA Secretary-Treasurer Mark Weinberger and wife, Joanne, at right, with Fifth District Trustee Jonathan Gellert and wife, Cheryl.
The Eighth Annual Session of the NYSDA House of Delegates came together June 2-4 at the Turning Stone Resort and Casino, Verona, NY. Photos on this page and the following pages capture significant moments, when members were recognized for achievements and for outstanding service to the Association.

2017 Distinguished Service Award winner Michael Breault receives his award from Dr. Andolina.
Fifth District delegation is recognized with Hallmarks of Excellence Award, presented by Council on Membership and Communications for society’s innovative “speed dating” event, which brought together dental employers and dentists seeking employment.

EDPAC Chair and member, NYSDA Council on Awards, Joel Friedman, left, with Eli Eliav, director, Eastman Institute for Oral Health, who attended meeting to accept Association Jarvie-Burkhart Award on behalf of Institute.

Past president David Miller, at far right, with members recognized for service as chairs of NYSDA councils. They are, from left: Guenter Jonke, Ethics; Kevin Henner, Professional Liability Insurance; Joseph Gambacorta, Membership and Communications; Richard Speisman, Dental Health Planning & Hospital Dentistry.

Suffolk County Executive Director Paul Markowitz, left, congratulates Paul Leary, elected to serve as ADA Trustee beginning in October 2018.

Immediate Past President Richard Andolina, at center of photo, with trustees who have completed their term of office. They are, from left, David Miller, Paul Leary, Robert Buhite, Edward Miller.
Richard Andolina, who moved from president to immediate past president at June meeting, receives standing ovation, acknowledgment of his accomplishments at helm of NYSDA.

Newly installed NYSDA trustees are, from left: David Shipper, New York County; Kevin Henner, Suffolk County; Jay Skolnick, Seventh District.
Brendan P. Dowd, D.D.S., NYSDA President-Elect, was honored by the New York State Dental Foundation, which in June presented him with its Foundation of Excellence in Community Service Award. Dr. Dowd received his award during the NYSDF annual luncheon, June 3, held in conjunction with the Annual Meeting of the NYSDA House of Delegates at Turning Stone Resort and Casino in Verona.

Also honored at the luncheon was the University at Buffalo School of Dental Medicine, which received the Foundation of Excellence in Academics Award for its demonstration of “creative and innovative use of science curricula to reach oral health.” The school was cited in particular for combining state-of-the-art academics with unique community health programs that have increased access to care for at-risk populations while fostering community partnerships and providing dental students with beneficial learning experiences.

Accepting the award on behalf of the dental school was its dean, Joseph Zambon.

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Dan Rothstein, D.D.S., M.B.A., C.P.A.
Member ADA, NYSDA, NYSSCPA and AICPA
The foundation’s community service award recognizes an individual who has helped to improve oral healthcare for individuals, particularly underserved and at-risk populations, through advocacy that emphasizes education and prevention and fosters partnerships with a wide spectrum of stakeholders.

Dr. Dowd has worked tirelessly over the past two years to develop dental demonstration projects across the state to provide free care to the disadvantaged and those lacking ready access to standard care. Among the beneficiaries of his efforts are military veterans, who were specifically targeted for care at a free clinic he organized last November at UB.

Dr. Dowd is clinical assistant professor for restorative dentistry and senior group director at UB. He is a past president of the Eighth District Dental Society.

The keynote speaker at this year’s luncheon was Karin Irani, D.D.S., of Beverly Hills, CA. Dr. Irani is founder of the nonprofit “School of Smiles,” which she established to provide optimum care to families in need. She also played a leading role in the creation of Veterans Smile Day, with the goal of providing free dental care and support to military veterans.

Dr. Irani is president of the San Fernando Dental Society, California Dental Association Leadership Development Chair and 13th ADA Trustee District representative to the ADA Council on Membership.

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Increased Alveolar Crestal Bone Loss in Older HIV-infected Women


A B S T R A C T
The aim of this study was to evaluate alveolar bone loss and the number of teeth in middle-age and elderly HIV-infected women compared to uninfected women. A retrospective chart review of existing panoramic oral radiographs was performed in HIV-infected women over the age of 40 (n=48). Age and race/ethnicity matched uninfected controls (n=131) from the same dental clinic in New York City. Alveolar crestal height (ACH) and the number of existing teeth were determined from oral radiographs. Univariate and multiple regression analyses were performed.

ACH was greater in HIV-infected women than in age-matched uninfected controls (2.75+0.8 vs 2.15+0.8 mm, p=0.006), reflecting greater alveolar bone loss. HIV status remained a significant predictor of ACH after adjusting for age, diabetes and current smoking. Among women over age 50, there was a trend for fewer teeth in HIV-infected women than in uninfected controls (11.7+8.1 vs 14.9+8.1, p=0.08).

Authors concluded that older HIV-infected women had greater alveolar bone loss compared to age-matched uninfected controls. Prospective studies are needed to assess the impact of the menopausal transition on alveolar bone loss in HIV-infected women, and to identify preventive measures for early tooth loss.

With the advent of effective combination antiretroviral therapy (cART), HIV-infected women are living longer and transitioning through menopause. In the U.S., more than half of HIV-infected individuals are over age 50.1 Prior to the widespread use of effective cART, patients were diagnosed with HIV-infection based upon severe and pathognomonic oral manifestations, including serious periodontal manifestations, such as necrotizing ulcerative periodontitis (NUP). With effective cART, many of the HIV-associated oral health issues have improved dramatically.2,3 In fact, several recent studies comparing HIV-infected individuals on cART to uninfected, age-matched controls have similar prevalence of periodontal disease,2,4 bleeding on probing, number of teeth5 and alveolar bone loss.6,7,8 However, few of the studies included older HIV-infected individuals, especially older postmenopausal women.

Women undergo menopause between the ages of 45 and 50. Menopause is associated with a sudden decrease in overall estrogen levels, which cause many systemic effects, such as increase risk of osteoarthritis and osteoporosis. In the oral cavity, menopause is associated with increased clinical attachment loss,9,10 increased alveolar bone loss11,12 and decreased bone density of the
mandible. The effects of menopause on tooth loss is less clear, with some studies finding a decrease in the number of teeth, while other studies have not. We have previously demonstrated that rates of bone loss at the lumbar spine, hip and radius, and rates of fragility and non-fragility fractures are higher in HIV-infected women than in uninfected controls after menopause.

Since oral health in older HIV-infected women around the menopausal transition has not been well characterized, we performed a retrospective assessment of alveolar bone loss and number of teeth present in HIV-infected women and matched controls over the age of 40. We hypothesized that HIV-infected women would have more alveolar bone loss and fewer teeth present than uninfected women, and that these differences would become even greater with increasing age.

Materials and Methods
A retrospective chart review of existing panoramic oral radiographs and dental records was performed in HIV-infected women over age 40. In this review, we identified 48 HIV-infected women with panoramic oral radiographs and bitewing radiographs performed at the Columbia University College of Dental Medicine Dental Clinic. We then identified 144 age- and race/ethnicity-matched uninfected controls from the same clinic for a 3:1 match; but only 131 had available panoramic oral radiographs and bitewings (Table 1). Using oral radiographs, we determined the number of teeth present and alveolar crestal height (ACH). Approval from Columbia University’s Institutional Review Board was obtained before research, and the study was performed in compliance with regulations.

ACH was measured according to published methods. It was defined as the distance in mm between the cemento-enamel junction and the most coronal part of the alveolar crest directly adjacent to the root surface along the long axis of the tooth. Increased ACH translates to increased alveolar bone loss. It was measured from bitewing radiographs in the posterior region and periapical radiographs for the anterior teeth. All radiographs were calibrated within MiPACS to account for any magnification error. To obtain ACH, the mesial and distal sites were assessed for each tooth present in up to 48 sites from 24 teeth except third molars and canines. Whole-mouth mean ACH was calculated by averaging the ACH levels in all teeth measured in the mouth; therefore, mean ACH was not overly influenced by extremely high or low values at a single tooth.

The number of teeth was calculated from panoramic radiographs and included all the teeth present except for third molars and supernumerary teeth; therefore, the maximum number of teeth present was 28.

ACH and tooth measurements were performed by two separate examiners (orthodontic resident and orthodontic intern) 24 hours apart. Both examiners followed the steps outlined above. Inter-observer reliability was found to be 0.938.

Statistical Analysis
All statistical analyses were performed using SPSS (version 22, Armonk NY: IBM Corp.). Continuous data were presented as mean value + standard deviation; categorical data were presented as percentage or absolute number. Means between groups (HIV-infected and uninfected) were compared using Student’s t-tests. Between-group differences in categorical measures were assessed with Fisher’s exact test. After parameters were determined to be normally distributed, correlations between parameters were evaluated using Pearsons coefficients. Univariate associations of demographics, medical and lifestyle variables and HIV status with ACH and numbers of teeth were examined. These variables entered a stepwise multiple regression (P of 0.20 to enter and 0.05 to be retained in the model). P values of <0.05 were considered significant.

Results
HIV-infected and uninfected controls were similar in age (53.7±7 vs 52.7±7, p=0.37) and did not significantly differ by history of
diabetes (30% vs 21%, p=0.23) or cigarette use (29% vs 12%, p=0.13) (Table 1). Based on their medical records, these HIV-infected women had a mean CD4+ T cell count of 653±364 cells/ul; 87% were on cART, including protease-inhibitor containing regimens (37%) and non-nucleoside reverse transcriptase inhibitors (37%); and 81% had plasma HIV-1 RNA levels<50 copies/ul.

Among women over age 50, there was a trend for fewer teeth in HIV-infected women than in uninfected controls: 11.7±8.1 vs 14.9±8.1, p=0.08 (Table 1). Further, 14% of HIV-infected women had a mean CD4+ T cell count of 653±364 cells/ul; 87% were on cART, including protease-inhibitor containing regimens (37%) and non-nucleoside reverse transcriptase inhibitors (37%); and 81% had plasma HIV-1 RNA levels<50 copies/ul.

In patients who had cigarette use and diabetes history completed, multiple regression analysis was performed. HIV remained significantly associated with ACH after adjustment for age, cigarette use and diabetes (Table 3). In contrast, age remained a strong predictor of number of teeth in a multiple regression model, but not HIV (Table 3). Among HIV-infected women, ACH correlated with age (r=0.579, p=0.001) and number of teeth present (r=-0.472, p=0.048). CD4 T cell count was directly correlated with number of teeth (r=0.364, p=0.01), but not ACH.

### Discussion

In this retrospective study of oral radiographs, we found that HIV-infected women had increased alveolar crestal bone loss compared to age-matched controls, even after adjustment for smoking and diabetes.

Our study findings were similar to findings from the only other study of oral health in older HIV-infected women. Caputo et al. examined mandibular bone alterations by oral radiographs and found an increase in antegonial depth and a decrease in mental index height in HIV-infected postmenopausal women compared to age-matched, uninfected controls. Since antegonial depth may correlate with bone density, the authors concluded that older HIV-infected women have increased mandibular bone resorption. Taken together, these data suggest that in older HIV-infected women, there is loss of mandibular bone mass or density similar to the decrease at the hip and spine observed in HIV-infected individuals. Our study results differ from Aichelmann-Reidy et al., which found no difference in ACH in younger HIV-infected and uninfected men; therefore, it is possible that HIV-associated increases in alveolar bone loss occur only with older age, or in the context of the menopausal transition, or both.

The increased alveolar bone loss in older HIV-infected women may be due to increased oral inflammation. HIV infection has been shown to cause an increase in oral inflammatory markers. For example, de Brito et al. compared CD4+CD28+ and CD8+ T cell cytokine gene expression in cells from the peripheral blood of HIV-infected patients on combination antiretroviral therapy (cART) with root canal infections with cells from uninfected controls. Samples collected seven days after root canal cleaning showed that T cells from HIV-infected individuals exhibited higher expression of pro-inflammatory cytokines (IL1β, TNFα, IL7α, INFγ) and chemokines (CCL-2, CXCR4 and CCR5).

---

**TABLE 1**

Demographics, Comorbidities, Number of Teeth, Alveolar Crestal Height by HIV Status (Mean±SD)

<table>
<thead>
<tr>
<th>HIV+ (N=48)</th>
<th>HIV- (N=131)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>53.7±7.0</td>
<td>52.7±6.5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>30%</td>
<td>21%</td>
</tr>
<tr>
<td>Smoking</td>
<td>29%</td>
<td>12%</td>
</tr>
<tr>
<td>Number of teeth</td>
<td>15.1±8.8</td>
<td>16.6±8.1</td>
</tr>
<tr>
<td>% edentulous</td>
<td>10.4%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Alveolar crestal height (mm)*</td>
<td>2.75±0.8</td>
<td>2.15±0.8</td>
</tr>
<tr>
<td>CD4 count (cells/ul)</td>
<td>653±364</td>
<td></td>
</tr>
<tr>
<td>ART exposure</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>PI-based regimen</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>NNRTI-based regimen</td>
<td>37%</td>
<td></td>
</tr>
</tbody>
</table>

*Data in HIV+ (N=18), HIV- (N=71). Abbreviations: antiretroviral therapy (ART); protease inhibitor (PI); non-nucleoside reverse transcriptase inhibitor (NNRTI).

**TABLE 2**

Demographics, Comorbidities, Number of Teeth, Alveolar Crestal Height Stratified by HIV Status, Age (Mean±SD)

<table>
<thead>
<tr>
<th>Age 40-50</th>
<th>HIV+ (N=20)</th>
<th>HIV- (N=54)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>46.6±2.0</td>
<td>46.2±2.0</td>
<td>0.46</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12%</td>
<td>18%</td>
<td>0.72</td>
</tr>
<tr>
<td>Smoking</td>
<td>26%</td>
<td>10%</td>
<td>0.12</td>
</tr>
<tr>
<td>Number of teeth</td>
<td>18.8±7.6</td>
<td>18.4±7.7</td>
<td>0.64</td>
</tr>
<tr>
<td>% edentulous</td>
<td>5%</td>
<td>2%</td>
<td>0.47</td>
</tr>
<tr>
<td>Alveolar crestal height (mm)*</td>
<td>2.36±0.4</td>
<td>1.89±0.7</td>
<td>0.053</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age ≥50</th>
<th>HIV+ (N=28)</th>
<th>HIV- (N=77)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>58.8±4.4</td>
<td>57.2±4.1</td>
<td>0.12</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12%</td>
<td>18%</td>
<td>0.43</td>
</tr>
<tr>
<td>Smoking</td>
<td>30%</td>
<td>14%</td>
<td>0.11</td>
</tr>
<tr>
<td>Number of teeth</td>
<td>14.9±8.1</td>
<td>14.9±8.1</td>
<td>0.08</td>
</tr>
<tr>
<td>% edentulous</td>
<td>14%</td>
<td>8%</td>
<td>0.26</td>
</tr>
<tr>
<td>Alveolar crestal height (mm)*</td>
<td>3.24±0.8</td>
<td>2.41±0.8</td>
<td>0.01</td>
</tr>
</tbody>
</table>

*Data in HIV+ (N=18), HIV- (N=71)
than those from uninfected controls. In stimulated saliva, levels of IL-8 were also found to be higher in HIV-infected individuals on cART than in healthy controls. Menopause has also been shown to cause an increase in oral inflammatory markers. For example, studies have shown that IL-1β and IL-8 were elevated in the gingival crevicular fluid (GCF) of estrogen-deficient postmenopausal women compared to estrogen-sufficient postmenopausal women. Therefore, the combination of HIV infection and menopause may cause a synergistic increase in local oral inflammation, leading to the increase in alveolar crestal bone loss.

In sharp contrast to other studies of “healthy,” similarly aged patients, our uninfected controls had an average of only 15 teeth. For comparison, the mean number of teeth in women age 50 to 64 in the National Health and Nutrition Examination Survey (NHANES) was 22. The exact cause of this discrepancy is uncertain, but one possible explanation is that our patient population is predominantly of lower socioeconomic class, which has been strongly associated with missing teeth. Another explanation is that selection bias may have contributed to the lower number of teeth in our controls, since patients who have active periodontal disease and/or more missing teeth may be more likely to have had radiographs.

