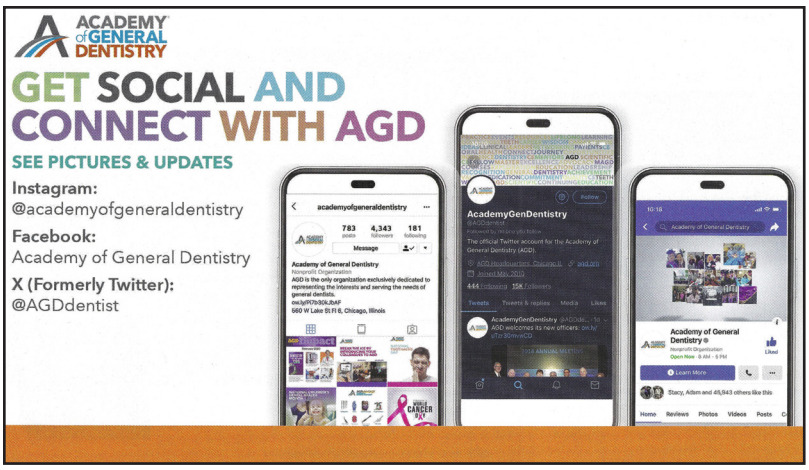
FLORIDA FOCUS

June 2024

the publication exclusively for the general practitioner

Executive Director Patricia Jenkins with Lisa and William

FLORIDA ACADEMY of GENERAL DENTISTRY



FLORIDA FOCUS JUNE 2024

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President's Message

It has been a pleasure to serve as your President, and it is hard to believe that we are already approaching summer.

I would like to thank our members for attending our General Assembly in Orlando. Our assembly was held at the Grand Bohemian, in the heart of downtown Orlando. At the assembly, we were able to offer free CE courses to our members. Thank you to our sponsors who were able to join us at our luncheon and General Assembly. Many members had positive reviews about the day and we are hoping to make our 2025 Assembly even better. We look forward to seeing everyone at next year's General Assembly.

I urge each member to extend a warm invitation to your colleagues and peers to join our esteemed organization. By expanding our membership base, we can strengthen our collective voice and increase our impact in advocating for the needs of our profession. Together, we can face the challenges that lie ahead with unity.

Additionally, I encourage all members who are interested in becoming more involved with our organization to consider serving on our board. There are opportunities such as a Public Information Officer, Membership, or Legislative Affairs, or other opportunities to contribute your expertise and passion to our mission. If you are interested in taking on a leadership role, please don't hesitate to reach out to us at flagdinfo@gmail.com or call us at 352-663-3763. Your involvement is invaluable to the success of our academy, and we welcome your active participation.

I am incredibly grateful for the trust and confidence you have placed in me to lead our esteemed academy. Here's to a successful and fulfilling year ahead!

Warmest regards,

Toni-Anne Gordon, DMD

President, Florida Academy of General Dentistry

Editor's Note

Here's a question practice management consultants like to ask: What makes your practice different in the eyes of your patients? What makes *you* stand out? As your editor, I am constantly struck by the impressive variety of procedures and management philosophies practiced in our remarkable profession, a diversity that's on display in this issue, with articles ranging from guided meditation to 3D-printed stackable surgical implant guides to the Standard of Care dental hygiene appointment.

As always, thank you to everyone who contributed to this issue, including our wonderful Florida AGD Executive Director, Patricia Jenkins. Several of our authors will be speakers at this month's Florida Dental Convention: Dr. Waji Khan, registered dental hygientist Kathy Forbes, and cybersecurity guru Debi Carr. If you find their articles helpful, please consider attending their courses! Another contributor is my friend Dr. Michael Thomasino, who began using guided relaxation techniques in his practice in 2015 and, shortly afterward, gave a fascinating lecture to the Jacksonville Dental Society during his term as President. I found the story of his first use of hypnotherapy for an anxious patient to be unforgettable, and I hope you'll read his article. Thank you as well to Drs. Ara Nazarian and Tarek Himida for contributing their excellent article on the use of 3D-printed surgical guides.

With our focus on continuing education, AGD members are constantly elevating their level of care. We'd love to feature more about **Florida AGD members** and the treatment you provide.

- **Have you presented a case to a study club or dental organization?**
- **Have you found a more efficient or innovative way of providing treatment?**
- **Would you like to share your experience of participating in a volunteer dental trip?**

If you'd like to contribute your professional knowledge and experience to the September *Florida Focus*, please contact me or send your article to flagdeditor@gmail.com. Thank you for your support of the Florida AGD!

Wishing you a safe and healthy summer,

Millie K. Tannen, DDS, MAGD

LEADERSHIP DEVELOPMENT SYMPOSIUM

On April 12 and 13, the AGD held its Leadership Development Symposium in Chicago. Every two years, about 80 new leaders from the different constituents and components are invited to participate in this event.

During the symposium, attendees had the experience of participating in small sessions and group discussions to understand the true meaning of leadership, identify their strengths, and learn techniques to enhance their growth, such as "The Power of You." In addition, participants received approximately 8.75 hours of CE in Self-Improvement.

On this occasion, four members of Region 20 had the opportunity to participate: Drs. Nibaldo Morales, Francisco Marcano, and Roberto Galíndez, and student Sofía Vega. The next Leadership Development Symposium will be held in 2026.

LDS participants, from left: Dr. Aldo L. Miranda, Region 20 Regional Director and LDS Chair; Dr. Nibaldo Morales; Sofia Vega; Dr. Merlin Ohmer, AGD President; Dr. Roberto Galíndez; and Dr. Francisco Marcano.

AGD Senior Student/Florida AGD Crystal Award recipients: far left, Dr. Giselle Navarro with Nova faculty adviser and AGD Region 20 Treasurer Dr. Harvey Gordon; left, Dr. Roxanna Font Garcia; below, Drs. Miles Turner and Sydney Shepard; below left, Dr. Trent Woodruff. Not pictured, Dr. Brett Skillet.

CONGRATULATIONS

to the **AGD Senior Student Dental Award** and the **Florida AGD's Crystal Award** recipients! Presented annually to two outstanding dental students at each of Florida's three dental schools, these new dentists receive a complimentary one-year membership in the AGD and the Florida AGD.. The 2024 awardees are:

Dr. Roxanna Font Garcia from LECOM

Dr. Giselle Navarro from Nova Southeastern University

Dr. Sydney Shepard from the University of Florida

Dr. Brett Skillet from Nova Southeastern University

Dr. Miles Turner from the University of Florida

Dr. Trent Woodruff from LECOM

Dr. Navarro writes:

"Dear Members of the Academy of General Dentistry,

"I am writing to express my gratitude for being selected for the Academy of General Dentistry's Senior Dental Student Award. I am deeply touched and humbled by this recognition, and I am grateful for considering me for such a prestigious award.

"To be recognized by the Academy of General Dentistry is truly a highlight of my career. This award stands as evidentce of the years of hard work, dedication, and passion I have invested in my profession. It is a reminder of the importance of striving for excellence and making a meaningful impact on the lives of our patients and the dental community as a whole.

"Once again, thank you from the bottom of my heart for this incredible recognition. I am truly honored and deeply appreciative of this esteemed award.

"With sincere gratitude,

"Giselle Navarro"

Dr. Skillett writes:

"Dear Esteemed Members of the Florida AGD,

"I hope this message finds you all well. I am writing to express my deepest gratitude for being honored with the prestigious Academy of General Dentistry's Senior Dental Student Award. It is with immense humility and joy that I accept this recognition from such a distinguished organization.

"Receiving this award is not only a tremendous honor but also a validation of the dedication and hard work that I have invested in my journey towards becoming a dentist. Your recognition serves as a motivation force, inspiring me to continue striving for excellence in my future endeavors within the field of dentistry.

"I am truly grateful to the Florida AGD for its unwavering support and commitment to fostering the growth and development of aspiring dental professionals like myself. Your dedication to promoting hight standards of dental care and education is commendable and serves as a guiding light for all members of our dental community.

"As I embark on the next phase of my career, I carry with me the lessions learned and the encouragement received from the Florida AGD. I am committed to upholding the values of professionalism, excellence, and compassion in all aspects of my practice, and I am grateful for the opportunity to represent the ideals of the AGD.

"Once again, thank you from the bottom of my heart for this incredible honor. I am deeply grateful for your support and recognition.

"Warmest regards,

"Brett Skillett

"Nova Southeastern College of Dental Medicine, DMD Candidate 2024"

Words Matter:

Why guided meditation - a.k.a. hypnosis - can help your patients and you!

by Michael Thomasino, DMD

In 2015, my practice was exclusively focused on dental emergencies, characterized by a fast pace and high volume, serving many Medicaid patients requiring numerous extractions and who typically presented with high anxiety. Oral sedation was not a viable option for emergent dental pain, and while Nitrous Oxide was adequate, it wasn't ideal. I was getting burned out. During this time, I began exploring Stanley Malamed's "Sedation - A Guide to Patient Management," which introduced me to iatrosedation—a technique for reducing anxiety without drugs, incorporating methods like hypnosis. Dr. Malamed, whose background was heavily rooted in pharmacosedation, openly shared his astonishment at the effectiveness of hypnosis in reducing the amounts or completely eliminating the need for anesthetic and sedative medications.

Prompted by Dr. Malamed's recommendation, I visited the American Society of Clinical Hypnosis (ASCH - pronounced "ash") website, where I watched a video by my future mentor Judy Thomas, a dentist and ASCH member. She described a case where a patient underwent a root canal treatment for irreversible pulpitis, without any local anesthesia, using only hypnosis. Intrigued by this, I was fortunate to discover that ASCH's annual scientific meeting was scheduled in Jacksonville, Florida, where I lived and worked. This presented a perfect opportunity for me to delve deeper into the practice of hypnosis.

ASCH conducts regional workshops annually across the country and hosts its annual meeting each spring. These workshops, spanning four days, cater to varying levels of expertise, including beginner, intermediate, and advanced. At this beginner workshop in Jacksonville, I experienced a profound transformation during just one weekend of training, where I learned the techniques of inducing hypnosis in fellow beginners. The impact was astonishing—it raised the intriguing question of how mere words could so dramatically alter one's state of consciousness.

The Monday morning after the workshop was pretty typical, and we had a very anxious patient needing extractions of tooth #4, which was asymtomatic, and tooth #12, which was symptomatic and abscessed. I was struggling to achieve profound anesthesia, and the patient felt the pain was getting worse as I proceeded to use more local anesthetic. That was when I decided, What do I have to lose? Let's go for it! I was very anxious myself about trying hypnosis, but I said to the patient that "I learned a great technique to help patients relax. Would you like me to show you?" The patient agreed. I asked her to focus on my finger, which was positioned about two feet away from her forehead and angled so she would have to roll her eyes high up. Then I said, "As my finger approaches your forehead, your eyes may feel tired, and whenever you are ready, you can close your eyes." Sure enough, the patient closed her eyes, and then I continued to deepen her trance. I did not add any additional local anesthetic. I just started working on the teeth, and within a few minutes they were gone. I showed the patient the teeth and then started re-alerting her. Once out of the trance, the first question she asked was "Did you take the teeth out yet?" I was perplexed; so she had amnesia? My dental assistant looked at me with astonishment and disbelief. I looked at my dental assistant just the same way. This is when I was hooked. This is when I wanted to know so much more about this amazing tool and see how it could benefit me, my patients, dental students, and colleagues.

Benefits for our Profession

Hypnosis in dental education for students and dentists can be a valuable tool, serving multiple purposes, from managing their own stress and anxiety related to their studies and practice, to learning how to use hypnosis to assist their patients. Here are several ways hypnosis can be beneficial for dental students and dentists:

1. **Stress and Anxiety Management**: Dental studies and practice can be highly stressful, with students often facing significant academic pressure, performance anxiety, and apprehensions about patient care. Hypnosis can help students and dentists manage these stressors more effectively by promoting relaxation, improving focus, and enhancing overall well-being.

2. **Pain Management Education**: By learning hypnosis, dental students and dentists can gain skills in non-pharmacological pain management techniques. This is especially useful in dentistry, where pain and anxiety are common barriers to successful patient care. Hypnotic techniques can be employed to reduce patient discomfort and anxiety during dental procedures.

3. **Improvement of Communication Skills**: Hypnosis training often includes components that enhance communication skills, such as active listening, empathy, and effective verbal cues. These skills are crucial for building rapport with patients and ensuring a positive dental care experience.

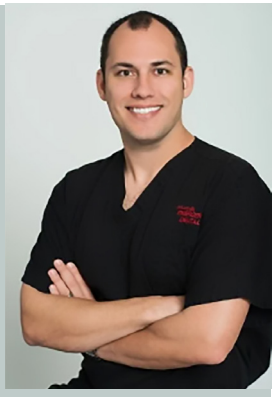
4. **Enhancement of Academic Performance**: Hypnosis can aid in improving concentration, memory, and learning efficiency, which are vital for the rigorous academic demands faced by dental students. Techniques learned through hypnosis can help students prepare for exams, manage time more effectively, and retain information more efficiently.

"Explore how guided meditation can transform your practice and benefit your patients. Why not give it a try with your next patient interaction? The results might just surprise you."

5. **Personal Development and Self-Care**: Dental students and dentists can use hypnosis for personal growth, including enhancing self-confidence, overcoming personal fears or limitations, and promoting a healthy work-life balance. These personal benefits can contribute to a more successful and fulfilling career in dentistry. I had a fear of public speaking that was just paralyzing. I would get a catch in my throat, my mind would start racing, and my heart rate and breathing would rapidly increase. With hypnosis I could relax myself and use anchoring to stimulate my parasympathetic response to combat my subconscious sympathetic response.

6. **Preparation for Clinical Practice**: Understanding and applying hypnosis in clinical settings prepares students for a broader range of patient care strategies. It equips them to offer additional comfort measures for patients who are anxious, have phobias, or experience difficulty with traditional pain control methods.

Incorporating hypnosis into dental education requires a structured approach, including theoretical knowledge, practical training, and supervised clinical experience. It's important for dental schools to partner with experienced practitioners and accredited hypnosis training programs to ensure students receive a comprehensive and ethical education in hypnosis. Furthermore, while hypnosis is a valuable tool, it is essential for dental professionals to recognize its limitations and use it as a complement to conventional dental care practices.



Dr. Michael Thomasino, DMD is the owner and founder of Jacksonville Emergency Dental. He is a graduate of the University of Florida, College of Dentistry. After practicing traditional dentistry for several years, he discovered the overwhelming need for urgent dental care in North Florida. In 2006, he opened Jacksonville's first acute Dental Care Center, Jacksonville Emergency Dental, to fill the medical/dental gap in patient care. He has now dedicated his career to serving emergency dental patients with quality, affordable and convenient care.