Even though the number of teeth present in HIV-infected individuals was not statistically lower than that of our controls, an average of only 12 teeth with 14% edentulism in the older HIV-infected group is a significant clinical finding. The number of teeth present in our HIV-infected group is much lower than in a previous study that found an average of 22 teeth in HIV-infected individuals between 50 and 69 years of age. One explanation for these differences is that we studied older women, whereas over 70% of the participants in the other study were male.

Another reason for the greater tooth loss in the HIV-infected group is that increased alveolar bone loss may predispose HIV-infected individuals to losing their teeth. In support, we found that ACH correlated with HIV infection and number of teeth present. In addition, it has been shown that each millimeter of alveolar bone loss is associated with a three-fold increased likelihood of tooth loss.

The major limitations of this study are related to its retrospective chart review study design. For example, diagnosis of diabetes was based solely on documentation in the dental records and not confirmed by laboratory testing or medication verification. In addition, other comorbid conditions that could affect alveolar bone loss or tooth loss, such as a history of illicit drug use or malignancies, were not available. Since this was a retrospective study, the radiographs were taken for clinical purposes by different technicians on different scanners; however, standard operating procedures were in place for clinical radiographs. Our study, like all other published studies, only utilized oral radiographs to assess alveolar bone loss; therefore, little is known about how HIV

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>Standard Error</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>0.589</td>
<td>0.777</td>
<td>0.006</td>
</tr>
<tr>
<td>Age</td>
<td>0.047</td>
<td>0.015</td>
<td>0.003</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.513</td>
<td>0.201</td>
<td>0.012</td>
</tr>
<tr>
<td>Cigarette Use</td>
<td>0.341</td>
<td>0.251</td>
<td>0.179</td>
</tr>
</tbody>
</table>

**ERI C J. PLOUMIS, D.M.D., J.D.**

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infection affects the microarchitecture of mandibular bones. Future studies using cone beam imaging are necessary to address this gap. Finally, we were limited by a modest sample size.

Conclusion
HIV-infected women have significantly greater alveolar bone loss and a trend for increased tooth loss compared to uninfected controls, especially in women over age 50, after the menopausal transition. With aging of the HIV-infected population in the United States and in Europe, oral health has become an increasingly important part of healthcare for people living with HIV. Future studies are necessary to define the causes of increased alveolar bone loss and measures to prevent early tooth loss in HIV-infected women.

Queries about this article can be sent to Dr. Wadhwa at sw2680@cumc.columbia.edu.

REFERENCES
Case Report of Multiple Keratocystic Odontogenic Tumors Presenting as Nevoid Basal Cell Carcinoma Syndrome in Pediatric Patient


A B S T R A C T

In 2005, the World Health Organization (WHO) altered the classification and nomenclature of odontogenic keratocysts (OKCs). The change to keratocystic odontogenic tumor (KCOT) more accurately reflects the aggressive and recurrent nature of the lesions. KCOT is a benign intraosseous neoplasm of the jaw that occurs in two distinct types: most commonly as a sporadic solitary-lesion; or as part of the nevoid basal cell carcinoma syndrome (NBCCS), in which multiple KCOTs are observed. NBCCS can also be found in the literature as its original name Gorlin-Goltz syndrome (GGS). Only approximately 5% of all KCOTs are associated with NBCCS. NBCCS is an autosomal-dominant, inherited genetic disorder with variable expressivity encompassing multiple jaw radiolucencies (KCOTs), palmar or plantar pits, first-degree relatives with a history of the syndrome and skeletal anomalies. The clinical features of NBCCS and our treatment and future plans for a case are described.

Odontogenic keratocysts (KCOTs) are cysts of the jaws displaying keratinization of their epithelial linings. KCOTs are most often histologically identified as parakeratinized. Parakeratinization displays superficial cells that are non-vital but retain their nuclei. A similar lesion, microscopically, is the keratinizing cyst, which most consider to be a separate entity. These cysts have a histological characteristic in which the nuclei are lost in the epithelium. The parakeratinized KCOTs are more aggressive than the orthokeratinized cysts and, as a result, are associated with higher recurrence. There is a male predilection of approximately 2:1, with 65% to 85% of cysts occurring in the posterior mandible.

The development of KCOTs derives from the dental lamina and its remnants after this structure has functioned for odontogenesis. KCOTs that occur in the dentate areas of the maxilla and mandible most likely result from those remnants. The predicted prevalence of nevoid basal cell carcinoma syndrome (NBCCS) is estimated to occur with 1 in 60,000. People with no known affected family members are estimated to account for up to 60% of all affected individuals.

Case Report

An 11-year-old male patient presented to the Nassau University Medical Center, referred from a private oral and maxillofacial surgeon, with bilateral mandibular and maxillary radiolucencies associated with multiple impacted teeth (Figure 1). The patient was asymptomatic, reported no tenderness, swelling or discharge. Medical
The patient's medical history was positive for scoliosis, which had been addressed surgically years prior. The patient had no known drug allergies and reportedly took no medications. All other medical conditions were denied. The family history was noncontributory. The patient appeared to be well-nourished, well-developed, with age-appropriate growth.

Extraoral head and neck exams were positive for right orbital strabismus (Figure 2). No other significant findings were present. The patient had a good overall dentition; and the intraoral exam displayed no signs or symptoms of infection. Also, the patient had a retained primary tooth #H. A medical grade computed tomography (CT) scan was completed. Findings were consistent with the panoramic radiograph. The CT scan displayed impacted teeth #1, #11, #15, #16, #17 and #32, with associated soft-tissue lesions (Figure 3). The working differential diagnosis was, in descending order of likeliness, keratocystic odontogenic tumor(s), dentigerous cyst(s), ameloblastoma(s) and central giant cell lesion(s). The preoperative diagnosis of multiple KCOTs, with a high suspicion of NBCC syndrome, was made. The decision was made to bring the patient to the operating room for extraction of all teeth listed, along with enucleation, curettage and peripheral ostectomy, when indicated, of all cystic lesions.

During surgery, extraction was completed of teeth #1, #15, #16, #17, #32 and #H. It was decided intraoperatively to leave #11 in situ for possible eruption due to the age and reliability of the patient and his family for follow-up appointments. Also, a decision was made at the time of surgery to extract #18 because of its close proximity to the adjacent lesion. Carnoy’s solution and peripheral ostectomy of all mandibular lesions were completed.

After extraction of teeth #15 and #16, enucleation of the left maxillary sinus lesion produced significant cystic material (Figure 4). All specimens were sent to Long Island Jewish Oral Pathology Department for histologic analysis. The histologic analysis resulted in the diagnosis of KCOTs, with a recommendation that a NBCCS work-up be completed. A postoperative immediate panoramic radiograph was taken (Figure 5), showing the final treatment.

**Discussion**

This case presents an interesting discussion of the pretreatment, intraoperative and postoperative plans for multiple cystic lesions of the jaw. Before any treatment can be rendered, it is imperative to obtain a thorough and accurate medical history, along with all needed diagnostic imaging. Besides the standard panoramic radiograph, this case warranted advanced imagery, such as a CT scan, which allowed for more detailed analysis of the vital structures and the pathology in question.

Pretreatment planning for KCOTs involves minimizing the incidence of recurrence, which is the most common complication associated with KCOTs. Preventing and lowering the incidence of recurrence can be completed using multiple techniques. The procedure with the lowest recurrence rate is en bloc resection.13,14

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**Figure 1.** Preoperative panoramic radiograph displaying radiolucent lesions associated with multiple impacted teeth.

**Figure 2.** Right eye strabismus.

**Figure 3.** Preoperative CT imaging exhibiting bilateral fluid present in maxillary sinuses.

**Figure 4.** Cystic lesion removed from left maxilla.
When appropriately performed, this procedure will have close to 0% recurrence rate; however, one must consider the aggressive nature of this surgery, particularly in a child.

The second most effective procedure is marsupialization with enucleation, curettage and peripheral ostectomy. The recurrence rate reported varies from 20% to 30%. The third most effective procedure is enucleation and curettage, which carries a 30% to 50% recurrence rate. Adjunctives, such as Carnoy’s solution or liquid nitrogen cryotherapy, can be applied, along with surgical techniques, to further lower the rate. One must be careful when using these agents because while effective, they can be caustic to vital anatomy located in the area.

Having a surgical plan prior to surgery is essential; however, intraoperative surgical plans often are adjusted to fit the actual in situ disease process. In our case, given the patient’s age and cooperation, a decision was made not to take a preoperative biopsy. Surgical plans involving suspected KCOTs revolve around several factors, including the patient’s age, location and size of the pathology. As previously mentioned, our plan was to extract all impacted teeth associated with the lesions. Carnoy’s solution was used in the posterior mandible to minimize the recurrence rate. It was not used in the maxilla because of the size of the cysts and close approximation to the floor of the orbits. Lastly, because of the age of the patient, the very good compliance of the patient and his family, and importance of canines for growth and development, the decision was made to keep tooth #11.

The presence of multiple keratocystic odontogenic tumors is the initial diagnostic feature of nevoid basal cell carcinoma syndrome. Additionally, positive syndromic patients demonstrate a spectrum of developmental anomalies, which have been described as major and minor criteria of the syndrome. The developmental abnormalities and neoplasms seen in NBCCS are caused by a germ line mutation of tumor suppressor gene (PTCH) on chromosome 9q22.3–q31. Without genetic testing, the confirmation of a combination of major and minor criteria ultimately establishes the foundation for empirically making the diagnosis of NBCCS. The diagnosis is typically made when two major or one major and two minor criteria are present.

The following are the most common major criteria:
- More than two basal cell carcinomas or one basal cell carcinoma at younger than 30 years of age or more than 10 basal cell nevi.
- Odontogenic keratocyst.
- Three or more palmar or plantar pits or ectopic calcification (i.e., falx cerebri calcification).

Minor criteria are defined as:
- Macrocephaly.
- Congenital anomalies (cleft lip or palate, frontal bossing and hypertelorism).
- Skeletal anomalies (syndactyly of the digits and vertebral changes).

Our findings of two major and one minor criteria confirmed the diagnosis of NBCCS syndrome. The patient had a chest radiograph taken (Figure 6), which confirmed bifid ribs.

Lo Muzio et al. reported that KCOTs were the first symptom of Gorlin-Goltz syndrome in 78% of their cases, thereby allowing for earlier diagnosis. Oral and maxillofacial surgeons, therefore, are most often the first to diagnose the syndrome. When NBCCS is suspected, it is prudent for the OMS to notify the patient’s pediatrician, so a team effort can be organized, including dermatologist evaluation and genetic testing for proper planning. Lastly, patients with NBCCS are extremely sensitive to ionizing radiation and should be counseled to avoid sun exposure.

The postoperative plan calls for close observation and periodic panoramic radiographs and CT scans. Normal, insignificant healing was observed at all postoperative appointments to date. Postoperatively, if the KCOTs recur around tooth #11, the decision can be made to perform another enucleation and curettage or extraction. The ultimate goal is to get the patient to a stable age when skeletal growth has finished. Once growth is completed, grafting bone and placing implants can be initiated.
Conclusions
A case of five cystic lesions, each with the diagnosis of odontogenic keratocyst and associated with nevoid basal cell carcinoma syndrome, has been presented. When treating oral pathology, there are many different choices and decisions to be made. A fine balance must be maintained between eradicating the disease process and limiting disfigurement of the patient. As with KCOTs, they are not at risk for malignant transformation and are relatively slow growing. Therefore, a more conservative surgical approach can sometimes be taken, especially in a child.

Queries about this article can be sent to Dr. Green at mgreen3@numc.edu.

REFERENCES

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Victor Nannini, D.D.S., is associate program director, Nassau University Medical Center, East Meadow, NY.

Rory Sadoff, D.D.S., is program director and chairman, Nassau University Medical Center, East Meadow, NY.
Multiple Miliary Osteoma Cutis of the Cheeks
Incidental Dental Radiographic Finding with Long-Term Follow-Up
John K. Brooks, D.D.S.

A B S T R A C T

Miliary osteoma cutis (MOC) is a rare dermatopathic disorder of heterotopic bone formation, often associated with acne and primarily involving the cutaneous tissues of the head and neck. To increase awareness of this cutaneous process, this case report documents the 22-year history of MOC. Asymptomatic, scattered and extremely faint amorphic calcifications were discernible at age 44 years, which increased in size and number with age. Supplemental radiographs localized these structures, which exceeded 100 in total, within the cheeks. Dental practitioners should be familiar with the radiographic and clinicopathologic features of MOC and associated comorbidities.

Osteoma cutis (OC) is a rare cutaneous process that leads to the formation of heterotopic bone within the connective tissue, primarily of the face, neck and scalp. Smaller osseous structures are referred to as miliary osteoma cutis (MOC). The etiopathogenesis has not been clearly elucidated. Typically, ectopic calcifications emerge gradually after 40 years of age and occur in multitudes of painless, hard, skin-colored papular eruptions. Typically, ectopic calcifications emerge gradually after 40 years of age and occur in multitudes of painless, hard, skin-colored papular eruptions. Some lesions of OC have a blue-gray hue, imparted by the administration of tetracycline and minocycline. Linear, plate-like bony aggregations can achieve 30 mm in length and extrude through the skin surface. Affected patients often elicit a history of acne and seek cosmetic improvement from scarring. They present less frequently for lesional tenderness or irritation.

Other predisposing factors include severe sunburn, artificial tanning, hair electrolysis and bisphosphonate intake. Occasionally, MOC has been observed in cohorts in the absence of acne or other cutaneous diseases. There is no apparent relationship of dermal ossification and the degree of fibrosis. Various studies of subpopulations with MOC have discerned either female or male predilection.

MOC has received extensive attention in the medical literature, principally in case reports and series in dermatologic journals, yet only limited information has been available in dental publications. The following case report describes a 22-year ra-
doiographic study of MOC, initially discerned as an incidental discovery in a 44-year-old male. MOC appeared on dental bitewing radiographs as amorphic radiopaque structures that gradually increased in number and sizes. Relevant clinical findings, medical history and blood chemistries are also provided.

**Case Presentation**

A 48-year-old man without any chief complaint presented to the dental office for a periodic oral evaluation and prophylaxis. Bite-wing radiographs revealed bilateral clusters of 1 mm to 2 mm amorphic calcifications, several of which displayed radiolucent centers (Figure 1). Retrospectively, scattered, extremely faint opacifications were evident on bitewing radiographs taken when he was 44 years of age (not shown). Comparable radiopacities were seen on subsequent series of bitewings. By age 58, these objects had gradually increased in size and number, varying from 1 mm to 5 mm, with some seeming to have coalesced.

Supplemental radiographs placed in the buccal vestibules corroborated these structures within the cheeks; more than 50 calcifications were seen bilaterally in these 3 cm x 4 cm fields of view (Figure 2). Considering the surface area of the cheeks, these radiopacities could have greatly exceeded 100 in total.

The patient’s medical history was significant for Type II diabetes, obesity (height-67 inches; weight-300 pounds), hypercholesterolemia and allergy to aspirin. He was being managed with sitagliptin, valsartan, amlodipine and simvastatin. Suspecting pseudohypoparathyroidism and pseudopseudohypoparathyroidism, an examination of the patient’s hands was performed. It was negative for brachydactyly involving the fourth metacarpals (Figure 3A) and the knuckle sign (dimple formation with

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**Figure 1.** Multiple, 1 mm amorphic radiopacities with radiolucent centers on bitewing radiographs at age 48 years.

**Figure 2.** Radiographic localization of numerous calcified structures within cheeks at age 58 years.
a closed fist rather than the normal outward projection of the metacarpal heads) (Figure 3B). The patient exhibited a round face with papular hypertrophic scarring, and he had a shortened neck. Palpation and visual inspection of the cheeks were otherwise unremarkable.

Laboratory studies established normal or near-normal levels of calcium, alkaline phosphatase, phosphorus, parathyroid hormone and thyroid-stimulating hormone. Of significance, there was an elevated glucose of 123 mg/dl (normal range 65-99 mg/dl and an HbA1C of 6.7% (normal range 4.8% to 5.6%). The patient acknowledged having experienced “moderate” acne as a teenager. He denied any other cutaneous diseases or having received any dermal fillers. Based on the absence of metabolic bone disease, the radiographic opacifications ostensibly represented MOC.