Dr. Thomasino, along with his team of Dental Associates and Assistants, provides exceptional emergency and comprehensive care to patients who have unexpected issues and those who lack comprehensive care. His number one goal is to get the patient out of pain quickly, so they can go on with their daily life. He now operates three locations, open seven days a week, to accommodate most dental emergency cases efficiently, effectively and then get patients back on track with comprehensive dental treatment.

Dr. Thomasino enjoys teaching and has stayed active at the University of Florida as a faculty member instructing dental students in the oral surgery clinic in Gainesville. He also serves as a faculty member in the American Society of Clinical Hypnosis. He continues to support the dental community through memberships in the ADA, FDA, NEDDA and Jacksonville Dental Society (JDS) where he served on the board for four years. Dr. Thomasino has proudly called the First Coast home for most of his life and resides in Jacksonville with his wife, daughter and son.

FAQs

How important are semantics and the words you use? When a patient asks "Will this hurt?," your quick and confident response is "I am going to take great care of you and make it comfortable." Do not put negative suggestions such as "It might hurt a little" or "There may be a little pain." The human brain can not get rid of a negative suggestion until they are thinking about something else. So why put it there? Would you rather have less pain or more comfort? Same thing, but most would prefer more comfort. Sort of like a glass half full or half empty: one implies you have something, the other implies you are close to having nothing. Words matter to our subconscious brain, so be careful what you say and practice your scripting with your patients until you eliminate all those negatives. Like all skills, you will go through the four stages of competence. Unconscious incompetence (no awareness) is where you were until now, so now you are consciously incompetent (aware but lacking the skill). Then you will become consciously competent (have the skill but applied with concentrated effort), and finally you will become unconsciously competent (the skill will be second nature). So fake it until you make it!

Do you need to use formal trances on every patient? No, but to build your confidence, the most anxious patients are the easiest to go into a hypnotic trance, because they are already in a trance. The anxious patient is already very focused on the possible bad outcomes of treatment. They are not thinking about their next meal or what a great weekend they had. So you are using those specific focused brain waves and leading them into positive suggestions. If the patient is that anxious, what do you have to lose? You can always use sedation yourself or refer to someone else.

You might ask from a business perspective, can you bill for hypnosis? Possibly, but I feel that when I can win over a patient and get them through dental procedures more efficiently and more comfortably, then the value is all there. The time you save not having to stop for more anesthetic or gagging is worth a lot.

Does it take long to induce a trance? There are endless rapid inductions ,and I would recommend that you attempt an induction for about 5 minutes. If you are not there, then move on, but usually the patient can appreciate what you are doing and you have built some rapport. With that rapport they will most likely relax anyway.

Do I mention the word hypnosis? No, I feel it is unfortunately counterproductive because of the stigma the word "hypnosis" has developed from movies and stage performances. So I just ask the patient, "Are you anxious about the procedure?" if I am not sure. If the patient says yes, I ask "Can I show you some ways to relax?" Then I go into a rapid induction. I have found that one of the best inductions for someone less experienced or confident in hypnosis is to use the "rehearsal induction". The rehearsal goes like this but can be modified and has been modified many times by other clinicians. You tell the patient, "This will be as easy as 1,2,3. So let's practice. Step one: Roll your eyes up as high as you can. Step two: You are going to keep your eyes rolled up and then close your eyes. Now open your eyes. For the last step, you do three things. Roll your eyes up. Now close your eyes and let your eyes relax down with the rest of your body." Often the patient will not get past the rehearsal and will just fall into the trance. At that point, you would deepen the trance. If unsuccessful, repeat and see what happens.

Will patients get stuck in a trance like in the movies? No, the patient will come out of the trance undisturbed in 20 minutes or less.

Here's a Monday morning tip to try: Right before you inject local anesthetic, tell the patient, "I would like you to focus on my foot tapping your shoulder," which is the cue for your assistant to tap the patient's shoulder. A few things might happen: the patient will laugh, the patient will be confused and distracted from the shot, or they will say, "I don't like that and don't do that again." Either way, you are showing your patients you care and that you are different from the last dentist that just "stuck it in there". Give it a shot with your next shot! You may not be that surprised, but your patient will be.

Hypnosis isn't appropriate for every situation or every patient, but it can be a valuable tool in the dentist's kit, especially for managing patient anxiety. It's also worth noting that while you might be able to bill for hypnosis, the real value lies in the enhanced patient experience and efficiency.

For those interested in exploring hypnosis further, ASCH provides excellent resources and training opportunities:

American Society of Clinical Hypnosis

529 14th St NW, Suite 1280,

Washington, DC 20045

Phone: 410-940-6585

Email: info@asch.net

Explore how guided meditation can transform your practice and benefit your patients. Why not give it a try with your next patient interaction? The results might just surprise you.

Cyber Security and HIPAA

by Debi Carr, HCISPP, CAHIMS

I recently had a doctor tell me, "I'm just a dentist. Why would anyone want my patient information?" The reality is that the information in a dental office is the crown jewel of health care, as the information collected can be used to create a "whole person." When your credit card is compromised, you simply call the bank and have your card canceled, but who do you call when your health record has been compromised?

These records can be used for a variety of criminal activities: obtaining prescription medicines, filing fraudulent medical claims, having medical procedures completed, and identity theft. Hackers can use the information to falsify records to take out loans, credit cards and even transfer properties. The repercussions of identity theft can last for years and be very expensive for the individual victim.

We hear a lot about the large data breaches that have happened, but what we do not hear about are the little ones that happen every day and the financial and reputational impact that it has on practices. The loss of production alone can range into the thousands; and still, you have to meet payroll?? Not to mention the cost of investigation and restoration.

One reason why small practices continue to be a prime target is that hackers know that small practices are not implementing wise security protocols. It is not that practices do not want to defend against such attacks; it is because most do not know where to begin. Security does not have to be expensive, but it does take some time and effort, and it does require a budget. I recommend that practices allocate approximately 2% of their annual net collections to security and compliance in their practices.

Our government has given us two tools that can guide and protect a practice and implement compliance at the same time. The first is the security rule from the Health Insurance Portability and Accountability Act. That's right, HIPAA! When you look at the HIPAA security rule, it describes the best security practices. One of the requirements under HIPAA is to have a security management plan, and this is where the second tool comes in. It is known as the Cybersecurity Framework. In fact, just this past February 2024, Health and Human Services (HHS) which oversees HIPAA, released new guidance for the security rule which pointed to the Cybersecurity Framework. Under the Cybersecurity Framework, there are six areas: governance, identify, protect, detect, respond, and recover.

Any strong security program begins with strong leadership. This is why the Cybersecurity Framework begins with governance. This means that the doctor or the owner of the practice is responsible and should take security and compliance seriously. Often, I see practices where the office managers are trying to implement a HIPAA program, but they lack the doctor's support. HIPAA's security rule is much more than just annual security awareness training.

Many practices feel that their Information Technology (IT) vendor or Managed Service Provider (MSP) are handling their HIPAA compliance. IT/MSP are integral parts and very critical to any security management plan, but they take care of only the technical side. A cyber security consultant reviews security throughout the entire practice, not just the technical aspects. A strong security management plan will have a team, but it starts with having leadership. The HIPAA security rule requires that a Security Officer be appointed to oversee the security in the office.

The next step of the cybersecurity framework is to identify. You cannot protect what you don't know. It is important to identify and classify what information or data is in the practice that is considered sensitive and should remain private or confidential. We have recently learned how third parties could adversely affect the practice. Every practice should know where their sensitive information is created, transmitted, or stored. Practices should maintain a master inventory list of all devices, including tablets and any other device that accesses patient information, and should create a data mapping of how patient information flows through the practice. A risk analysis should be conducted periodically, at least annually or when there are any environmental changes, to determine any potential vulnerabilities that if exploited could adversely affect the practice. This is the first requirement under the HIPAA Security rule, which requires practices to conduct an accurate and thorough assessment of potential risk and vulnerabilities to the confidentiality integrity and availability of electronic protected health information held by the practice. Sadly, this is an area that many practices fail to complete.

Debi Carr is recognized as a leader in Cyber Security and Compliance and is a Speaker and a Consultant. Having over 30 years in healthcare and technology, she assists healthcare entities in obtaining and maintaining security in their practices and assists doctors navigate through a ransomware and other cyber-attacks. Debi holds several internationally recognized certifications including being one of 1455 individuals that is certified by ISC2 as a HealthCare Information Security and Privacy Practitioner, as well as being certified by HIMSS as a Certified Associate Healthcare Information and Management Systems and is a member of AADOM, ADMC, HIMSS, ISC2, ISSA, ISSAC, InfraGard Patriots Circle, NSCHBC, SCN and Women of Cyber Security.

Once we identify what information we have and where it is created, transmitted, or stored, we need to create protocols or methods to protect the information. A manual which has the practices' security policies and procedures should include:

- An acceptable use policy directing team members about the use of computers and devices.
- An access control policy directing team members about what information they may access and for what reasons.
- A policy and process for screening and training new hires and a process for terminating team members.
- An ongoing security awareness training program
- A sanction policy when team members fail to follow the policies.

Detection is the next area. We have set up safeguards to protect information, but now we need to create activities to monitor the protections to make sure they are effective. This is where working with an IT/MSP is critical, as they will deploy the necessary technology to monitor user activity and any abnormal activity or events that happen.

This is why each team member should be assigned unique credentials, not only to the practice management software but to the computers and devices. When team members have unique credentials, user activity can be monitored. Internal threats can be just as damaging as external. Assigning unique credentials can act as a deterrent for embezzlement and other criminal activity as the team member knows that their activity can be monitored.

Eventually, we will have to respond to a security incident. It is important to have a plan to respond to not only cyber-attacks, but any event that could cause a disruption of production and patient care, such as an earthquake, hurricane, or tornado. Having a plan in place ensures that everyone knows what their responsibility and roles are.

This is when having redundancy in the backup strategy should be part of the plan, with multiple backups and multiple locations. I have seen hackers corrupt or completely delete local and cloud backups. Recently, I have seen a trend where practices are relying on just cloud backups. I have found that when a practice must respond to a security incident, in most cases those backups are not usable. HIPAA requires that every practice have a disaster recovery plan and an emergency operation plan.

The goal when there is any kind of disruption to production and to seeing patients is to recover, which happens to be the last area. The goal is to get back up and running as quickly as possible. This is why multiple backups in multiple locations is important so that if one backup is corrupted, perhaps another one is usable.

HIPAA is not meant to be restrictive; it is meant to be protective. Cyber-attacks are going to continue, and hackers have become more sophisticated, using multiple methods of extortion. Implementing a security management plan in a practice does not have to be expensive, but having such a plan can help protect a practice from both outside and insider threats. Dental practices need to be proactive to protect their businesses.

A Converstion With FLAGD Executive Director Patricia Jenkins

What would you like our members to know about your role as Executive Director, Tri?

As the Executive Director of the FLAGD, my role is to provide strategic leadership and oversee the day-to-day operations of the organization. I work closely with the board and members to ensure that our mission and goals are being effectively pursued. My aim is to support and empower our members, foster collaboration within the dental community, and advocate for the interests of general dentists across Florida.

Can you please share some of your favorite memories of working with the FLAGD?

Since I've taken on the role of Executive Director, I've had some really cool moments that stand out. One thing I really enjoy is hosting our continuing education courses and meetings because I get to see members who attend a lot of our courses and an overwhelming amount of members who are attending for the first time. One of the best parts of my job is making those connections between dentists at different stages of their careers, such as introducing a newer dentist who's been practicing for under ten years to someone who's been in the game for decades and is thinking about retirement. Or just seeing the exchange of wisdom between an associate and a seasoned pro—it's like passing the torch in a way. The moments where I witness our organization's purpose developing in real time and seeing the support and mentorship-forming is truly magical.

When did you become our Executive Director, and what attracted you to the position?

I assumed the role of Executive Director at FLAGD in November 2017. What initially attracted me to this position was the opportunity to lead an organization like FLAGD, which places a strong emphasis on education, advocacy, and community engagement. At the time, my daughter was just 5 months old, and the flexibility of working from my home office allowed me to balance the responsibilities of motherhood with my professional career—a true blessing.

Securing the position wasn't easy; it involved a rigorous application process. Despite not having a background in dentistry, my degree in Marketing from the University of Florida and experience managing other businesses equipped me with the necessary skills. I'm immensely grateful to FLAGD for their faith in me and for giving me the opportunity to demonstrate my abilities.

This role has had a significant impact on my life. Working remotely has afforded me the opportunity to be present for the special moments of raising young children while pursuing a fulfilling career. It's been a rewarding journey, both personally and professionally and I look forward to sticking around as long as FLAGD allows :)

What would you like to see the FLAGD accomplish in the next 2-3 years?

Over the next 2-3 years, I would like to see FLAGD continue to grow and have more member involvement. This includes expanding our membership base, enhancing our educational offerings, increasing our advocacy efforts on behalf of general dentists, and furthering our partnerships with other organizations to promote oral health and professional development. By getting involved with our committees, you can directly help us steer the ship in the right direction. Our committees range from continuing education and membership to legislative efforts. There's something for everyone, no matter what stage your career is in, and if there's not, we are open to forming new ones!

What do you think we should do to promote the FLAGD to Florida's dentists and increase membership?

To promote the FLAGD to Florida's dentists and increase membership, we should focus on raising awareness about the benefits of membership, such as access to quality continuing education, networking opportunities, and advocacy efforts to address the specific challenges and concerns facing general dentists in Florida, and highlight how it will further strengthen our relevance and value to our members. The Florida Focus and our website are currently the two mediums that our members have. We would love to find a public information officer who could help us with the media, special events, and conferences.

Could you please tell our members a little about your professional background and personal life?

Professionally, I earned a Bachelor of Science in Business Administration-Marketing (BSBA-MKG) from the University of Florida (Go Gators). One of my proudest achievements during my academic years was being chosen as the lead presenter to represent my school at the National Student Advertising Competition.

On a personal note, I grew up in an Italian American family in New Jersey—yes, the stereotype fits perfectly. Picture family gatherings with homemade food and kids running around—that was my upbringing. As an adult, I live in Gainesville, Florida and I'm blessed with two wonderful children, Lisa (6) and William (3), along with a menagerie of three dogs, two cats, chickens, giant tortoises, and a bearded dragon. We're a bit animal obsessed, to say the least.

Beyond our permanent household members, we also foster kittens and puppies from our local humane society, particularly those requiring bottle feeding, providing them with a safe and loving temporary home until they find their forever families. We strive to lead an environmentally conscious lifestyle, embracing the concept of 'Urban Homesteading.'

Maintaining a healthy work-life balance is paramount to me, and I find true fulfillment in both my professional career and personal endeavors.