A follow-up at age 66 noted persistent, conspicuous calcifications. Several calcified structures had become evident on the left side, owing to the extraction of the maxillary second molar, which had apparently obscured their presence (Figure 4). The cheeks remained soft upon palpation, and the patient was asymptomatic. At present, a baseline 25-hydroxy vitamin D level was determined to be 22 ng/ml (normal range 30 ng/ml to 100 ng/ml), and the patient has since been prescribed a 4000 mg vitamin D supplement.

Discussion
OC is associated with a myriad of primary and secondary disorders, while some cases are idiopathic. The primary subtype is far less common and considered to belong to a continuum of endocrinopathic syndromes with phenotypic overlap that has been implicated in mutations in the GNAS gene complex locus (G-nucleotide binding protein-α subunit).17 In particular, Albright hereditary osteodystrophy (AHO) is noted for ectopic cutaneous calcifications, skeletal abnormalities (obesity, short stature, fourth metacarpal brachydactyly, flattened nasal bridge), round facies, intellectual impairment and broad, short fingernails.
One variant of AHO, pseudohypoparathyroidism, includes many of these aforementioned features coincidental with hypocalcemia, hyperphosphatemia and an elevated parathyroid hormone level. Another form of AHO is pseudopseudohypoparathyroidism, defined by similar physical anomalies, but distinguished by normal serum calcium and phosphate. Progressive osseous heteroplasia (POH) commences in childhood and consists of increasing productions of extraskeletal bone that arise in the skin and extend to muscle and fascia, leading to a severe reduction in mobility. Plate-like osteoma cutis is an attenuated expression of POH, characterized by the formation of prominent ossified plaques in the scalp and, infrequently, on the trunk. Fibrodysplasia ossificans progressive also begins in childhood and is associated with progressive heterotopic calcifications in the face, tendons, ligaments and skeletal muscles, which ultimately restrict ambulation; other distinctions include shortened halluces, hearing loss and baldness.

The preponderance of cases of MOC develop secondary to a diversity of etiopathologies. A comprehensive literature review found 55% of patients affected with MOC elicited a history of acne vulgaris; 13% acknowledged hormone replacement therapy. Although the patient described here had been diagnosed with obesity, diabetes, hypertension and hypercholesterolemia, the lack of other comorbidities and otherwise normal blood chemistries substantiated that the MOC within the cheeks was consistent with the dermatologic literature and likely represented a postinflammatory consequence from acne. Other processes associated with OC are inflammatory disorders (folliculitis, dermatitis, dermatomyositis, myositis ossificans), injury (severe sunburn, trauma, thermal burn), systemic sclerosis, venous stasis, an array of benign lesions (melanocytic nevus, pilomatricoma, epidermoid cyst, trichoepithelioma, sebaceous hyperplasia, chondroid syringioma, seborrheic keratosis, apocrine hidrocystoma, lipofibroma, fibroma, neurofibroma, pyogenic granuloma, nevus sebaceous) or malignancies (basal and squamous cell carcinoma, melanoma, extramedullary

Energy-dispersive radiographic microanalysis can intimate the existence of hydroxyapatite, corroborating the presence of osseous tissue.15
acutely leukemia). Moreover, facial dystrophic calcifications have been seen following autologous fat injections.

Microscopically, excised specimens resemble normal bone, composed of a lamellar pattern containing haversian canals, osteocytes and osteoblasts; osteoclasts, chondrocytes and an inflammatory infiltrate are notably absent. Energy-dispersive radiographic microanalysis can intimate the existence of hydroxyapatite, corroborating the presence of osseous tissue. The clinical differential diagnoses of MOC include calcified milia, sebaceous hyperplasia and comedones. Radiographically, MOC often resembles clusters of snowflakes, varying in size up to 5 mm, which can exhibit radiolucent centers (as seen in this case report). The radiographic differential diagnosis should include phleboliths, sialoliths, soft-tissue dystrophic calcifications (lymph nodes, tonsils, inflammatory fibrous hyperplasia), carotid atheromas, calcified cysticercotic nodules and foreign bodies, such as inclusions of calcium hydroxyapatite dermal microspherical fillers.

As far as could be determined, this report provides the first long-term radiographic assessment of a patient with MOC followed over 22 years. Radiographic emergence of the MOC was detected at 44 years of age, which is in agreement with the dermatologic literature mean age of 47 years. As the patient aged, the MOC continued to increase radiographically in number, and attained sizes up to 5 mm. Analogously, some patients’ self-observations have noted a gradual increase in the number of their clinical facial MOC. In contrast, the patient described here was unaware of his facial calcifications.

Histopathologic evaluation is warranted for atypical clinical presentation or nodularity. Treatment modalities for MOC mainly employ excision (surgical blade, curettage, needle microincision with extirpation), dermabrasion, topical tretinoin, and laser resurfacing. Complete eradication is not always possible for widespread disease, and recurrence is encountered infrequently.

The extant field of dermatopathology regards MOC as a rare phenomenon, with only 47 cases with a biopsy-proven diagnosis published. Kishi et al. ascertained a 2.2% (45/2,089) incidence of MOC of the cheek and chin among hospitalized patients, as seen on radiographic projections of the jaws. Furthermore, Safi and coworkers identified the presence of MOC in 2.0% (130/6,500) of cone beam computed tomography scans of the maxillofacial region. However, some evidence suggests that MOC is not as exiguous as previously thought. Shigehara et al. performed soft-tissue radiographic imagery involving 39 cadavers with clinically normal facial skin and found evidence of MOC within all the specimens examined and an incidence
of 27.8% (44/158) among living individuals, ultimately concluding that MOC was simply an ancillary finding of aging and not related to local or systemic disease. Interestingly, a preliminary investigation has found that a low vitamin D level may play an immunomodulatory role in the development of nodulocystic acne. As such, this invites the question whether vitamin D deficiency could be implicated with the pathogenesis of acne-related MOC.

Conclusion
This case report accentuates the importance of recognition and interpretation of subtle radiographic findings that could identify various occult pathologic processes and, potentially, lead to earlier therapeutic intervention and improved clinical outcome.

Patients who present with possible radiographic manifestations of MOC should undergo a physical examination and comprehensive review of their health history and assays for serum calcium, phosphorus, parathormone and, perhaps, vitamin D, to establish whether there is any correlation with metabolic and systemic disorders.

Queries about this article can be sent to Dr. Brooks at jbrooks@umaryland.edu.

REFERENCES
Delayed Diagnosis of Burkitt’s Lymphoma in HIV Patient after Third Molar Removal

Case Report


A B S T R A C T

Infection with the human immunodeficiency virus (HIV) remains associated with a greater risk of malignancies despite widespread use of combination antiretroviral therapy. Burkitt’s lymphoma is a highly aggressive B-cell non-Hodgkin’s lymphoma (NHL). It has a prognosis of weeks without treatments. There were an estimated 356,000 new cases of NHL and 192,000 deaths from NHL worldwide in 2008. NHL accounts for approximately one-third of AIDS-related malignancies. It seems to develop early during the evolution of HIV infection in patients with a CD4 count above 200/microliter.

A 23-year-old HIV-positive male was referred to our department for diagnosis and management of lower right mandibular pain. We describe an initially misdiagnosed case of BL with mandibular involvement. The patient, after third molar extraction, was treated as a dental infection complicated by osteomyelitis. The patient expired nine months after his initial consultation. Burkitt’s lymphoma is a very aggressive neoplasm and its rapid progression necessitates prompt recognition. Its diagnosis, especially when the sole presentation is in the maxillofacial region, can be troublesome, as it may mimic a variety of more commonly encountered disorders. Concomitant HIV-positive status should be a concern to add to Burkitt’s lymphoma in the differential diagnosis in the initial evaluation. A biopsy should be performed promptly.
HIV patients are more susceptible to infection and to a variety of oral pathologies. Non-Hodgkin’s lymphoma (NHL) is a frequent HIV-associated malignancy. Lymphoma can occur anywhere in the oral cavity; and there may be soft-tissue involvement with or without involvement of underlying bone.¹ The lesion may present as painless, non-ulcerated, with or without paresthesia. Other oral lesions may appear as small shallow ulcerations.² There is no pathognomonic radiologic feature. Hence, it is a highly aggressive disease that can mimic multiple benign pathologies.

Burkitt’s lymphoma (BL) is a high-grade, B-cell non-Hodgkin’s lymphoma that occurs in three clinically distinct forms: endemic, sporadic and human immunodeficiency-associated. There is a high incidence of BL in endemic regions such as equatorial Africa and Papua New Guinea, where it is most commonly found in children with a male preponderance. Sporadic BL is a worldwide phenomenon with no specific geographic or climatic association, accounting for 1% to 2% of adult lymphomas and up to 40% of child lymphomas in the United States and Western Europe. Burkitt’s lymphoma is strongly associated with HIV infection and accounts for approximately 5% to 40% of cases of HIV-associated NHL.

A case of mandibular BL in a HIV-positive male has been reported. The purpose of this case report is to illustrate the clinical features of Burkitt’s lymphoma, to help clinicians recognize such cases readily and to facilitate prompt referral and treatment.

Case Report

A 23-year-old African-American male with a past history of well-controlled HIV infection (CD4 649/mcL, undetected HIV RNA viral load) was referred to the oral and maxillofacial clinic complaining of intense pain in his right lower jaw. The clinical examination was unremarkable. A panoramic radiograph revealed partial bony impaction of four third molars with no other significant findings (Figure 1). Clinical and radiographic findings to date implicated the impacted lower right third molar as the likely etiology of the patient’s chief complaint. All impacted third molar teeth were extracted under IV sedation without complications.

Three weeks postoperative, the patient returned reporting persistent lower right jaw pain. He also mentioned that one week following the procedure, he visited another dentist, who attempted to treat his jaw pain with extraction of his lower right first molar. In addition to jaw pain, he now presented with right jaw swelling and numbness on the right side of the lower lip. A panoramic radiograph was obtained and was negative for remnants of extracted teeth or bony pathology. Clinical examination showed edematous and erythematous marginal gingiva in the lower right posterior mandible, tenderness to palpation and mobility of the mandibular right second molar with purulent discharge. Intraoral incision and drainage were performed and the patient was placed on clindamycin 300mg PO TID for five days.
Five weeks postoperative, the patient presented with increased pain and swelling of the right face and persistent numbness of the right lower lip. Intraoral examination revealed soft-tissue edema now extending anteriorly beyond the molar region. A CT scan showed permeative bone changes in the right mandible, phlegmon of the buccal space, cellulitis and swelling of the platysma muscle. Lymphadenopathy was present in the right neck. Laboratory tests showed only relatively lower hematocrit and leukopenia (38%, 4.4 K/uL, respectively).

Extraction of the symptomatic right second mandibular molar, as well as incision and drainage and debridement of the right mandibular body and ramus were planned and performed in the operating room in the sixth week postoperative. Drains were placed; cultures came back negative. The combination of radiographic bony changes (moth-eaten aspect), clinical findings and past medical history led to a diagnosis of acute osteomyelitis. The patient was admitted following surgery and placed on IV ampicillin—sulbactam 3 grams q6h. Following consultation with the department of infectious diseases, the regimen was changed to ertapenem 1 g IV q24h to complete a six-week course. A PICC line was inserted to facilitate outpatient IV antimicrobial infusion at discharge.

Seven weeks postoperative, reduced right facial swelling was noted. However, within the same week, the patient returned with worsening of pain and severe right-side facial edema overlying the mandibular angle. Class 1 mobility of the right first and second mandibular premolars was noted. A second CT scan revealed cellulites of the peri-osseous soft tissues extending from the buccal space into the masticator space, involving the masseter and pterygoid muscles, and a 2.1 cm x 2 cm abscess anterior to the mandibular foramen. The tongue was slightly displaced to the left, but the airway remained patent.

The patient was admitted for incision and drainage of the submandibular and submental regions, debridement of the right posterior mandible and extraction of the right second mandibular premolar. Soft-tissue biopsy was performed. Drains were placed. The mandibular anterior teeth were also found to be mobile but were not extracted. Specimens were sent for histopathological analysis. The patient remained intubated postoperatively because of lateral pterygoid and posterior pharyngeal edema. The infectious disease team recommended initiation of IV antibiotic therapy. Administration of vancomycin and piperacillin—tazobactam was started and ertapenem was discontinued. OR cultures were negative.
for acid-fast bacilli, pyogenes, anaerobes and fungi. Antibiotics were changed to clindamycin 900mg IV q8h and meropenem 1g q8h.

Within the postoperative 8th week after the initial third molar teeth extractions, the patient underwent debridement of multiple right fascial spaces and the right mandible, as well as extraction of all remaining mandibular teeth, together with the left lateral and central incisors. A finalized histopathology report revealing Burkitt’s lymphoma was received the following day.

At the time, antibiotic therapy was discontinued. The patient underwent bone marrow biopsy, which revealed normal cellular marrow, with no tumor cells detected. The patient voluntarily enrolled in a clinical trial utilizing etoposide-prednisone-Oncovin-cyclophosphamide-hydroxydaunorubicin regimen (EPOCH) therapy. The first phase occurred the week following the Burkitt’s lymphoma diagnosis. After a 21-day hospital stay, the patient was discharged in the postoperative 10th week after the initial third molar extractions. Significant decrease in the size of the mass around the jaw was noted the following week. Succeeding follow-ups revealed considerable reduction of the tumor size and resolution of the intraoral symptoms. Despite initial response to cytotoxic therapies, relapse occurred and the patient expired nine months after his initial consultation.

Figure 4. Histopathology of Burkitt’s lymphoma. A. Low-power magnification shows diffuse infiltrate of lymphoid cells with prominent “starry-sky” appearance due to presence of multiple tangible body macrophages (H&E, 10x). B. High-power magnification shows atypical lymphoid population of medium-sized, round, uniform cells with prominent nucleoli and mitotic figures (H&E, 100x). C. Immunohistochemical stain of CD20, confirming population of cells to be of B-cell lineage (20x). D. Immunohistochemical stain of Ki-67 demonstrates proliferation index of 110% (10x).
Discussion
HIV-associated BL accounts for 20% to 40% of HIV-associated non-Hodgkin’s lymphoma cases. The risk of BL onset is 261 to 1,000 times more common in patients with AIDS than in the general population. Jaw involvement in sporadic and HIV-associated forms of BL can easily be misdiagnosed as various other jaw lesions, resulting in a delayed definitive diagnosis and treatment. The most common clinical findings of BL with jaw involvement are pain, swelling, disturbances in eruption, loosening of teeth, paresthesia and poor improvement with antibiotic therapy. Radiologic findings include attenuation of the tooth crypts and lamina dura, and development of ill-defined lytic lesions. Involvement of other sites in the head and neck region, such as the tongue, parapharyngeal space, tonsils, maxillary sinus, nasopharynx, mastoid, orbit and nasal cavity, have also previously been reported.

Histological features of the HIV-associated BL are identical to those seen in other Burkitt’s lymphomas. Cell population is characteristically uniform, and cells have round nuclei with clumped nucleoli and an abundant basophilic cytoplasm that contains lipid vacuoles. Consistent with a rapid growth pattern, mitotic figures are abundant. The tumor has a diffuse pattern of infiltration. The “starry-sky appearance” under low magnification is caused by the presence of macrophages that contain ingested apoptotic tumor cells. Molecular testing in HIV-associated BL commonly reveals genetic lesions of C-MYC and TP53 mutations that may be significant in the pathogenesis of BL.

Clinical and radiographic features of BL similar to those seen with various jaw lesions often complicate its differential diagnosis. It is therefore recommended to include BL in differential diagnosis of various oral lesions, such as periapical lesions, den- toalveolar abscess, osteomyelitis, ameloblastoma and eosinophilic granuloma. Moreover, some authors recommend that a rapidly growing jaw tumor with tooth displacement be presumed to be BL unless a biopsy proves otherwise.