3D Printed Prosthetic Seat: Small Piece, Big Difference — An Upper Arch Rehab Case

by Ara Nazarian, DDS, DICOI
and Tarek Himida, BDS, MDPH

Introduction

Immediate implant placement after teeth extraction in patients with terminal dentition can be challenging. In full-arch rehabilitation cases, large-scale alveoplasty may be required to provide enough space between the jaws to accommodate the preplanned prosthesis of choice.

In some cases, alveoplasty is done to widen the thin bony ridge enough to enhance the implant-recipient area by creating an architecturally sound base for implant placement. Too much or too little bone reduction will create unfavorable restorative space and compromise the positioning of the dental implants.[1]

CAD/CAM technology offers increased accuracy with regard to the outcome of the treatment of choice.[2,3] Currently, there are three main categories of CAD/CAM implant surgical guides; namely, tooth-supported, mucosa-supported, and bone-supported.[3]

Both mucosa- and bone-supported implant surgical guides are indicated for completely edentulous patients, and issues related to their stability have been reported in a number of studies[4]. One solution to increase their stability is the use of anchoring pins which stabilize the guide inside the patient's mouth. With that said, tooth-supported implant surgical guides are the most stable among the CAD/CAM guides.

This case demonstrates the advantages of an innovative fully-guided protocol for full-arch rehabilitation which utilizes a 3D printed surgical guide that consists of multiple attachable pieces (i.e., stackable).

Clinicians have been adopting this digitally-guided approach to implant surgery due to its simplicity, accuracy and speed of workflow.[5] With enhanced outcomes for the patients, this protocol offers a less invasive and more comfortable solution for patients requiring implant-supported fixed dentures.

Case History

The patient was a 65-year-old male with a partially edentulous upper arch with most of the teeth missing. It was a clear cut case of terminal dentition with the upper remaining teeth and roots indicated for extraction due to their poor prognosis (Fig. 1). The treatment options were discussed with the patient, which included a full rehabilitation of the upper arch, involving extraction of all the teeth and remaining roots followed by placement of six dental implants, which would support a screw-retained bridge. Due to sensitivity and the desire for an aesthetic and long-lasting fixed restoration, the patient opted for this option.

Presurgical Phase

The goal was to deliver treatment from beginning to end with a fully digital workflow. The Anatomic Guide® is an all-in-one system for full-arch rehabilitation which incorporates 3Sixty (3Sixty Atlanta, Georgia, USA) Treatment Planning services provided by 3Sixty Dentists using 360dps dental planning software, as well as 3Sixty's CAD/CAM stackable system for guided implant placement.

An intraoral scan of the patient's dentition and a CBCT scan were taken. This data was then imported into 360dps and merged together with the digital wax-up. Combining these layers of data into one image enabled 3Sixty Dentists to plan the treatment according to the patient's restorative needs (Fig. 2).

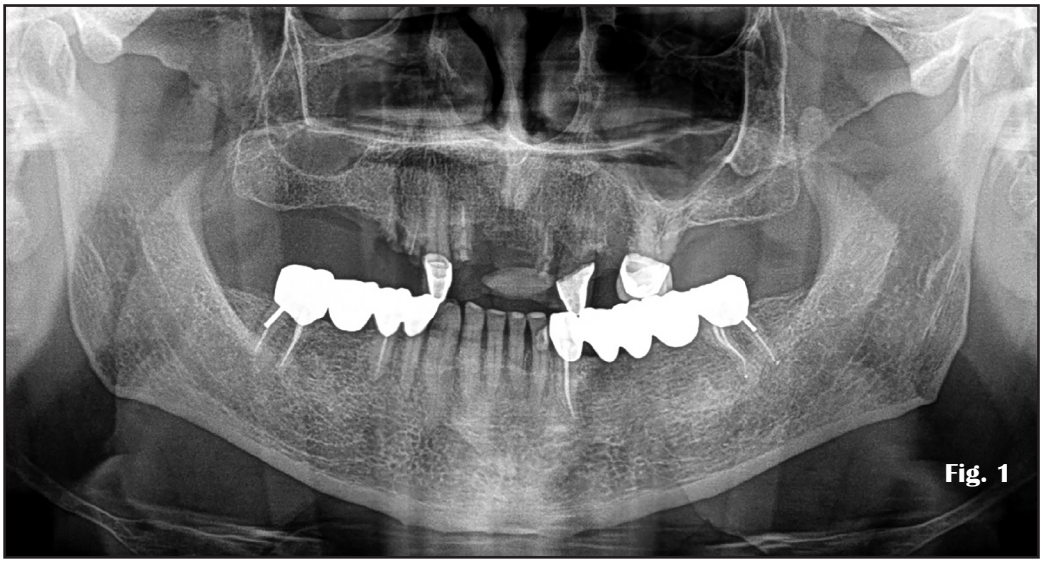


Fig. 1

360dps was used to create an accurate guided surgery plan for an All-on-6 fixed complete, screw-retained prosthesis. During this process, six Adin TouaregTM-S implants were virtually placed in the maxilla to provide support for the final restoration (Fig. 3). By analyzing every radiographic segment of the maxillary bone, the implants' position, diameter and length were selected. The ideal angulation of the fixtures was verified. Similarly, the proper height and angulation of the six abutments was determined. To place the Anatomic Guide®, three fixation screws (2 mm x 13 mm) were virtually planned in the upper arch. Special care was given to avoid any interference between their positions and those of the implant fixtures. The patient was found to have sufficient maxillary bone to allow for the use of the 3Sixty Anatomic Guide® with Prosthetic Seat (PS) treatment protocol.

Treatment Planning (Fig. 2-3)