HIV-associated BL generally presents relatively early on in the course of HIV infection and at a fairly young age. Therefore, intraoral symptoms may be the primary clinical findings and may aid in the initial diagnosis of HIV. In the case presented here, the patient had been previously diagnosed with HIV, which should have raised a suspicion of BL after he failed to respond to anti-microbial therapy. Likewise, the diagnosis of BL in an otherwise healthy appearing individual should raise concern about under-
lying immunosuppression and appropriate investigations of HIV must be performed.9

Intensive combination chemotherapy is the primary treatment of HIV-associated BL. As BL is among the fastest growing tumors, with a high mitotic index, neoplastic cells are highly sensitive to cytotoxic agents, with five-year survival rates ranging from 75% to 95%.9 In the past, HIV-associated BL was treated with the standard cyclophosphamide, hydroxydaunorubicin, vincristine and prednisone (CHOP) therapy that is now less favored in the current literature. Introduction of highly active antiretrovirals (HAART therapy) enabled improved CD4 counts, as recorded in the case presented here (649/mcL). HIV patients with higher CD4 counts better tolerate current regimens of full-dose, high-intensity chemotherapy, which commonly includes combinations of cyclophosphamide, doxorubicin, vincristine and methotrexate.6 In the presented case, the patient was put on etoposide, prednisone, Oncovin, cyclophosphamide, hydroxydaunorubicin (EPOCH) therapy and a rapid resolution of symptoms was observed.

In conclusion, awareness of BL and its intraoral manifestations are crucially important not only for the diagnosis of BL, but also for the diagnosis of HIV, as they may be the initial findings in an HIV-infected patient. Recognition of its characteristics by dental practitioners and clinicians is momentous. Clinical and radiographic findings of BL can be mistaken for various other jaw lesions, resulting in delayed definitive diagnosis and treatment. Therefore, BL should always be included in the differential diagnosis of intraoral lesions of similar extent. A biopsy should be performed promptly in non-resolving or improving cases with its current regimen.

Queries about this article can be sent to Dr. Boivin at gboivin@montefiore.org.

REFERENCES

Lasers to Manage Tooth Hypersensitivity
A Review

Zahed Mohammdi, D.M.D., M.S.D.; Hamid Jafarzadeh, D.M.D., M.S.D.

ABSTRACT
Dentinal hypersensitivity (DH) is a common occurrence in dentistry. In order to prevent pulpal damage and patient discomfort, on-time diagnosis and treatment of DH are essential. There are several methods for managing DH, one of them is laser. The purpose of this review is to present an update on the applications of different types of laser, including Nd: YAG, Er: YAG, CO₂, and Nd: YAP, to manage DH.

Albert Einstein proposed the concept of stimulated emission of radiant energy in a short but elegant paper. This concept became the foundation for modern laser physics. The possibility of stimulation emission of radiant energy in the form of photons in the infrared and visible or optical portions of the spectrum has been demonstrated, which led to laser development. The first laser was constructed by exciting a ruby rod with intense pulses of light from a flash lamp. The first actual continuously generating laser ("He-Ne" 633nm laser) was invented using a mixture of helium and neon gases.

Many of these initial researchers, such as Stern and Sognaes, and Goldman et al., investigated potential applications of the ruby laser in dentistry. Thereafter, other types of lasers, such as argon (Ar; 514nm), carbon dioxide (CO₂; 10,600nm), neodymium:yttrium-aluminum-garnet (Nd: YAG; 1,064nm)), and erbium (Er): YAG (2,940nm), were used.

Characteristics of Laser
Laser is an acronym for light amplification by stimulated emission of radiation. It is an artificial single photon wavelength. Stimulating an excited atom to emit a photon before the process occurs spontaneously causes the lasing process. Spontaneous emission of a photon by one atom stimulates the release of a subsequent photon, and so on. It is a single wavelength (monochromatic), collimated (very low divergence) and coherent (photons in phase). The wavelength of a released photon depends on the state of the electron’s energy. When the states of electrons of two identical atoms are the same, wavelengths of released photons are identical. The characteristics of a laser are defined by its wavelength.

Depending on the optical properties of that tissue, laser light can have four different interactions with the target tissue. It can reflect, scatter, be absorbed or be transmitted to surrounding tissues (Figure 1). Proteins, pigments and free water molecules are the major components responsible for the absorption of laser by tissues. The absorption coefficient strongly depends on the wavelength of the incoming laser irradiation. Absorption by water molecules plays a significant role in thermal interactions.

Dentinal Hypersensitivity
Dentinal hypersensitivity (DH) is a short, sharp pain arising from exposed dentin in response to various thermal, evaporative, tactile, osmotic or chemical stimuli that cannot be attributed to any other dental disease. Based on the hydrodynamic theory, rapid dentinal fluid flow serves as the final stimulus in activating intradental nocic-
ceptors for many different types of stimuli. The patency of the dentinal tubes is a prerequisite for the sensitivity of exposed dentin.13-15

It should be noted that dental pain is elicited by cold stimuli in up to 90% of patients. Several factors, such as anatomic defects, gingival recession, periodontal treatment, attrition, erosion and abrasion, have been suggested as possible risk factors for DH. Regarding the prevalence of DH, at least one in seven patients suffers from some degree of dentinal hypersensitivity.13-15

The most affected areas are the cervical region of incisors and premolars, often on the side opposite the dominant hand.

Management of Dentinal Hypersensitivity

DH management involves the application of materials or devices that reduce the flow of dentinal fluid or lower the activity of dentinal neurons. The requirements for treatment of DH are as follows: should be nonirritating to the pulp; relatively painless on application; performed easily; act rapidly; effective for a long period of time; devoid of staining effects; and consistently effective.16

Clinical interventions include: application to exposed dentinal tubules of resins, oxalate salts, isobutyl cyanoacrylate, and fluoride-releasing resins or varnishes; and the use of devices that burnish exposed dentin. Another approach to managing DH is laser use.13,17

Laser and Dentinal Hypersensitivity

Mechanism of Action

The rationale for laser-induced reduction in dentinal hypersensitivity is based on two possible mechanisms. First, laser irradiation may exert a direct effect on the electric activity of nerve fibers within the dental pulp. Second, laser can modify the tubular structure of the dentin by melting and fusing the hard tissue or smear layer and subsequent sealing of the dentinal tubules.16,17

Classification of Lasers for Treating Hypersensitivity

Nd: YAG laser is a middle output power laser. Matsumoto et al.18 applied Nd: YAG laser to treat dentin hypersensitivity for the first time and found that it was 100% successful. Gelskey et al.19 found that He: Ne and He: Ne + Nd: YAG laser treatment can be used to reduce dentin hypersensitivity without adverse pulpal effects. White et al.20 found that irradiation of dentin using Nd: YAG pulsed laser did not cause detrimental intrapulpal temperature rise. Lan and Liu21 found that Nd: YAG laser treatment reduced dentin hypersensitivity to air by 65% and to mechanical stimulus by 72% over three months. All teeth remained vital after laser treatment, without adverse reactions or complications.

Hong et al.22 showed that Nd: YAG laser was effective in desensitizing hypersensitive dentine after preparing occlusal seats for removable partial dentures. Lan et al.23 demonstrated that over 90% of the dentinal tube orifices were occluded by sodium fluoride varnish combined with Nd: YAG laser irradiation. Orchardson and Whitters24 revealed that Nd: YAG laser could depress intradental nerve responses to dentin stimulation. Tokita et al.25 demonstrated that spot irradiation with a pulsed Nd: YAG laser for dentin desensitizing purposes could cause nerve injury and irreversible pulpal damage. Yonaga et al.26 showed that the method of irradiation by a pulsed Nd: YAG laser at cervical regions with black ink was most effective for cervical dentin treatment of hypersensitivity and that recurrence by this method was less than in other methods. A study demonstrated that combining

Figure 1. Schematic view of laser-tissue interaction.
fluor protector with Nd: YAG laser occluded most of the dentinal tubule orifices even after brushing.\textsuperscript{27}

In a double-blind, controlled, split-mouth designed clinical trial, Lier et al.\textsuperscript{28} showed that the effect of treatment of hypersensitive teeth with Nd: YAG laser was not different than from placebo. Ciaramicoli et al.\textsuperscript{29} evaluated the effect of Nd: YAG laser to treat DH. The results showed a statistically significant reduction of hypersensitivity in groups that received the treatment with Nd: YAG laser compared to the control teeth. However, the reduction of cervical DH was statistically greater when there was an association between the removal of etiologic factors with the application of Nd: YAG laser. Hu\textsuperscript{30} revealed that at both one month and six months, Nd: YAG laser was effective in managing DH. Lan et al.\textsuperscript{31} evaluated the morphologic changes of hypersensitive dentin after Nd: YAG laser irradiation. The impression of the dentin surface after Nd: YAG laser treatment revealed no protrusive rods (a measure of open dentinal tubules), in contrast with the presence of numerous rods before laser irradiation.

de Magalhães et al.\textsuperscript{32} found that Nd: YAG laser was an effective measure for occluding dentinal tubule openings. Kumar and Mehta\textsuperscript{33} found that the combination of Nd: YAG laser and 5% sodium fluoride varnish was effective in treating DH, compared to either treatment alone. Furthermore, the scanning electron microscopy (SEM) evaluation showed a reduction in number/patency of tubules. Al-Azzawi and Dayem\textsuperscript{34} showed that both Nd: YAG laser and Sensodyne toothpaste were similarly effective in occluding dentinal tubules. However, the Nd: YAG laser occluded dentinal tubules within seconds, whereas Sensodyne takes at least three weeks.

Birang et al.\textsuperscript{35} found that Nd: YAG laser was more effective than Er: YAG laser in reducing DH. Zapletalova et al.\textsuperscript{36} showed that covering the dentin surface with erythrosin solution occluding dentinal tubules could be accomplished using pulsed Nd: YAG laser safely and effectively. Dilisz et al.\textsuperscript{37} found that the Nd: YAG laser was more effective than the diode laser in desensitizing teeth with gingival recession. A randomized prospective controlled clinical trial assessed the desensitizing effects of the Nd: YAG laser and fluoride varnish by considering the degree of pre- and post-treatment pain, discomfort and functional complications.\textsuperscript{38} Findings showed that laser treatment resulted in significant improvements of discomfort immediately after treatment and after one week. At the two-, three- and four-week examination, the discomfort in the fluoride group decreased by up to nearly 75% to 85% of baseline scores, whereas the effect of the laser stayed nearly unchanged.\textsuperscript{38} The visual analog scale scores for pain at the four-week examination were significantly lower in the fluoride group compared with those in the laser group.

CO\textsubscript{2} laser. Using microradiography and electron probe analysis, Kantola\textsuperscript{39} revealed that creating a crater in dentin resulted in higher levels of calcium and phosphorus in the fused or recrystallized dentin, compared to normal dentin. He attributed this phenomenon to the burning off of the organic component by the laser energy. A study using radiographic diffraction analysis demonstrated that laser irradiation caused structural changes and recrystallization of dentin so that it closely resembled the crystalline structure of normal enamel hydroxyapatite.\textsuperscript{40} A study to assess the long-term effects of combined CO\textsubscript{2} laser treatment and fluoridation on cervical tooth hypersensitivity revealed that compared to conventional fluoridation, combined CO\textsubscript{2} laser irradiation and fluoridation were more effective.\textsuperscript{41} Scanning electron microscopic evaluation four to six months after laser treatment showed complete closure of the dentinal tubules. Atomic absorption spectroscopy showed that combining laser and fluoridation resulted in permanent integration of fluoride in the dentin surface.\textsuperscript{41} Zhang et al.\textsuperscript{42} showed that over three months, the CO\textsubscript{2} laser treatment reduced DH to air stimulus by 50%. All teeth remained vital, with no adverse effects. Furthermore, they revealed thermographically no temperature increase on irradiated tooth surfaces subjected to water coolant.\textsuperscript{42}

Diode laser. For the first time, Matsumoto et al.\textsuperscript{43} reported effectiveness of diode laser to treat DH, ranging from 85\% to 100\%. This finding was confirmed by Yamaguchi et al.\textsuperscript{44} Gerschman et al.\textsuperscript{45} demonstrated the effectiveness of diode laser to treat thermal and tactile DH. Furthermore, they reported no adverse reactions. Corona et al.\textsuperscript{46} found that both low-level diode laser and sodium fluoride varnish (Duraphat) were effective in decreasing cervical DH, and low-level diode laser was more effective in treating teeth with higher level of DH. Marsilio et al.\textsuperscript{47} revealed that with the minimum and maximum energy recommended by the manufacturer, diode laser was effective in 86\% and 88\% of the irradiated teeth, respectively.

The difference was not statistically significant. A study evaluated the effectiveness of two types of diode lasers (660 nm wavelength red, and 830 nm wavelength infrared) to manage DH and their immediate and late therapeutic effects in patients 25 to 45 years old.\textsuperscript{48} Results demonstrated decreasing DH only in 25- to 35-year-old patients. In addition, the 660 nm red diode laser was more effective than the 830 nm infrared laser, and treatment was more effective at the first 15 and 30 minutes. Furthermore, the 660 nm red diode laser was more effective immediately and at long periods in 25- to 35-year-old patients with the 830 nm infrared diode laser.

Tengrungsun and Sangkla\textsuperscript{49} found that both diode laser and dentin bonding agent were effective in desensitizing dentin to tactile and thermal stimuli up to 15 days. Sicilia et al.\textsuperscript{50} demonstrated that the 810 nm diode laser and a 10% potassium nitrate bioadhesive gel were effective in treating DH immediately and after 15 and 30 minutes, although diode laser was more effective immediately after treatment. In a randomized, placebo-controlled, double-blind clinical study, Vieira et al.\textsuperscript{51} revealed that low-level diode laser, a 3% potassium oxalate gel, as well as control group, were effective for the treatment of DH immediately and after three months, compared with the hypersensitivity at baseline.

Helium-neon laser. The mechanism of DH reduction by He-Ne laser is not apparent. However, it seems that this laser af-
fects electric activity (action potential) rather than Ad- or C-fiber nociceptors. There is only one study concerning the application of He-Ne laser to manage DH. Senda et al. applied the helium-neon laser in treating DH for the first time. An output power of 6 mW was used, which did not affect the morphology of the enamel or dentin surface, but allowed a small fraction of the energy to reach the pulp tissue. It was reported that the effectiveness of this treatment ranges from 5.2% to 100%.

**Er: YAG laser.** Schwarz et al. compared the desensitizing effects of an Er: YAG laser and Dentin Protector on DH and found that both treatment forms resulted in significant improvements of discomfort immediately after and one week post-treatment. After two months, the discomfort in the Dentin Protector group increased up to 65% of the baseline score and even up to 90% after six months, whereas the effect of the laser remained at the same level that was achieved immediately after treatment. The differences immediately after, one week, two and six months post-treatment between both groups were statistically highly significant. Compared to the untreated control group, both treatment forms resulted in a significant reduction of discomfort at each follow-up examination. Another study showed that Er: YAG laser at 60 mJ, 2 Hz was useful for decreasing dentin permeability.

**Nd: YAP laser.** Lee et al. assessed the efficacy of Nd: YAP laser and bioglass to treat DH. Four types of energy parameters to melt the composition-modified bioglass were used. These four types were 30 Hz, 330 mJ/pulse (G+ mode), 30 Hz, 160 mJ/pulse (G- mode), 10 Hz, 400 mJ/pulse (D+ mode) and 10 Hz, 200 mJ/pulse (D- mode). The temperature elevation, occlusive depth of bioglass, and phase changes in the bioglass after laser irradiation were evaluated by scanning electron microscope (SEM), thermometer and X-ray diffractometer (XRD). Findings showed that the occlusive depths of 2 and 10 µm in the dentinal tubules were achieved when the bioglass underwent 30 Hz, 160 mJ/pulse (G- mode) and 30 Hz, 330 mJ/pulse (G+ mode) of laser treatments, respectively. The bioglass experienced a temperature increase of less than 600º C, and no phase transformation was observed after Nd: YAP laser irradiation.

**Conclusion**

According to the findings of this review, Nd: YAG, CO2, diode, Nd: YAP, Er: YAG and helium-neon lasers are effective in treating DH. Furthermore, the effectiveness of lasers for treating DH varies from 5% to 100%, depending on the type of laser and the treatment parameters. Furthermore, literature review demon-
strated some side effects, such as nonsurgical and irreversible pulpal damage for Nd: YAG laser.