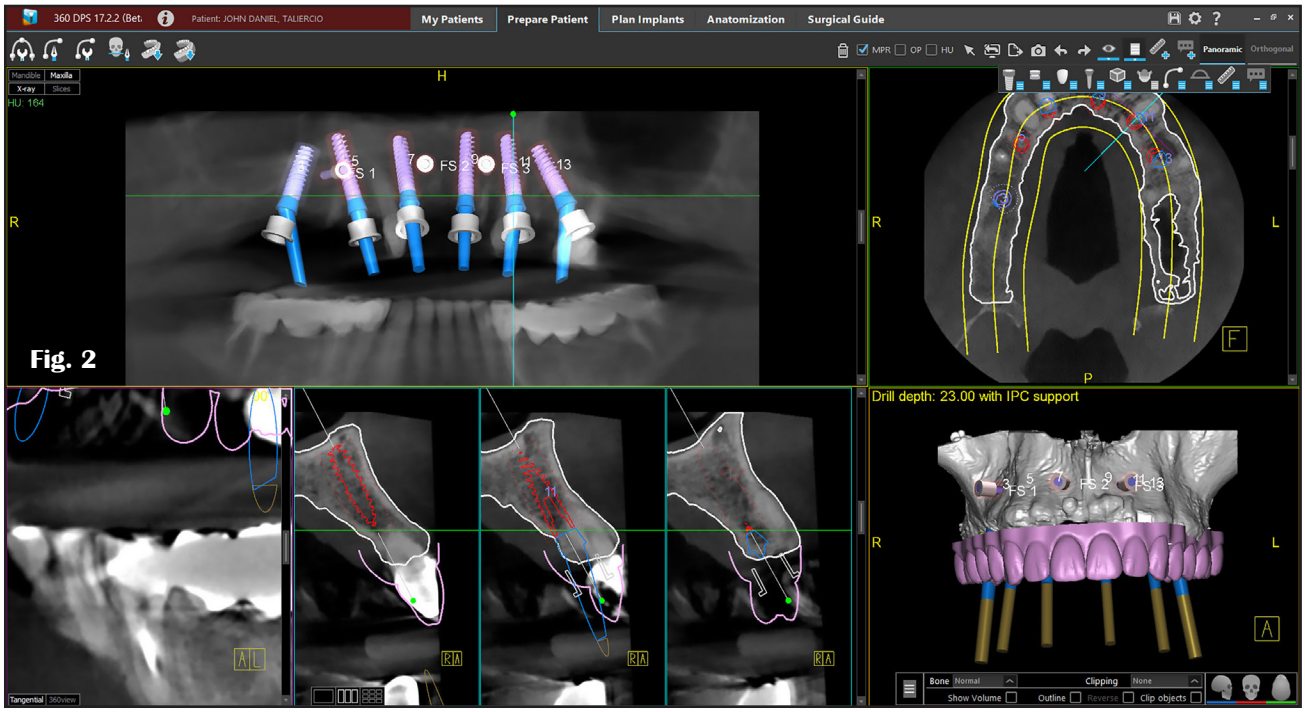


Fig. 2

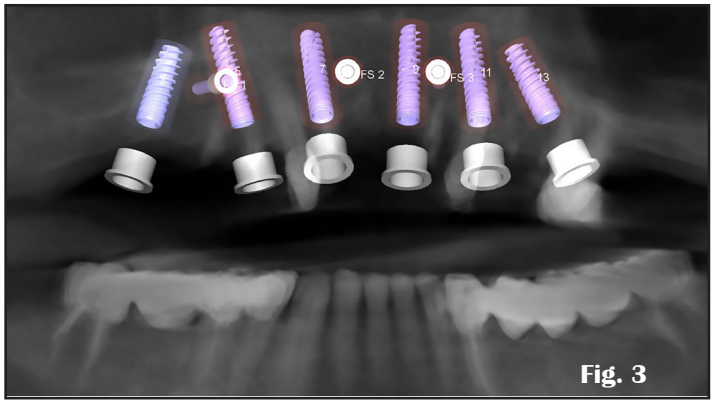


Fig. 3

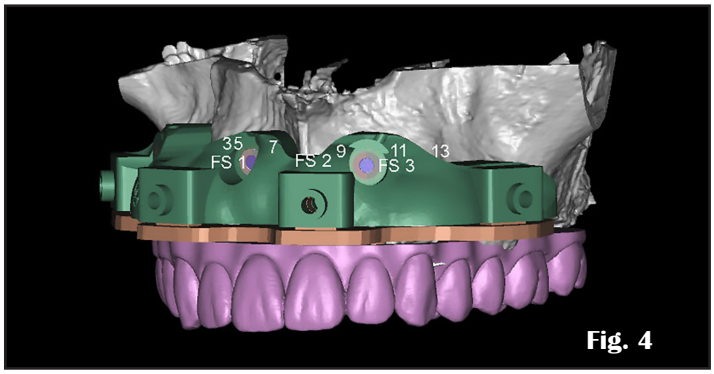


Fig. 4

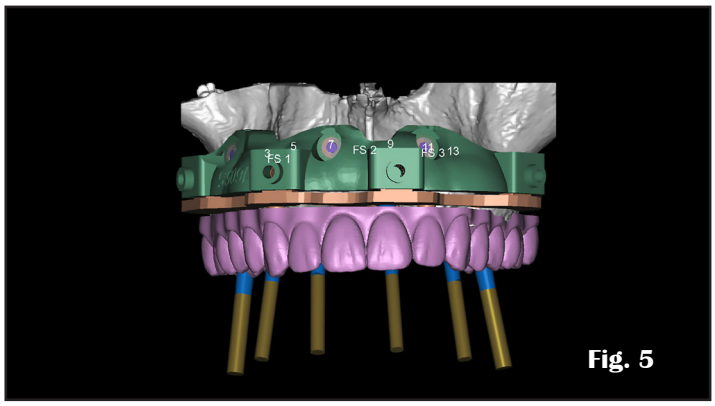


Fig. 5

Drill Protocol

3Sixty Drill Protocol was then generated outlining the diameter and length of each Adin Implant Systems TouaregTM-S implant, the length and offset of each sleeve, as well as drill tool height, total drill depth and which drill to use.

Anatomic Guide® Design

After planning the implant and abutment positions in 360dps, the Anatomic Guide®, Implant Placement Guide and Prosthetic Seat (PS) were digitally designed by 3Sixty Dentists (Fig. 4-7). This stackable system for guided full-arch rehabilitation consists of the Anatomic Guide® (i.e. bone reduction guide) which is screwed into the bone. Through the latch system, additional pieces can be attached to the guide including the Tooth Verification Mount, Implant Placement Guide and PS. The PS makes it possible for the PMMA temporary prosthesis to be attached to the Anatomic Guide® without latches. This eliminates the need for lengthy chairside adjustments which dramatically reduces surgery time.

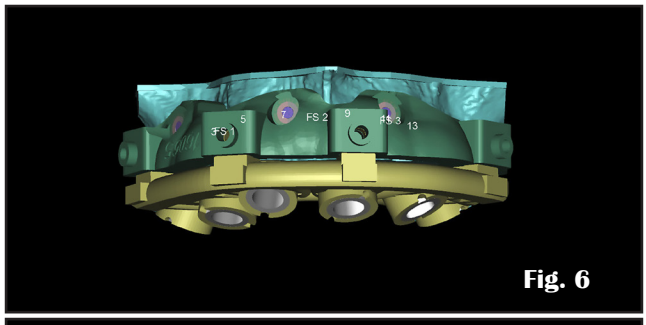


Fig. 6

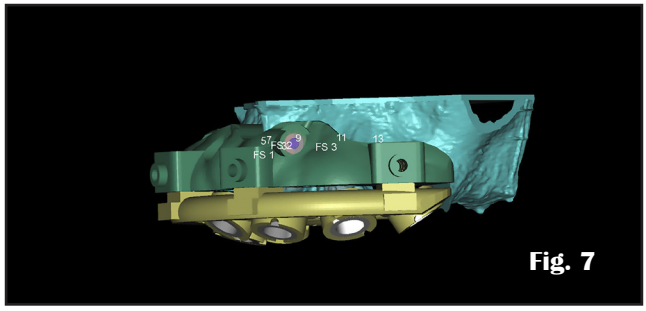


Fig. 7

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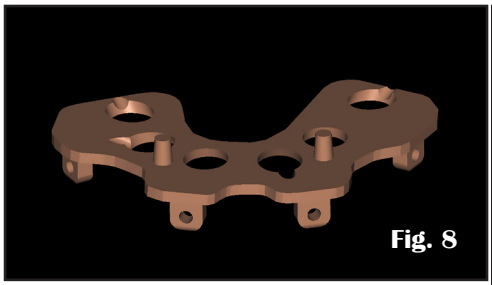
Fig. 8