Queries about this article can be sent to Dr. Jafarzadeh at JafarzadehBH@mums.ac.ir.

REFERENCES
EIGHTH DISTRICT  
Kevin J. Hanley, D.D.S.

Save a Life
Erie County Dental Society sponsored “Basic Life Support for Health Care Providers” Aug. 7 at the Eighth District Dental Society’s office. This course fulfilled the New York State requirement for CPR. Attendees completed both a skills test and written exam for certification. The certification is for two years.

Erie County holds these CPR courses throughout the year so that members can keep their certification current. Participants received four MCE credits.

Becoming HIPAA Compliant
Lucarelli’s Banquet Center in Lackawanna was the site Sept. 7 for the Eighth District’s evening CE lecture “HIPAA Compliance & Security: All You Need to Know to Protect Your Patients and Your Practice.” Ikram Massabini, owner and CEO of MVP Network Consulting, covered many HIPAA-related topics, among them, what HIPPA actually is and what the law requires of dentists in their practice, what it means to be HIPAA-compliant and how to achieve that status. Given the growing incidences of breaches of patient information and ransomware attacks, this was a wonderful opportunity to get up to speed on this very important issue.

Understanding and Treating TMD
Chef’s restaurant in downtown Buffalo will be the venue for Erie County Dental Society’s evening CE presentation “TMD: A Multi-disciplinary Approach to a Multi-dimensional Disorder” Tuesday, Sept. 19. Six speakers from various dental and medical disciplines will give their perspectives on treating TMD.

Every practicing dentist knows TMJ disorders come in many forms, from the occasional clicking jaw to full blown chronic pain. The speakers, who will explore the various elements at play in TMD and related conditions, will include dental school faculty involved in research and academic trends in the field of TMD, a mental health professional concerned with the psychological and emotional elements of chronic pain, and a headache clinician, who will discuss the relationship between TMD and other craniofacial pains.

Attendees will see live demonstrations of physical therapy techniques for facial and neck pain and a demonstration of technology used in dedicated TMD practices for assessing mandibular function, all aimed at clarifying what can be a confusing and frustrating syndrome.

NASSAU COUNTY

Appointment
ADA delegate and past president Eugene G. Porcelli, D.D.S., was appointed by ADA President Gary L. Roberts, D.D.S., to the Reference Committee on Legislative, Health Governance and Related Matters of the 2017 House of Delegates Meeting being held in October in Atlanta, GA.

Continuing Education
- Monday, October 2: General Membership & Nominations Meeting: “Oral Mucosal Disease/Ulcerative Conditions” (2 CE credits). 6:30 p.m. dinner and business meeting. Course 7:30-9:30 p.m. Instructor: Robert Kelsch, D.M.D. Jericho Terrace, 249 Jericho Turnpike, Mineola.
- Wednesday, October 11: “Scrubs & Stilettos Women’s Dental Conference” (3 CE credits). 8 a.m.-12:30 p.m. Various instructors. Joint event with Suffolk County Dental Society. Carlyle at the Palace, 1600 Round Swamp Rd., Plainview.
- **Wednesday, October 25:** “HIPAA Security Compliance” (3 CE credits). 7-10 p.m. Instructor: Bijan Anvar, D.D.S. NCDS Headquarters, Lower Conference Level.

- **Friday, October 27:** Mandated Infection Control (4 CE credits). 9 a.m.-1 p.m. Instructor: Peter Mychajliw, D.D.S. NCDS Headquarters, Lower Conference Level.

- **Monday, November 6:** General Membership & Elections Meeting; “Non-Traditional Occlusal Therapies: Do They Work?” (2 CE credits). 6:30 p.m. dinner and business meeting. Course 7:30-9:30 p.m. Instructor: Kenneth Kurtz, D.D.S. Jericho Terrace, 249 Jericho Turnpike, Mineola.

- **Wednesday, November 29:** “Fundamentals of the TMD and the Dental Sleep Practice” (3 CE credits). 9 a.m.-noon. Instructor: Barry Rozenberg, D.D.S. NCDS Headquarters, Lower Conference Level.

- **Friday, December 8:** Risk Management (4 CE credits). 9 a.m.-1 p.m. Instructors: Robert Peskin, D.D.S.; Michael Kelly, Esq. NCDS Headquarters, Lower Conference Level.

Pre-registration is required for all courses. Payment is due upon registration, where applicable. For pricing, to register and to view course details, click on the calendar tab at www.nassaudental.org.

**Community Service**

NCDS President Fabiola Milord participated in the annual medical mission to Cap Haitian, Haiti, in June. Services were rendered out of Fort Liberté Hospital. Notably, she was also an invited speaker at the Second Annual Conference—World Health: Special Focus on Haiti—at the Université D’État D’Haïti in Limonade, which took part immediately before the mission. Dr. Milord’s lecture topic was “The Oral and Systemic Health Connection.”

Both the mission and the conference were part of a joint venture involving NOAH-NY, Howard University College of Medicine and Healthfirst.

**SUFFOLK COUNTY**

**Scrubs & Stilettos Returns**

Claudia Mahon-Vazquez, D.D.S

Scrubs & Stilettos, the joint Nassau-Suffolk conference for women dentists that was an ADA Golden Apple and NYSDA Hallmarks of Excellence winner, is returning on Wednesday, Oct. 11, to the Carlyle at the Palace in Plainview. Another great list of presenters offering a wide variety of topics has been drawn up. Attendees will be invited to select their top five preferred speakers. Please visit our website or read the Fall Bulletin for specific information.

This year we are pleased to have Irene Marron-Tarrazzi, ADA First Vice President, giving the keynote address. In addition, Maria Maranga, chair of the ADA Council on Membership and a SCDS past president, will be honored. This is a great networking opportunity for all of our female members.

For full details, go to www.suffolkdental.org, or call (631) 232-1400.

**Grape Escape**

SCDS’s annual fall Grape Escape will take place Sunday, Sept. 10, again at the Laurel Lakes Vineyard in the heart of Long Island’s wine country on the North Fork. The event will run from noon to 3 p.m. All dentists, their families and friends are welcome to attend and enjoy free wine and snacks. Please visit our website for more information.

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**Special Events**

The ADA Dentist and Student Lobby Day, formerly, the “Washington Leadership Conference,” took place in March in Washington, DC. Robert Peskin attended the conference in the capacity of action team leader for Congressman Peter King (R-Seafood). This was the first time national lobbying events for the ADA and American Student Dental Association were combined. About 900 dentists and students participated in this highly successful undertaking.

**Save the Date**

The 70th annual Officers’ Installation Gala and General Membership Meeting is set for Saturday, Jan. 13, at the Sephardic Temple, 775 Branch Blvd., Cedarhurst.
General Membership Meeting
The SCDS General Membership Meeting will take place from 6 to 9:30 p.m., Wednesday, Sept. 27, at the LI Radisson Hotel in Hauppauge. The program will feature the presentation “Dental Sedation Update,” by Mana Saraghi, dental anesthesiology residency program director at Jacobi Medical Center in the Bronx. A free buffet dinner will be available for all those who pre-register. CE credits will be awarded. Call SCDS at (631) 232-1400 for details.

CPR Courses Available
SCDS will offer CPR with AED training on Friday, Oct. 6, and Wednesday, Oct. 25. Courses start at 9 a.m. and finish at noon. The cost is $100 for ADA members; staff is welcome, space permitting. CPR/AED certification is required every two years for all dentists as a prerequisite to renewing their licenses with the New York State Department of Education. Contact SCDS to register for this member benefit.

Seminar Series 2017
The third seminar in the Stephen B. Gold Seminar Series will be presented 9 a.m. to 4 p.m., Wednesday, Oct. 4. Registration begins at 8:30 a.m. in the Media Center of SCDS headquarters on Motor Parkway in Hauppauge. The lecturer will be Steven Fallon, who will present “Fixed Implant Rehabilitation for the Terminal Dentition and Edentulous Arch.” SCDS thanks Nobel Biocare for sponsoring this course.

Check the Suffolk Dental Bulletin or the SCDS website for specifics about this and other courses.

East End Course
SCDS is excited to offer a special continuing education course for members on the East End of Long Island. On Friday, Oct. 13, at the Hilton Garden Inn in Riverhead, SCDS past president Eugene Antenucci will present a program titled “Image is Everything—Restorative Dentistry From an Entirely New Perspective.” Registration and breakfast begin at 8:30 a.m.; the course will follow from 9:30 a.m. to 12:30 p.m. It is partially sponsored by Henry Schein Dental and Planmeca USA. Contact SCDS to register and for additional information.

Risk Management
It is time again for many members to take the NYSDA risk management course. SCDS will offer it on Wednesday, Nov. 1, from 9 a.m. to 1 p.m. at its headquarters. If you are due to retake this course, please make sure to sign up to receive a 10% discount on malpractice premiums from MLMIC and select other insurance companies.

NYSDA HIPAA Course
Craig Ratner will make a return appearance to present the NYSDA HIPAA course on Wednesday, Nov. 8, at SCDS headquarters. For those who have not yet taken this course, it provides your office with the tools to comply with the HIPAA security requirements in a comprehensive, easy-to-understand format geared to dental practices. Visit the SCDS website for course and registration information.

New Dentist Program
SCDS New Dentist Committee Chair Brian McCormack hosted the Fourth annual Summer Social at Insignia in Smithtown in August. This was a great opportunity for our new dentists to meet many of our officers, connect with friends and make new acquaintances. Thanks to Jillian Deo from Implant Direct for again sponsoring this event.

SEVENTH DISTRICT

Rochester Center is
Grant Recipient
Bradley Davidson, D.D.S.

St. Joseph’s Neighborhood Center received a $10,000 grant to support its comprehensive dental care program. The grant giver, Delta Dental Community Care Foundation Helping Hands, Healthy Smiles program, focuses its annual support on nonprofit community clinics and healthcare programs.

The center, located in Rochester’s South Wedge, has seen an increase in demand for
dental services, since many health insurance plans do not provide dental benefits. The uninsured and underinsured people who use the center benefit from recently acquired equipment in three fully equipped dental operatories.

The volunteer dentists and hygienists who work at the center partner with Dental Director Mona Haleem, D.D.S., M.P.A., and her assistant, Ashley Ross, to treat individuals and families with limited access to dental care.

American College Enjoys Summer Outing

The Western New York Section of the American College of Dentists held its Annual Meeting and “Get-together” Aug. 5 in Auburn and Aurora. Fellows and their guests enjoyed a lovely time together, seeing a musical at the Merry-go-Round Playhouse and sharing dinner overlooking Cayuga Lake.

This group of “all stars” is particularly proud of the rapport it has with the University at Buffalo School of Dental Medicine, where every year they present ethics programs for both the incoming freshman and senior classes. Their regent, Mark Bauman, was present and reviewed ACD activities at the national level and discussed the opportunities presented by the University at Buffalo School of Dental Medicine, which will be held in conjunction with the ADA meeting, Oct. 18-19, in Atlanta.

At that meeting, the 7th District’s own William Zugner will receive his fellowship, as will Gerald Danaher of the 5th District.

Come to the Fair

Allen Glied will be heading up a committee dedicated to setting up dental job fairs in the Bronx, beginning in 2018. The purpose of the job fair is to bring together dentists looking for associates in the Bronx. Dental residents and other dentists looking for positions will be invited to attend.

Attendance at the fair will be restricted to BCDS members. Contact Joy at BCDS headquarters for more information.

Big Apple Dental Meeting

A fantastic program is being prepared for the 32nd annual Big Apple Meeting March 21-22. Visit the website www.bigappledentalmeeting.us for more information starting this fall.

SDDS Oral Health Committee volunteers participated in Body Sculpt, New York’s 14th annual Children’s Sports and Fitness Expo, June 24 at P.S. 92 in Brooklyn. The full-day event aims to educate families about proper nutrition, exercise and overall health. SDDS volunteers did their part by providing dental screenings and oral health education to attendees. Attendees also received free toothbrushes, toothpaste and literature on proper oral healthcare.

This makes five years SDDS has participated in the Children’s Sports and Fitness Expo. Many thanks to the diligent volunteers who generously gave their time to help make this year’s outing a tremendous success. They are Angela DeBartolo, Bridget Glazarov, Juan Martinez, Reneida Reyes, John Tawadrous, and Audra Haynes, R.D.H., and Lynette Fronerberger, R.D.H. Their efforts help ensure SDDS’s continued involvement in community outreach and education.

BRONX COUNTY

Bronx County Dental Society September Stated Meeting

Laurence Schimmel, D.D.S.

William Paveletz will present a lecture entitled “How Small Can They Go: Nano Hybrid and Ormocer Technology and How They Make an Impact on Today’s Composites” Sept. 12. Dr. Paveletz will review the different types of nano filler technologies used in some resin-based materials. Adhesives, flowable and universal composites will be looked at, and the clinical benefits of nano-inclusion will be discussed. Focus will be on understanding the chemical interaction and construction of materials as those qualities relate to the clinical efficacy and success of the procedure involved. Participants will be introduced to Admira Fusion, the first purely ceramic base restorative material.

Email Joy at bronxdental@optonline.net for more information.

SECOND DISTRICT

SDDS in Fitness Expo

Second District Dental Society Oral Health Committee volunteers participated in Body Sculpt, New York’s 14th annual Children’s Sports and Fitness Expo, June 24 at P.S. 92 in Brooklyn. The full-day event aims to educate families about proper nutrition, exercise and overall health. SDDS volunteers did their part by providing dental screenings and oral health education to attendees. Attendees also received free toothbrushes, toothpaste and literature on proper oral healthcare.

This makes five years SDDS has participated in the Children’s Sports and Fitness Expo. Many thanks to the diligent volunteers who generously gave their time to help make this year’s outing a tremendous success. They are Angela DeBartolo, Bridget Glazarov, Juan Martinez, Reneida Reyes, John Tawadrous, and Audra Haynes, R.D.H., and Lynette Fronerberger, R.D.H. Their efforts help ensure SDDS’s continued involvement in community outreach and education.

SECOND DISTRICT

SDDS Oral Health Committee Chair Reneida Reyes teaches Expo visitor about infant oral healthcare.
Component NEWS

NEW YORK COUNTY

Young Professionals Enjoy Culinary Event
Richard Lewenson, D.D.S.

Mark Bauman made a second guest appearance at New York County Dental Society, utilizing his training from the Culinary Institute of America to provide another incredible tasting event. This time, Dr. Bauman showcased extra-virgin olive and balsamic vinegar in several mouth-watering appetizers and one remarkable dessert. He taught members about varieties, qualities and properties of olive oil and vinegar. Everyone agreed it was a special night, enjoyed by all.

Charity Golf Outing a Win-Win

It was a day to enjoy golf, tennis, sun, drinks and, most importantly, to support a worthwhile charity. NYCDS’s Third annual Charity Golf Outing on July 20 was held at the beautiful Fenway Golf Course in Scarsdale. The event, chaired by David Koslovsky, raised the most ever for a society-sponsored charity golf outing—over $55,000 for Paul Newman’s Hole in the Wall Gang Camp. The camp offers seriously ill children and their family members “a different kind of healing,” all completely free of charge.

Many thanks to the dedicated committee members, sponsors and donors who made the outing such a remarkable success. Bravo!

September Membership Meeting


Restorative Yoga and Meditation for Dentists

NYCDS is offering “Restorative Yoga and Meditation Designed for Dentists,” a special wellness class, on Sept. 28 at Yoga Vida NoHo. The class will provide gentle and restorative movements to release back pain, a common affliction in the dental profession. To register, go to Eventbrite.com and enter NYCDS.

Preparing for Retirement and Selling your Practice

This popular evening workshop on Oct. 18 is led by three experienced professionals—a practice broker, a dental CPA and a financial professional—who will address all aspects of this key professional and transitional step. Call (212) 573-8500 to register.

Continuing Education

The Henry Spenadel Continuing Education Program offers a new roster of courses on Wednesdays and Fridays this fall, including a final “Speed Learning: 6 Speakers 6 Hours 6 Credits,” with new speakers and topics, and a reasonable tuition, on Oct. 20. A new and important course, “Child Abuse: Implications for the Dental Professional,” co-sponsored by the Dental Hygienists’ Association of the City of New York, will be offered on Nov. 8.

Practice Management Series

NYCDS has teamed with Henry Schein Dental Business Solutions to offer “Dentistry’s Changing Landscape,” a series of management programs designed to demonstrate the steps dentists can take to run a better dental practice. Course titles and times are listed below.

- Sept. 27, 9:30 a.m.-4:30 p.m.: “The Corporate-proof Practice,” by Matthew Krieger, D.M.D.
- Oct. 4, 7-9 p.m.: “Effective PPO Management,” by Scott Hironaka, Unitas Dental.
- Oct. 11, 7-9 p.m.: “Marketing in New York City,” by Abe Kasbo, Verasoni Worldwide.
- Nov. 1: 7-9 p.m.: “Building a High Profit PPO Practice,” by Matthew Krieger, D.M.D.

Visit www.nycdentalsociety.org for course and registration information.
Events Past and Future

Olga Lombo-Sguerra, D.D.S.

The fall calendar is filled with events of interest to Ninth District members. Most recently, on Sept. 7, the association invited students from Touro College of Dental Medicine in Valhalla, Westchester County, to an Ice Cream Social at the college. Looking ahead, we find these other events planned.

- A New Dentist Reception on Tuesday, Sept. 26, at Saltaire in Port Chester. It’s open to all dentists out of dental school 10 years or less.
- Also of interest to new dentists, the Membership & Communications and New Dentist committees have planned an event for residents and new dentists to take place from 6:30-9 p.m., Wednesday, Dec. 6, at the River Market in Tarrytown. Members of the host committees will provide pointers on establishing practices.
- The Ninth District General Meeting is set for Wednesday, Sept. 13, at Crowne Plaza, Suffern. Randy F. Huffines, D.D.S., director of geriatric dentistry at the Quillen Medical Center in Johnson City, TN, will present “Simplifying the Medically Complex Patient” in the morning. He will return in the afternoon to present “Clinical Pearls for Treating Older Patients.”
- On Friday, Oct. 13, the Ninth District will present its Restorative Conference at the Westchester Country Club in Rye. Lyndon Cooper is the presenter.
- And the association’s end-of-the-year Annual Meeting will take place on Wednesday, Nov. 15, at the Westchester Country Club in Rye. Gerard Kugel, D.M.D., M.S., Ph.D., will present “Esthetic Dentistry: Materials & Techniques” in the morning. His afternoon presentation is entitled “Adhesive Dentistry and Direct Restoratives: Is Newer Always Better?”

For further information about NYSDA Endorsed Programs, call Michael Herrmann at 800.255.2100
Nominees Sought for NYSDA Honors

The NYSDA Council on Awards is seeking nominations for the Association’s two merit awards—the William Jarvie and Harvey J. Burkhart Award and the Distinguished Service Award.

The council will consider nominees according to its criteria and guidelines for selecting recipients. The guidelines are printed here. The council expects to make its selection at its teleconference at 11 a.m., Friday, Dec. 15, although it reserves the right to withhold either of the awards if it feels no nominee meets the criteria.

The 2018 Jarvie-Burkhart Award and Distinguished Service Award will be presented in June at the NYSDA Annual Session. Nominations must be submitted no later than Tuesday, Dec. 5.

Awards Criteria and Guidelines

The William Jarvie and Harvey J. Burkhart Award

The William Jarvie and Harvey J. Burkhart Award (also referred to as the Jarvie-Burkhart Award) is the highest honor bestowed by the New York State Dental Association and is presented in recognition of great service rendered mankind in the field of dentistry. It may be awarded to an individual dentist, a non-dentist or an organization. To be considered for the Jarvie-Burkhart Award, nominees must have demonstrated advancement in at least one of the following areas:

- promotion of continuing dental education;
- advancement of dental research;
- philanthropic endeavors in the field of dentistry; or
- original contributions to the science and application of dentistry.

Nomination Procedure: Annually, notice shall be published in an official publication of the New York State Dental Association in the month of September, requesting nominations for the Jarvie-Burkhart Award. The notice shall include the eligibility criteria, as well as the guidelines and instructions for submitting a nomination. The nomination form for the Jarvie-Burkhart Award shall be available from the New York State Dental Association’s Headquarters Office or from the Association’s website (www.nysdental.org). The completed form must include pertinent information substantiating why the individual being nominated should be considered.

The deadline for submitting applications shall be Dec. 5 after notice has been published. The Council on Awards shall meet to consider all eligible nominees and make its recommendations and report to the Board of Trustees before the first meeting of the Board of Trustees in the year following the Dec. 5 deadline for submission of nominations. Should the Board determine that an eligible nominee is to receive the award in accordance with Chapter V, Section 100 of the Bylaws, the Jarvie-Burkhart Award shall be presented at the Annual Session of the New York State Dental Association.

Inasmuch as the Jarvie-Burkhart Award is the highest award that NYSDA can bestow, it must not be seen as synonymous with the Distinguished Service Award, which was established to recognize an individual’s contributions to organized dentistry. Therefore, the Jarvie-Burkhart Award is not necessarily given every year. The Council on Awards shall only recommend presentation of the Jarvie-Burkhart Award if the Council is of the opinion that the above criteria and guidelines have been met.

Nominations of members serving on the Council on Awards must be deferred until completion of their service on the Council.

The New York State Dental Association’s Distinguished Service Award

The New York State Dental Association’s Distinguished Service Award is presented to an individual in recognition of numerous years of meritorious service and commitment to the Association. The criteria to be considered in determining eligibility for the Distinguished Service Award include:

- contributions to the New York State Dental Association;
- contributions to organized dentistry as a whole;
- the offices and positions held; and/or
- the tenure of the individual’s service.

Nomination Procedure: Annually, notice shall be published in an official publication of the New York State Dental Association in the month of September requesting nominations for the Distinguished Service Award. The notice shall include the eligibility criteria, as well as the guidelines and instructions for submitting a nomination. The nomination form for the Distinguished Service Award shall be available from the New York State Dental Association’s Headquarters Office or from the Association’s website (www.nysdental.org). The completed form must include pertinent information substantiating why the individual being nominated should be considered.

The deadline for submitting applications shall be Dec. 5 after notice has been published. The Council on Awards shall meet to consider all eligible nominees and make its recommendations and report to the Board of Trustees before the first meeting of the Board of Trustees in the year following the Dec. 5 deadline for submission of nominations. Should the Board determine that an eligible nominee is to receive the award in accordance with Chapter V, Section 100 of the Bylaws, the Distinguished Service Award shall be presented at the Annual Session of the New York State Dental Association.

Nominations of members serving on the Council on Awards must be deferred until completion of their service on the Council.
2018 William Jarvie and Harvey J. Burkhart Award

NOMINATION FORM

(Deadline for Submission – December 5, 2017)

Name of Nominee:

Submitted by:

The William Jarvie and Harvey J. Burkhart Award (also referred to as the Jarvie-Burkhart Award) is the highest honor bestowed by the New York State Dental Association and is presented in recognition of great service rendered mankind in the field of dentistry. It may be awarded to an individual dentist, a non-dentist or an organization. To be considered for the Jarvie-Burkhart Award, nominees must have demonstrated advancement in at least one of the following areas:

- promotion of continuing dental education;
- advancement of dental research;
- philanthropic endeavors in the field of dentistry; or
- original contributions to the science and application of dentistry.

Please specify how the nominee has accomplished advancement in the areas noted above.

m Please fill in circle if continued on attached pages.

Please list any other reasons you believe the nominee is deserving of this award.

m Please fill in circle if continued on attached pages.

Please attach curriculum vitae or other appropriate documents detailing the background and general information regarding the nominee. Remit to:

New York State Dental Association
20 Corporate Woods Blvd., Ste. 602
Albany, New York 12211
ATTN: Dr. Chad P. Gehani, Council on Awards Chair

2018 Distinguished Service Award

NOMINATION FORM

(Deadline for Submission – December 5, 2017)

Name of Nominee:

Submitted by:

The New York State Dental Association’s Distinguished Service Award is presented to an individual in recognition of numerous years of meritorious service and commitment to the Association. The criteria to be considered in determining eligibility for the Distinguished Service Award include:

- contributions to the New York State Dental Association;
- contributions to organized dentistry as a whole;
- the offices and positions held; and/or
- the tenure of the individual’s service.

Please specify how the nominee has contributed to the New York State Dental Association, or organized dentistry as a whole.

m Please fill in circle if continued on attached pages.

Please list any other reasons you believe the nominee is deserving of this award.

m Please fill in circle if continued on attached pages.

Please attach curriculum vitae or other appropriate documents detailing the background and general information regarding the nominee. Include the offices and/or positions held in organized dentistry. Remit to:

New York State Dental Association
20 Corporate Woods Blvd., Ste. 602
Albany, New York 12211
ATTN: Dr. Chad P. Gehani, Council on Awards Chair
Read, Learn and Earn

Readers of The New York State Dental Journal are invited to earn three (3) home study credits, approved by the New York State Dental Foundation, by properly answering the following 30 True or False questions, all of which are based on articles that appear in this issue.

When you have completed the questionnaire, return it to the New York State Dental Foundation, along with the appropriate fees: $60/dentists; $40/hygienists. Nonmember fees are: $120/dentists; $80/hygienists. All those who achieve a passing grade of at least 70% will receive verification of completion. Credits will automatically be added to the CE Registry for NYSDA members.

For a complete listing of online lectures and home study CE courses sponsored by the New York State Dental Foundation, visit www.nysdflearning.org.

Case Report of Multiple Keratocystic Odontogenic Tumors Presenting as Nevoid Basal Cell Carcinoma in Pediatric Patient—Page 27-30

1. The nomenclature of odontogenic keratocysts (OKCs) has been changed to kerato-cystic odontogenic tumor (KCOT) to more accurately reflect the aggressive and recurrent nature of the lesion.
   □ T or □ F

2. KCOT is a malignant intraosseous neoplasm of the jaw.
   □ T or □ F

3. KCOT occurs in two distinct types: most commonly as a sporadic solitary-lesion; or as part of the nevoid basal cell carcinoma syndrome (NBCCS), in which multiple KCOTs are observed.
   □ T or □ F

4. 50% of all KCOTs are associated with NBCCS.
   □ T or □ F

5. NBCCS is an autosomal-dominant, inherited genetic disorder.
   □ T or □ F

Enclosed is a check for the full amount. Members’ fees are $60/dentists; $40/hygienists. Nonmember fees are $120/dentists; $80 hygienists. (Make checks payable to the New York State Dental Foundation.) Mail to NYSDF, 20 Corporate Woods Boulevard, Suite 602, Albany, NY 12211. Questionnaires must be received within 90 days of Journal publication.

Please charge my: □ VISA □ MasterCard □ American Express

Telephone ________________________________

E-mail ________________________________

ADA # ________________________________

License # ________________________________

NYSDA Member? □ yes or □ no

Local/State Dental Society ________________________________
6. KCOTs do not display keratinization of their epithelial lining.
   - T or F
7. The development of KCOTs derives from the dental lamina and its remnants after this structure has functioned for odontogenesis.
   - T or F
8. CT scans are not warranted prior to treatment of multiple cystic lesions of the jaw.
   - T or F
9. The most common complication associated with KCOTs is recurrence.
   - T or F
10. The presence of multiple keratocystic odontogenic tumors is the initial diagnostic feature of nevoid basal cell carcinoma syndrome.
    - T or F

**Multiple Miliary Osteoma Cutis of the Cheeks—Page 31-36**

1. Miliary osteoma cutis (MOC) is a rare dermatopathic disorder of heterotopic bone formation, often associated with acne and primarily involving the cutaneous tissues of the head and neck.
   - T or F
2. The etiopathogenesis of MOC has been clearly elucidated.
   - T or F
3. MOC presents as ectopic calcifications that emerge gradually after 40 years of age and occur in multitudes of painless, hard, skin-colored papular eruptions.
   - T or F
4. Severe sunburn is not a predisposing factor of MOC.
   - T or F
5. MOC has not been observed in the absence of acne or other cutaneous disease.
   - T or F
6. The preponderance of cases of MOC develop secondary to a diversity of etiopathologies.
   - T or F
7. Microscopically excised specimens of MOC do not resemble normal bone.
   - T or F
8. Radiographically, MOC often resembles clusters of snowflakes.
   - T or F
9. Treatment modalities for MOC mainly employ excision, dermabrasion, topical tretinoin and laser resurfacing.
   - T or F
10. Complete eradication of MOC is always possible.
    - T or F

**Delayed Diagnosis of Burkitt’s Lymphoma in HIV Patient after Third Molar Removal—Page 37-42**

1. Burkitt’s lymphoma (BL) is a highly aggressive B-cell non-Hodgkin's lymphoma (NHL).
   - T or F
2. NHL accounts for approximately one-third of AIDS-related malignancies.
   - T or F
3. NHL has a prognosis of weeks without treatment.
   - T or F
4. BL is easily diagnosed, especially when the sole presentation is in the maxillofacial area.
   - T or F
5. NHL is a highly aggressive disease that can mimic benign pathologies.
   - T or F
6. The risk of BL onset is 261 to 1,000 times more common in patients with AIDS than in the general population.
   - T or F
7. The most common clinical findings with jaw involvement are pain, swelling, disturbances in eruption, loosening of teeth, paresthesia and poor improvement with antibiotic treatment.
   - T or F
8. Clinical and radiographic features of BL are easily differentiated from various lesions, such as periapical lesions, dentoalveolar abscess, osteomyelitis, ameloblastoma and eosinophilic granuloma.
   - T or F
9. Intensive combination chemotherapy is the primary treatment of HIV-associated BL.
   - T or F
10. BL should always be included in the differential diagnosis of intraoral lesions of similar extent (various other jaw lesions).
    - T or F
The Centers for Disease Control and Prevention has revised the guidelines for infection control in dental health care settings. Learn about the CDC’s new guidelines, and much more, with the New York State Dental Foundation’s all-new CD-ROM, Infection Control and HazCom Compliance.

The new program on CD-ROM is easier to use, includes movies, is partially narrated and works much like the old video course. To comply with the law for infection control training, view the CD on your home or office computer, complete the short exam that accompanies the CD, and mail it back to the Foundation. You will receive four (4) home study MCE credits. NYSDA members will automatically receive credits with the CE registry.

Share your CD with staff, study clubs and other allied professional groups by ordering additional exams.

All dentists and dental hygienists are mandated to complete the required infection control training once every four (4) years to maintain a New York State license.

Update Your Protocol With New PowerPoints and CD

ORDER FORM
PLEASE PRINT

Name __________________________________
Address ____________________________
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ADA # __________________ License # __________
Phone #(___ )_________ Fax #(____)_________
E-mail _____________________________
Local Dental Society ______________________

NYSFDA MEMBERS AND HYGIENISTS
CD-ROM & One Exam ______ x $75.00 ea. = $ ________
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Total Amount ______ ______

NON-MEMBER DENTISTS
CD-ROM & One Exam ______ x $125.00 ea. = $ ________
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Total Amount ______ ______

Enclosed is a check for the total amount.

Make check payable to: The New York State Dental Foundation.

Please charge my: [ ] VISA [ ] MasterCard [ ] AMEX
Card # ____________________________ Exp. ________

Mail this form to:
NYSDF, Suite 602, 20 Corporate Woods Boulevard, Albany, NY 12211
Credit card orders may be faxed to: 518-465-3219.

NEED TO TAKE YOUR COURSE SOONER RATHER THAN LATER?
You can always take the Infection Control and HazCom Compliance course online at: www.nysdentalfoundation.org

The New York State Dental Foundation is an ADA CERP Recognized Provider.
ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.

New York State Dental Foundation designates this activity for four (4) continuing education credits.
FOR SALE

MANHATTAN: High end FFS practice. 5 chairs. Grossing $1.65M, plus $56K rent. Price $1.35M firm. Inquiries to: giljoy89@optonline.net.

SARATOGA SPRINGS: Family practice collecting $850K with one dentist and one hygienist working 35-hour weeks and 4 weeks vacation/year. Only PPOs and private patients, with no Medicaid. 3 ops with room for 5. Inquiries to: SaratogaDentalCare@gmail.com; or call (518) 330-9372.