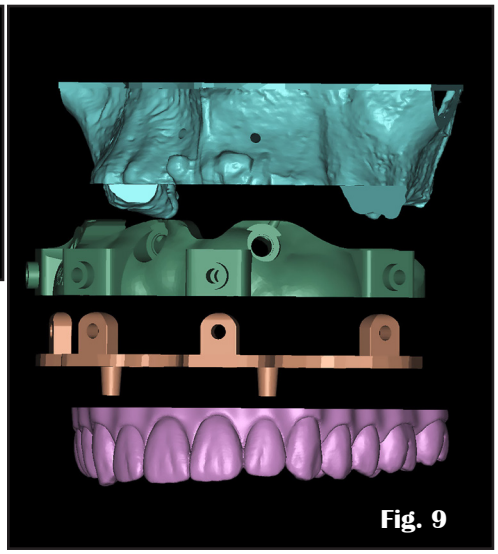
Fig. 9

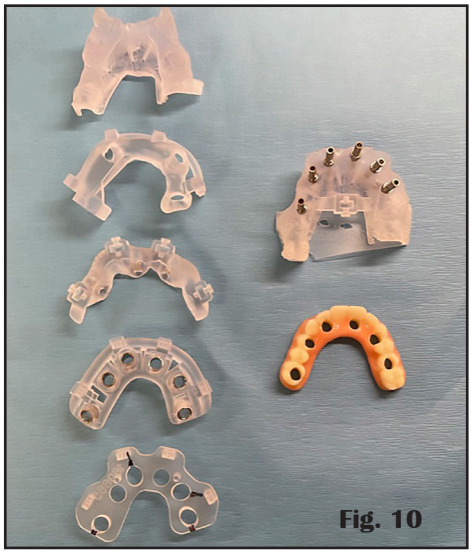
Fig. 10

Prosthetic Seat (PS)

This piece has two main functions:

- Instead of having pre-drilled latches (i.e. arms) on the temporary prosthesis that allow it to be attached to the Anatomic Guide® using short pegs, a PS can carry a prosthesis which is free from such latches (Fig. 8, 9).
- It has an abutment timing marker to assist the surgeon in placing angled abutments (i.e. prosthetic guide for the abutments).

To be able to use the PS for carrying the prosthesis, there needs to be a space of 5 mm from the zenith point of the anterior teeth of the prosthesis, to the reduction platform. Without this prerequisite, designing the piece will be challenging and will most likely fail or break during the surgery. However, this is not required if the PS is needed for abutment timing function only (i.e., without the cones to carry the PMMA temporary prosthesis).

Lab Phase

The STL files were sent to the 3Sixty dental lab in Atlanta, GA for production. The analog models of the patient's upper arch before and after bone reduction, Anatomic Guide®, Implant Placement Guide, PS and PMMA temporary prosthesis were all fabricated, verified and delivered to the office before surgery day (Fig. 10).

Surgical Phase

The surgery began with a single full-thickness facial flap to expose the outer cortical plate of bone where the Anatomic Guide® should be seated (Fig. 11, 12). After soft tissue is retracted, the Anatomic Guide® was inserted into place with the help of the Tooth Verification Mount (Fig. 13). The accurate seating of the Anatomic Guide® is facilitated by the Verification Mount which is placed on top of the remaining teeth provided that they are stable enough (i.e., immobile). Tooth position is the most accurate method to guide the placement of the Anatomic Guide®. In this case, this could be achieved due to minimal mobility of the remaining teeth. Once in position, three intraosseous holes were drilled to help secure it in place by means of titanium screws.

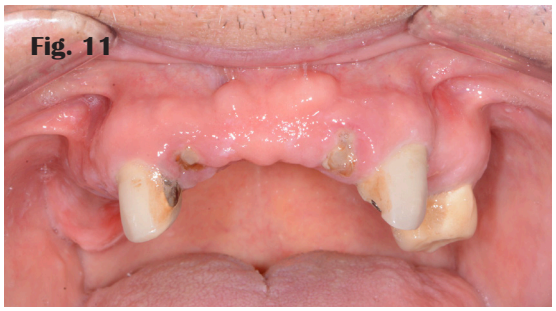
Fig. 11

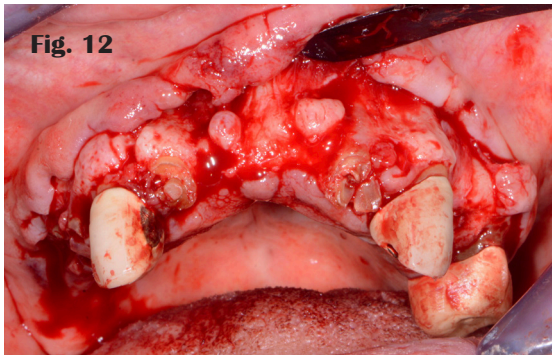
Fig. 12

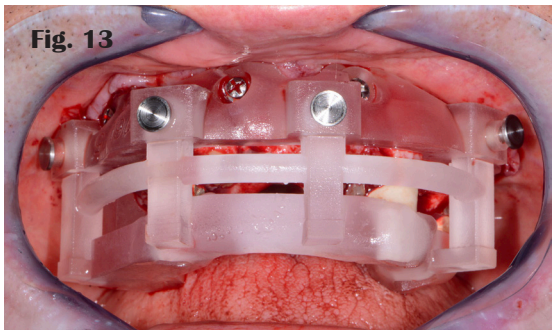
Fig. 13

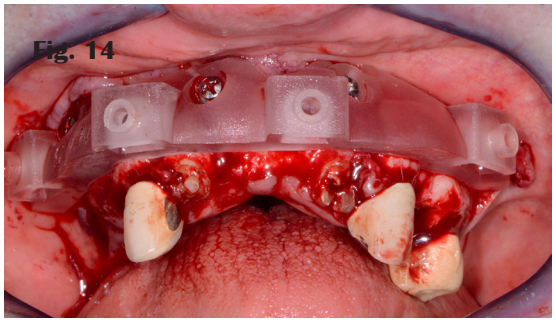
Fig. 14

After the Anatomic Guide® was screwed into the bone, the Verification Mount was removed and the remaining teeth were extracted (Fig. 14). Then bone reduction was carried out following the contour the Anatomic Guide® to ensure an ideal restorative space. Once the implant-recipient area was adequately prepared, the Implant Placement Guide was attached to the Anatomic Guide® using metal pins (Fig. 15).

3Sixty Drill Protocol was followed and a total of six Adin TouaregTM-S implants were placed through the Implant Placement Guide's sleeves with implant timing (Fig. 16). The challenge was placing the implants at the correct angle so that a good A-P spread would be obtained. The patient's sinuses were also relatively low, which is why long, angled implants were placed with distal orientation.

The Implant Placement Guide was then removed and six multi-unit abutments were screwed in place. The PS was then attached to the Anatomic Guide® and the immediate-load protocol was followed to place the PMMA temporary prosthesis (Fig. 17-21).

Conclusion

Fully-guided implant placement protocols are reported to give consistently accurate treatment outcomes. That said, many clinicians perceive such protocols as costly as well as requiring extensive training and skill. Many implant placement protocols are being developed constantly but not all systems are one-size-fits-all. With continuous innovation, we now have many affordable and reliable options that are accessible to dental practitioners of all skill levels.

Fixed implant-retained prostheses are superior to conventional dentures in functionality, aesthetics and overall quality of life they offer patients.[6] Guided surgery significantly

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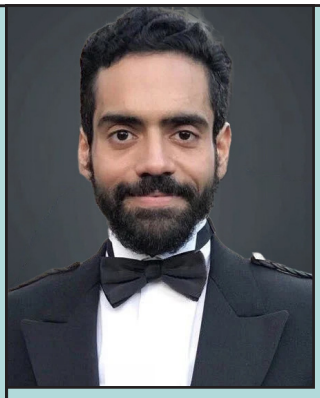
He teaches non-invasive extractions, grafting, full-mouth rehabilitation, and 3D diagnosis and treatment planning with CBCT. He has been published nationally and internationally in leading dental publications in the area of cosmetics, metal-free crowns, extractions, grafting, sinus lifts, immediate implant placement, same-day provisionalization, and CAD/CAM restorations.