WILLIAMSVILLE: Established private endodontic practice for sale. Prime location. 2,000 square feet. 5 ops; fully equipped. Gendex X-rays, Royal chairs, Pelton lights and stools, Global Protege’ microscope; many extras. $750K gross, $450K net, $50K retirement contribution. Lease assumable. Will sell all assets for $250K. Must see. For more information, contact: nsxendo@roadrunner.com.

CAPITAL DISTRICT: Established practice for sale. 5 operatories; computerized, digital X-ray. Building for sale; lease considered, along with practice. Dentist retiring. Price and terms very negotiable. Call Dave Connolly at (518) 925-1770; or email: dconnoll1@nycap.rr.com.

MID-HUDSON VALLEY: Established 30-year-old private practice recognized as one of area’s leading cosmetic and dental implant centers. 100% FFS; paperless and recession-proof. Perfect practice for advancing GP, specialist or multi-doctor group seeking to elevate quality of care and capitalize on burgeoning demand for comprehensive restorative and implant services. Real estate available; expandable. 1,800-square-foot, free-standing modern facility. AAA location. Flexible terms on building. Send inquiries to: midhvdds@gmail.com.

FINGER LAKES/SOUTHERN TIER: Family practice for sale in upstate NY village. Long-term practice established in 1919. Great setting with operatories overlooking river and within 2 blocks of numerous restaurants and shops. Last three years average gross $9830K/net; $420K on four-day workweek and 10 weeks vacation. Owner ready to retire, but will stay for transition. Building available for rent or purchase. Please contact: skident@aol.com.

MANHATTAN: 30 East 40th Street. Highly sophisticated, newly renovated 3-chair office in professional building. Approximately 1,100 square feet. Turn-key dental office; no practice (patient list). New, 10-year lease for buyer. 3 modern, right-/left-handed windowed operatories with A-Dec. Facing 40th Street. Reception area, sterilization lab, private office with restroom, waiting area with restroom. Must see. Price negotiable. Inquiries to: dentlwd@aol.com; or call: (516) 659-0289.

BRENTWOOD & HICKSVILLE: Dental practices for sale separately or combined. Brentwood office: High volume; grossing $1.4-$1.6M. High profit. 5 ops; computerized, digital pan, digital Kodak X-ray, iTero scanner, laser, N2O. Great location in medical center in front of railroad. All phases of general dentistry, Invisalign, implants, etc. Asking $1M. Smooth transition; owner planning to retire. Hicksville office: behind Sears on Route 107 in medical building. 2 ops, pan, digital X-ray, N2O. Grossing $80K. Satellite office operating 2 half-days. Asking $50K. Inquiries to: manilal@patelnyc.com; or call (516) 242-6154.

LONG ISLAND: Five dental offices for sale due to illness.

LINDENHURST: Brand new, state-of-the-art, 3-chair office on main highway.

QUEENS BOULEVARD/SUNNYSIDE: Owner retiring.

WOODHAVEN PRACTICE: Same owner as above, will sell as package or separate.

DYKER HEIGHTS, BROOKLYN: 4 ops, upstairs office, busy location.

BAY RIDGE: Established office, very good fees.

All offices for immediate sale. Broker. For info email: fed425@gmail.com.

RIVERDALE: Established dental office (65 years) in co-op apartment with private entrance. Prime location. Very reasonable maintenance; approximately 800 square feet. Good public transportation nearby. Reasonably priced. Office has been cleaned out, repainted and carpeted. Ready to go. Inquiries to (718) 230-7069.

CLASSIFIED INFORMATION

RATES: $60 for 45 words or less; 75 cents each additional word; Includes 30-day posting on NYSADA website. $10 additional for Journal box number. Web only, $40 for 30 days. Box display: 1 column wide by 1 inch deep (min.), $60; each additional 1/2 inch $25. Payment must accompany all ads. Copy due 1st of month, one month prior to date of publication. All ads are subject to editing by The Journal. Box replies to: NYS Dental Journal, 20 Corporate Woods Boulevard, Suite 602, Albany, NY 12211. Please use complete box number with replies.

RIVERDALE: Established dental office (65 years) in co-op apartment with private entrance. Prime location. Very reasonable maintenance; approximately 800 square feet. Good public transportation nearby. Reasonably priced. Office has been cleaned out, repainted and carpeted. Ready to go. Inquiries to (718) 230-7069.

MIDTOWN MANHATTAN: FFS, established, solo general practice. Grossing $784K with 3 treatment rooms — 2 functional and 1 plumbed. Includes digital X-ray. Clean and elegant office, just under 1,000 square feet, in high demand location. Contact Henry Schein Professional Practice Transitions Consultant Michael Apalucci: (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY177.

CAPITAL REGION: 100% FFS family practice with healthy finances. 4-operator practice equipped with digital X-rays and practice management software. Real estate for lease or purchase. Uniquely located. Doctor willing to stay for transition. Contact Henry Schein Professional Practice Transitions Consultant Donna Bambrik: (315) 430-0643; or email: donna.bambrik@henryschein.com. #NY170.

SYRACUSE: Eastern suburb. General practice. 4 ops with A-Dec equipment, Dentrix, digital. Stand-alone building with plenty of parking also for sale. FFS and insurance mix. Located near main highways. Contact Henry Schein Professional Practice Transitions Consultant Donna Bambrik: (315) 430-0643; or email: donna.bambrik@henryschein.com. #NY173.


NIAGARA COUNTY: Established general practice providing patients with diagnostic, preventative and restorative oral care. 2,000 square feet; 4 spacious ops; 950 active patients. Operating 22 hours/week. Paperless; SoftDent. Ample parking available. Grossing $233K. Contact Henry Schein Professional Practice Transitions Consultant Christine Palma: (585) 370-5301; or email: christina.palma@henryschein.com. #NY201.

POUGHKEEPSIE: Home/office for sale, suitable for dental office. 2-story house in city of Poughkeepsie. Will include equipment. Price is negotiable. Please contact Dr. Stanley Rudnicki at (845) 471-1000.

ORANGE COUNTY: High-quality, diversified, private general practice in terrific hometown setting. 5 ops and family-oriented patient base. Combination of FFS and high-end insurances generating $1.65M. Contact Henry Schein Professional Practice Transitions Consultant Michael Apalucci: (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY195.

WESTCHESTER COUNTY: Nicely designed office with 4 operatories. Diverse, high-demand area features 1,260-square-foot practice with strong insurance-based patients generating $700K with part-time hours. Contact Henry Schein Professional Practice Transitions Consultant Michael Apalucci: (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY202.

ORANGE COUNTY: Two-day/year ortho practice generating $570K on 16-hour week. 3 treatment rooms and 5 chairs. Part-Time office shares equipment and 3 days with successful Pedo practice. Contact Henry Schein Professional Practice Transitions Consultant Michael Apalucci: (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY202.

GENESEE COUNTY: Well-established general practice. Diagnostic, preventive and restorative oral care. Occupies 1,600 square feet. 4 ops, and ample parking. 1,740 active patients; 34 hours/week. Utilizes Softdent, intra-oral cameras and panoramic X-ray. Gross receipts $497K. Real estate also available. Henry Schein Professional Practice Transitions Consultant Christine Palma: (585) 370-5301; or email: christina.palma@henryschein.com. #NY206.

ALBANY/SCHENECTADY/TROY: Newly renovated, well-established, FFS family practice. Up-to-date practice management software and fully digital, 32-hour week. 4 spacious operatories providing diagnostic and restorative oral care. 1,980 square feet; ample parking. Gross receipts $470K. For more information contact Henry Schein Professional Practice Transitions Consultant Donna Bambrik: (315) 430-0643; or email: donna.bambrik@henryschein.com. #NY204.

ALBANY/SCHENECTADY/TROY: Double hygiene in NY’s Capital. $700K gross on 3-day week. Dentrix and digital X-rays. 3 ops and plumbed for 4 on busy street with off-street parking. Modern facility. For more information contact Henry Schein Professional Practice Transitions Consultant E. Scott Weinberger: (518) 512-9988; or email: escott.weinberger@henryschein.com. #NY213.

ROCHESTER: General practice gem. Across from major hospital. Always new patients and plenty of parking. 3 ops, great equipment, digital and Eaglesoft. Perfect satellite office. For more information contact Henry Schein Professional Practice Transitions Consultant Donna Bambrik: (315) 430-0643; or email: donna.bambrik@henryschein.com. #NY211.

PARAGON Practice Transitions
“We Put the SUCCESS in Succession”

ROCHESTER: Pedo. Partnership opportunity in growing suburb.

FINGER LAKES: $300K/year, part time, 4 ops.

BUFFALO: $185K/year; excellent for merger/satellite/semi-startup. SOLD.

BUFFALO/SOUTHERN TIER: Gorgeous GP office in brand new location. 4.1M/year. All the “bells & whistles.”

BRONX: 3 ops; digital; $500K/year.

SUFFOLK: $300K/year, part time. 2 ops with 2 more plumbed.

EASTERN SUFFOLK: $625K/year on 3 days/week. SALE PENDING.

BROOKLYN: $400K/year, 4 fully digital ops, beautiful facility.

NASSAU: North Shore. $1.2M/year; fully digital.

MID NASSAU: Perio. $400K/year, part time.

SOUTHERN NASSAU: $350K/year, perfect merger.

SOUTHERN NASSAU: $600K/year, high profit, GP office in most desirable town.

SOUTHERN SUFFOLK: $700K/year, fully computerized and digital. SOLD.

PUTNAM: $350K/year, 700 active patients.

WESTCHESTER: 3 modern ops; $500K/year; upscale area near CT border.

Visit our website www.paragon.us.com to learn more about all of our opportunities or contact us today!

Jonathan Carey, DMD; Ira Newman, DDS; Erin Page, DDS & David Page, MS
Phone: (866) 898-1867
E-mail: info@parangon.us.com.

SARATOGA COUNTY: Practice located on busy road. 40- new patients/month. Facility updated and modern. $850K gross. 3 ops; plumbed for 5. Eaglesoft and digital X-ray. For more information contact Henry Schein Professional Practice Transitions Consultant E. Scott Weinberger: (518) 512-9988; or email: escott.weinberger@henryschein.com. #NY214.
SYRACUSE DENTAL OFFICE: Western suburb. Rapidly growing modern office; all digital, new technology. Practice and real estate appraised at $790K, asking $700K. Willing to sell practice and real estate separately. 2016 production over $700K. Competent and enthusiastic staff will stay. Owner very motivated. Reply to: Syracusedentaloffice@gmail.com.

LONG ISLAND PRACTICES FOR SALE:

NORTHWEST NASSAU: General dentist, six operators, all digital with panorex. Grossing $1.1M. #NY170.

SOUTHWEST NASSAU: General dentist, 4 operators, all digital. Grossing $550K.

EASTERN QUEENS: General dentist, four operators, all digital with panorex. Grossing $1.5M. #NY209.

EASTERN SUFFOLK: General Dentist, five operators, all digital. Grossing $550K. #NY199.

MIDDLE SUFFOLK: General Dentist, four operators, all digital. Grossing $610K. Real estate available. #NY200.

NASSAU/QUEENS: Periodontist’s two offices, highly desirable locations with great leases. Grossing $590K. #NY203.

Contact Henry Schein Professional Practice Transitions Consultant Scott Firestone by phone: (516) 459-9258; or email: scott.firestone@henryschein.com.


MANHATTAN MIDTOWN: 30 East 40th Street. Newly renovated 5-chair office in professional building that is also being renovated. No practice. Takeover lease. Renter in place to offset reasonable rent. Private office includes private bath. Priced to sell. Email: MDAdentalgroup@gmail.com.

JACKSON HEIGHTS: Commercial co-op for sale or rent. 2 operators; state-of-the-art technology, equipment included. Ground floor on busy street with great visibility. 2 minutes from train station. Turn-key office. Inquiries to: turnier@gmail.com.

WESTCHESTER: General dental practice located within 5-minute walk to Metro North. Practice only participates with one PPO and collects over $470K. Four treatment rooms with digital X-ray. Located in beautiful building with great exposure. Real estate may also be available. Please contact Brian Hudson: (716) 908-3143; or email: brian@hudsontransitions.com.

FOR RENT

GRAND CENTRAL AREA: Up to 4 large, brand new treatment rooms in designer, state-of-the-art facility near Grand Central Station. Large rooms with large windows; Doctor’s office, front desk space, sterilization/lab areas, staff room, conference room. From as little as half-day or daily rentals to full-time lease. Both monthly or 5- and 10-year leases of 1-4 treatment rooms. Transportation: near 4, 5, 6, 7, S, B, D, F, M, N, Q, R, 1, 2, 3 trains. See virtual tour at: www.eenymproperties.com. Inquiries by email: info@enymproperties.com; or call (212) 752-3636.

MANHATTAN: Elegant Midtown FFS office with one operator for rent. Modern A-Dez equipment. One block from MOMA and shopping district. Amazing location. Inquiries to: (856) 261-3895; or email: dentistsny01@gmail.com.

MANHATTAN: Murray Hill. Boutique office for rent in Art Deco building with doorman. 2 operators available Monday and Wednesday. Email: seekingdentistmurrayhill@gmail.com.

MIDTOWN EAST: Dental operator for rent. Fully equipped dental operator available one or more days. Please call (917) 885-6692.

MIDTOWN MANHATTAN: Facing Central Park South. Fully digital dental office, including I-Cat for lease. Great opportunity to be on your own. State-of-the-art décor, newly renovated, modern office and equipment; WiFi; handicap accessible. Near all public transportation. Available immediately full time or part time. To schedule appointment, email: paroiplanbythepark@gmail.com; or call (917) 679-6013.

MIDTOWN MANHATTAN: Beautiful, new, large-windowed dental operations for rent. Pelton Crane equipment, massage chairs, private office, front desk space and staff available. Doorman, warm environment. Location——46th St. and Madison Ave. Please call (212) 371-1999; or email: karenjtj@aol.com.

MANHATTAN: Our highly sophisticated dental office at 200 Central Park South has 2 rooms for rent. Digital X-rays and Dentrix-based system. Located in one of most prestigious parts of New York, directly across from Central Park at 59th Street and 7th Avenue. Inquiries to: marcbenhuri@gmail.com; or call (917) 519-1213.

MANHATTAN: 10 x 12 operator with storage in op. Recently renovated, with modern facilities. First floor of luxury, doorman building in desirable Murray Hill, between Park and Madison Avenue. Daily rates available. Specialist or general dentist welcome. Inquiries to: nmnoussav1@yahoo.com; or call (212) 532-0690.

MIDTOWN EAST: Sublease 1 op in Midtown East office, located 1 block from Central Park South, Barney’s, steps to Bloomberg, trains. Newly renovated; Sirona chairs, op in private area of office. New vacuum, autoclave. Disposable included or negotiable. Contact: info@dxyondentistry.com; or call (212) 265-9800.

WHITE PLAINS: Modern, state-of-the-art operations available in large office with reception. Available FT/PT. Turn-key. Rent includes digital radiology with pan, equipment, Nitrous, all disposables. Start-up or phase down. Need a satellite or more space? Upgrade or down size. Please call (914) 290-6545; or email: broadwoyder@gmail.com.

MANHATTAN: Midtown. Operator for rent in newly renovated dental office conveniently located two blocks south of Grand Central. Full or part time. Spacious, attractive office with room for your practice to grow. Ideal for pleasant dentist seeking great place to stay long term. Reasonable rent and eventual buyout possible of prestigious Midtown restorative practice. If this sounds interesting, contact: (212) 685-0312; or email: skater8475@verizon.net.

MANHATTAN: One operator for rent in recently renovated Midtown building. Office located at Madison Avenue and 52nd Street. Reasonable rent. Inquiries to: (212) 688-2820; or email: info@okkaren.com.

DOWNTOWN BROOKLYN/FORT GREEN: Dental office available for long-term lease and/or possible purchase. Brooklyn Academy of Music and Barclays Center area. Convenient access to large transportation center, most NY subways, LIRR and buses. Clean, spacious, 1,260 square feet. Excellent natural light and views. Four modern, turn-key, left-/right-handed, windowed operatories with digital radiography and networked software. Reception, sterilization lab, private office and staff room. Contact: brooklyndentaloffice1030@gmail.com.

MANHATTAN: Dental office available for lease. Ideal situation for new or downsizing practitioners. Boutique dental office located on 60th Street Park/ Madison Avenue. Convenient access to public transportation, most NY subways and buses. Two modern, turn-key, left-/right-handed, windowed operatories with digital radiography (Dexis) and networked software. Reception area, sterilization lab, private office and office restroom. Contact: dental3060@gmail.com.

NYACK: 1,800-square-foot commercial office space for rent. Hudson River views, great light, plenty of free street parking. Currently set up as 4-chair orthodontic office; can easily be converted to pediatric or other specialty. Inquiries to: nyackdds@gmail.com.

NYC: Fully equipped, long-established, 1,600-square-foot dental office. Direct deal from landlord; long lease OK. Lower East Side/East Village/Avenue A area; 10009 zip code. Ground floor; storefront. Mostly all equipment still in place, plus equipped full lower level. Compressors, various types of equipment. Ten ops; all chairs in place. Other than a good clean-up, could be turn-key situation. Inquiries to RE Broker Mihana S. by email: mihana@ureach.com; or call (917) 405-0885.

THE NEW YORK STATE DENTAL JOURNAL • AUGUST/SEPTEMBER 2017
CLASSIFIEDS

MIDTOWN EAST: Spacious, fully digital 1-2 operatories with/without staff available for GP or specialist. Private elevator, office, panoramic and lab on premises. Full- or part-time arrangement available. Please contact: 964dental@gmail.com.

ROCKLAND COUNTY: Beautiful professional space available for lease in downtown Piermont. Space divided into 3 operatories rooms, front desk area and waiting room. Total space is 1,000 square feet. $2,500/month. Inquiries to Naomi Vargas at (845) 825-6997 or (917) 929-5848. Email: piermontdental@yahoo.com.

BUFFALO: Dental office for sale or rent. 3 ops with all supplies and equipment. Nucleus of patients may be available for introduction. $80-500K gross on 1 day/week. Will modernize to suit longer-term commitment. Three-bedroom, two-bath remodeled apartment above. Inquiries to: dentoff@gmail.com.

NASSAU COUNTY: Northern Boulevard, Manhasset. 7-operatory dental office (Prophodontic). Totally redone, equipped, gorgeous. Offering rental of 1 or 2 operatories F/T or P/T. Multiple long-term options for right practitioner. Unique opportunity. Contact Vanessa at (516) 365-3535; or email: 2prosthodontics@optonline.net.

MOUNT KISCO: Perfect location. Class A medical building in Mount Kisco at crossroads of Routes 117 and 128. Beautiful new lobby and common areas. First floor option currently with 8 exam rooms, 2 bathrooms and executive office. 1,718 square feet. We can design and build any configuration. Ample free parking. Call CJ Rockett at (914) 773-6264; or email: cjrockett@dpmgnt.com.

INDEX TO ADVERTISERS

3% Dental ................................................. 59
Accounting for Dentistry ......................... 20 & 26
Aftco .......................................................... 42
Blaustein & Gillen ......................................... 23
Clemens Group ........................................... 41
Dental Care Alliance ..................................... 35
Ecker & Ecker ............................................ 44
Epstein Practice Brokers ................................. 30
E-Vac .......................................................... 34
Excel Micro. .................................................. Cover II
Henry Schein .................................................. 6
Jacobson Goldberg & Kulb ................................. 36
MLMIC ....................................................... Cover IV
NYSDA Support Services .............................. 21 & 39
NYSDOM .................................................... Cover III
Paragon ...................................................... 19
Ploumis, Eric J .............................................. 25
Spiegel Leffler .............................................. 7
UB Continuing Education ............................ 49

EQUIPMENT FOR SALE

WILLIAMSVILLE
Never used, equipped operatory for sale:
Pelton & Crane stools (grey): $200/each
Gendex 770 Intraoral X-ray with remote: $900
Entire Porter Sentinel System: wall monitor system; Sentinel O2/N2O-4 tank manifold, 5 outlet stations with quick disconnects and pedastals, AMR flowmeter all hoses, rubber goods $1,500
Porter Office communication System (6 wall and 2 Desk top units-power pack): $350
Global Protégé System: ceiling mount, varifield illumination, inclinable binocular, complete video system, more and microsurgical’s chair-foot control arm rests
Total cost $20K; asking $6,800.
Contact: blang_68@yahoo.com.


SERVICES


NATIONWIDE DENTAL PRACTICE APPRAISALS: DENTAPIRAISE, since 1992. “Ballpark” and “Premier” editions. For buyers, sellers, estate planning, medical partnership. Created by experienced practice appraisers and brokers. For details and brochure, call Polcari Associates at (800) 544-1297, or visit online: www.dentapraisie.net.

PRACTICE TRANSITIONS: Over 30 dental practices for sale with NO buyers’ fees. General and specialty practices available in Buffalo, Rochester, Syracuse, Albany, the Hudson Valley and everywhere in between. Please contact Brian and Sean Hudson with Hudson Transition Partners, Inc., at (888) 803-6131; or info@hudsontransition.com. Please visit www.hudsontransition.com for more information and new listings and remember, NO buyers’ fees.

DENTAL PRACTICE SALES & PURCHASING: 3PercentDental.com is dental practice brokerage service with very simple goal: helping you sell your dental practice without the standard 8% to 10% commission typically charged. We charge just 3.99% commission. Are you selling real estate with your practice? We charge absolutely nothing to sell your real estate. Are you buying? Pay us absolutely nothing. That’s correct. Our brokerage services are FREE to buyers. Dentists are beginning to refer to 3PercentDental.com as the Costco of dental practice brokers. We are very proud of that fact. Please visit us at www.3PercentDental.com to see our current practice listings.

OPPORTUNITIES AVAILABLE

SUFFOLK COUNTY: Seeking general dentist for high-quality, private, non-insurance-based practice. Growing practice offers fantastic opportunity for long-term position, with excellent advancement potential. Recent grads OK. Are you ready to make positive change to advance your professional career? Inquiries to: esinfo@preservesteeeth.com.

UTICA: Seeking general dentist for full-time position at busy dental practice. Excellent pay. Contact: (315) 778-2443; or email: amandeperson1969@yahoo.com.

BROOKLYN HEIGHTS: Seeking Oral Surgeon for modern, multi-specialty group dental practice invested in high-end technology. Equipped with latest safety monitors and emergency medications, trained staff — all are CPR certified — and digital CT scan. We are developing our office to have young, sharp, talented specialists and general dentists in supportive environment to deliver highest level of care and service to patients. We currently provide full-mouth rehabilitation, including implants, sinuses lifts, ridge augmentations, PRF, socket preservations and 3rd molar extractions. Seeking candidates with ability to build good rapport with patients and staff and promote the success of the center. Inquiries to: bkdnestl@gmail.com.

FLUSHING/BRONX: Pediatric Dentistry of Flushing and Pediatric Dentistry of the Bronx are seeking Pediatric Dentist for weekend and/or evening coverage. Second-year residents strongly encouraged to apply. Training available. Significant earning potential. Full-time positions also available. Call (980) 218-9190; or email: somanthal@hqcms.com for more information.

FINGER LAKES: We are growing and need to add upbeat dental professionals passionate about patient care. We provide great career opportunities that include competitive salary and excellent benefit package. To support our expansion, we are currently hiring dentists, hygienists and dental assistants. To learn more, please email resume and cover letter to Jennifer DiMaio at: dimaioj@nadalgentgroup.com.
MANHATTAN: General dentist wanted for high-quality dental office located in downtown Manhattan (Soho). Saturdays a must. Must have minimum 5 years experience. Please send resume to: greenstreetdental@hotmail.com.

ROCHESTER AREA: Western New York Dental Group is doctor owned, multi-specialty group serving Rochester and Buffalo areas. Our doctors use comprehensive mouth-body approach to dentistry to bring patients highest quality of care possible. Regardless of treatment needed, new patients are often surprised at individual attention that comes with visit to Western New York Dental Group. As an accredited practice from Accreditation Association for Ambulatory Health Care (AAAH), we have standards and procedures that exceed government regulations for infection prevention and control, environmental safety, risk management and more. Proud to be among select group of practices nationwide accredited by AAAHC. With 18 practice locations, our group provides endless opportunities for networking, mentorship and collaboration. New dentists supported and guided by experienced professionals, and seasoned dentists appreciate camaraderie and collaborative approach to care. Western New York Dental Group seeks part-time and full-time General Dentists to join rapidly growing presence in Rochester area. Competitive compensation package, including comprehensive health benefits (Health, Vision, Dental), life insurance, long-term disability, professional liability insurance, 401(k) with employer match, and established mentor programs and leadership opportunities. To learn more, visit: www.amdpi.com and www.wnydental.com. Please email resume to Peter: pschwartz@amdpi.com.

ALBANY & DELHI AREAS: Great dentist wanted. Midwest Dental seeks great dentists to lead our Mondovi Dental practices in Green Island and Delhi, NY. Excellent compensation and benefits, great work-life balance and unlimited opportunity for professional development. Our support team handles administrative details, allowing you to lead your team while focusing on dentistry. If you possess passion for providing quality care and are looking for rewarding career opportunity, please contact Colleen Bixler at: (717) 847-9069; or email: cbixler@midwest-dental.com.

BROOKLYN HEIGHTS: Prosthodontist wanted part time for modern, multi-specialty group dental practice invested in high-end technology. We are developing our office to have young, sharp, talented specialists and general dentists in supportive environment to deliver highest level of care and service to our patients. We currently provide full-mouth rehabilitation, including implants, laminates and crowns. Seeking candidates skilled in full-mouth reconstructions (dentures, overdentures, partials, crown/bridge restorations), implant restorations (crowns, bridges, hybrid prosthesis). Ability to build good rapport with patients and staff and promote the success of the center. Inquiries to: bkddentist@gmail.com.

WESTERN NEW YORK: Orthodontist. Seeking orthodontist to join large, busy, general practice in Dansville, NY. Practice currently supports one clinic day each week and has potential to grow. Orthodontic clinic is located within dental practice served by eight general dentists. Opportunity for employment or partnership. Visit us online: Dansville Dental Professionals at www.dansvilledental.com; or email: juliehart@dansvilledental.com.

ALBANY: Seeking talented candidate for reputable private practice in Capital District. Practice established over six decades, offering chance of a lifetime. Seeking dentist to join our organization immediately. Professional should be competent, confident and enthusiastic about joining team that provides unparalleled treatment and care. Inquiries to: kgehres@lastingimpressionsalbany.com.

ASSOCIATESHIPS AVAILABLE

CAPITAL DISTRICT: Family practice established 40+ years with great reputation seeks motivated ethically associated with excellent communication skills to join our team. Buy in/buy out potential. Practice was my career move 23 years ago. Send CV to: taeonill59@gmail.com.

CENTRAL NEW YORK: Seeking full-time or part-time associate for high-quality, multi-specialty general practice in beautiful Central New York near Syracuse. Competitive compensation, 401(k) plan, dental benefits. Contact: (315) 317-0125; or email: sarks5@nol.com.

NORTHERN DUTCHESS COUNTY: Dental associate wanted 4 days/week for patient-centered, FFS family practice located 50 minutes south of Albany. State-of-the-art office, fully computerized, including Carex, Solea laser, cone beam and surgical microscope. Ideal candidate will have completed residency and seeks long-term opportunity to practice ideal dentistry in low-pressure environment with wonderful patients. CV and cover letter to: ndutchessdds@yahoo.com.

EASTERN SUFFOLK COUNTY: Associateship available. Part time to start. Candidate must have good diagnosis and comprehensive treatment planning skills. Award-winning, high-quality, fee-for-service practice, with great support staff. Beautiful neighborhood, great patients. Position can lead to partnership opportunity. Please reply to: easternsuffolksmiles@gmail.com.

MANHATTAN: Seeking OMFS with small practice to join long-established, newly built, state-of-the-art OMFS office located on Park Avenue. Clear path to partnership. Inquiries to: NYSDJ Box #: AS-101 via email: info@nysdentaltg.org. Please include Box # in subject line.

CAPITAL DISTRICT: Well-established family practice seeks full-time associate dentist. Equity financing available. Enjoy benefits of thriving rural practice only 30 minutes south of Albany. Low pressure environment; friendly staff. Generous compensation package, including health insurance, 401(k), vacation, CE and malpractice insurance. Reply with resume to: dentist_associate@yahoo.com.

ALBANY: Seeking associate with potential for partnership in growing state-of-the-art orthodontic practice. Busy 5-doctor practice with 4 locations across Capital District. Stand-alone FFS practice celebrating 56th anniversary. Leader in early treatment and functional jaw orthopedics, also providing traditional fixed appliances, lingual appliances, Invisalign (Elite provider) and sleep apnea appliances employing cutting edge technologies such as Acceleradent and Ito. Excellent opportunity for resident starting final year who wants to begin job search now. Position available summer 2018, but flexible. Students or recent grads. Please contact (518) 489-8377; or email: deddbalbanybraces@gmail.com.


Hire an Associate

The New York State Dental Journal offers top billing to associationships listings—and at a reduced rate. If you are a doctor looking for an associateship position, you can advertise free-of-charge in three consecutive issues of The Journal. If you are a doctor and a NYSDA member looking for an associate, you can take out an ad in three consecutive issues of The Journal and on NYSDA website for a one-time charge of $45. All ads are subject to editing by The Journal. We ask that you limit your copy to 30 words.

To place your ad or to obtain more information about advertising in The Journal, call Jeanne Deguire at 1-800-255-2100. Or you may write to her in care of The New York State Dental Journal, 20 Corporate Woods, Suite 602, Albany, NY 12211.
NYSDA and Foundation
Salute CE Achievers

The New York State Dental Association has a proud history of promoting lifelong learning for its members. Indeed, NYSDA was the first professional organization within New York State to mandate that its members take a certain number of continuing education (CE) hours as a prerequisite for relicensure.

Each year, NYSDA recognizes its members who earn 100, 300, 500, 1,000 and every 500 hours after that of CE, as recorded within the NYSDA Continuing Education Registry.

This year, the following awards were presented at each of the recognized levels: 100 hours (116); 300 hours (182); 500 hours (143); 1,000 hours (66); 1,500 hours (27); 2,000 hours (9); 2,500 hours (4); 3,000 (4); 3,500 (1); 5000 (1).

This year’s highest achiever, Edmond Mukamal, amassed 5,000 total hours. “Continuing my education in dentistry has been extremely important to me throughout my career,” Dr. Mukamal said. “Learning to use new equipment and techniques, and reinforcing my dental education have enabled me to develop new approaches to treatment challenges. My goal has always been to continually improve my skills and knowledge over time and, ultimately, employ what I learn to better serve my patients. I always learn something from any course I take—even if it’s just knowing that I am up-to-date.”

Recalling the words of Brian Tracy, a Canadian-born American motivational public speaker, who said, “Those people who develop the ability to continuously acquire new and better forms of knowledge that they can apply to their work and to their lives will be the movers and shakers in our society for the indefinite future.” Dr. Mukamal said he likes being a mover and a shaker, especially at this stage in his career. “My biggest fear,” he said, “would be to become out-of-date as a dental professional.”

CE credits are entered year-round for members. Dentists can submit credits that are up to a year old by mailing certificates of course completion to NYSDA: Continuing Education, 20 Corporate Woods Blvd., Suite 602, Albany NY 12211; by faxing them to (518) 465-3219; or by sending them electronically via the NYSDA website, www.nysdental.org.

Congratulations to this year’s top achievers, listed below.
When should you consult an oral and facial surgeon for corrective jaw surgery?

When a problem cannot be corrected through orthodontia alone, the patient should be referred to an Oral and Maxillofacial Surgeon (OMS). In cases where corrective jaw surgery is necessary, an OMS is uniquely qualified to determine which procedure is appropriate, to perform the actual surgery, and to work with the orthodontist to achieve an optimal esthetic and functional outcome. Visit MyOMS.org for further information.
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- A program designed to give NYSDA members the best liability protection available.

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