Dr. Tarek Himida is a 2014 Modern Sciences and Arts (MSA) University, School of Dentistry graduate, and holds a Master of Dental Public Health (MDPH) degree awarded by the University of Dundee in 2017. With over 10 years of experience, he is an accomplished clinician, published academic researcher and internationally-recognized dental education expert.

Dr. Himida leads the Planning Committee for the AGD PACE-approved program, 3Sixty Academy. He also serves as an Alumni Ambassador at the University of Dundee and is a member of the Health Services Research Unit (DHSRU) and Oral Health & Health Research (OHHR) program at Dundee Dental School.

increases the success rate and longevity of provisional as well as definitive restorations, particularly those involving the placement of multiple implants. Digital workflows streamline the rehabilitation procedure with the help of CBCT and intraoral scans. By utilizing virtual treatment planning, both the surgical and restorative phases can be examined, revised and approved prior to the day of surgery. This minimizes the overall time of the procedure and reduces the number of appointments.[7]

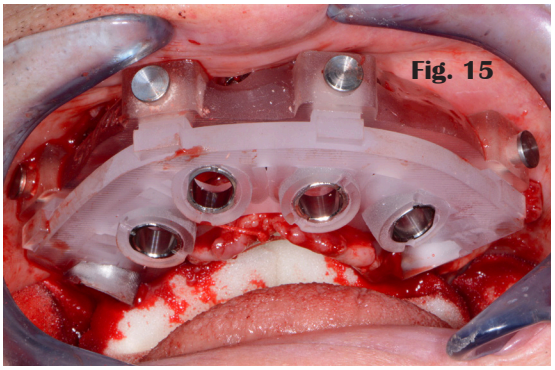
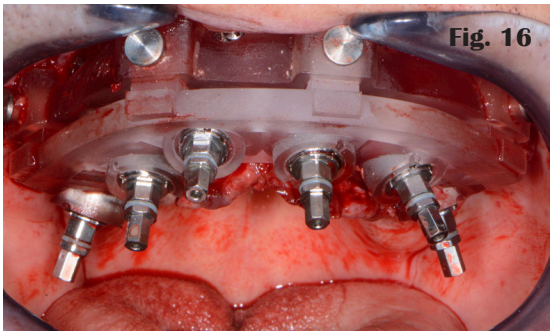


Fig. 15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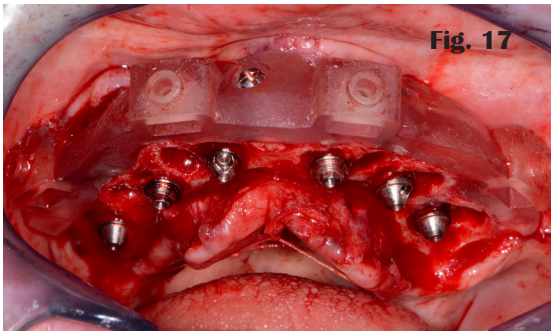
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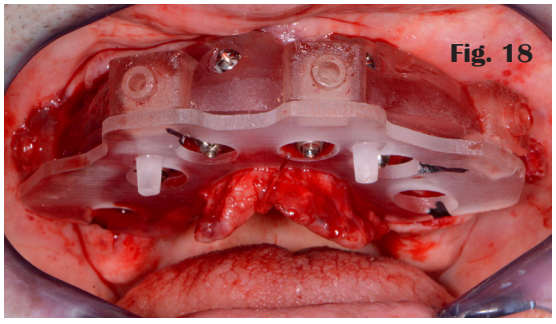
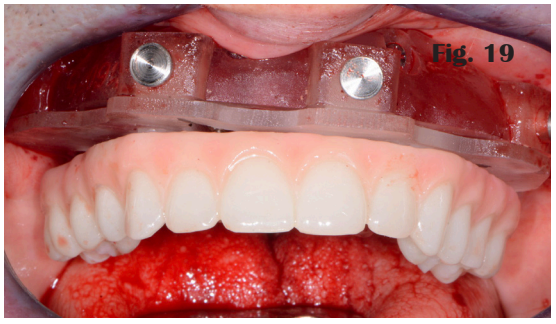


Fig. 18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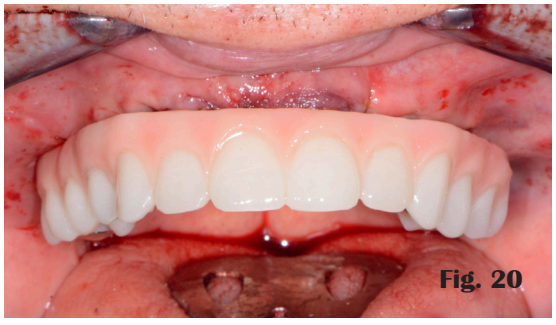
Fig. 20

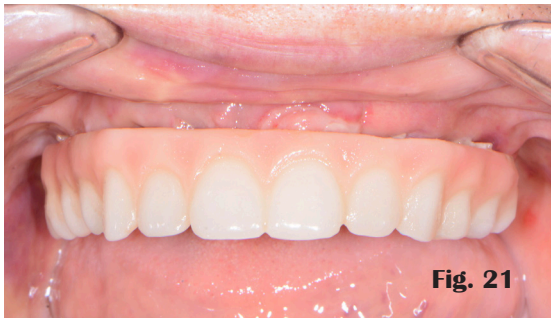
Fig. 21

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Is 60 Minutes Enough? What is the Standard of Care?

by Kathy S. Forbes, RDH, BS, FADHA

The dental hygiene appointment has traditionally been scheduled for 60 minutes throughout the past 50 years, while the number of procedures expected to be completed grows! Between infection control protocols, medical history/drug interaction evaluations, risk assessment protocols, aging population issues (mental and physical), and then clinical assessments before you ever get to the "cleaning", it is amazing that any hygienist can develop an appropriate dental hygiene treatment plan as well as provide quality dental hygiene/periodontal therapy which include necessary radiographs, periodontal chartings, patient education and more during that hour.

Driving these additional procedures are (1) Standards developed by the ADA Council on Dental Accreditation and taught in all dental hygiene programs, (2) Standards for Dental Hygiene Clinical Practice, developed by the American Dental Hygienists' Association and (3) Descriptors for ADA's CDT Procedure Codes which outline the specific elements which must be performed for each code to be able to plan appropriate treatment and bill properly.

Then there is the risk management issue of Standard of Care. This is the legal term to describe the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances. Most state dental hygiene practice acts have either statutes or rules/regulations outlining what the Standard of Care should be for the citizens of that state. If standards are not met (and it is reported to the state board), it could create a risk of disciplinary action or even loss of license.

There is an alarming trend where dental hygienists are told that their 60 minute appointment is going to be shortened to 40 minutes. Hygienists ask "I hardly have enough time now to provide quality care to your patients in 60 minutes! How can I do it in 40?" When the dentist comes in to perform the "periodic oral evaluation" (D0120), they see a "clean" mouth and do not realize the other services their hygienist performed which do not translate into a CDT procedure code or billable service.

Let's take a look at the hygiene/recare appointment starting from when the patient is seated in the dental operatory. This listing (including the appropriate CDT procedure code for that procedure) is not exclusive , and as technology and product development advance, more procedures may be necessary to provide patients with optimum dental care.

- If no **full face photo** has been taken for identification purposes, take "2D oral/facial photographic image obtained intra-orally or extra-orally" (D0350). If a copy of the driver's license is already included in the patient chart, this may be unnecessary.
- Take and record **vital signs (BP, pulse, respiration)**. The ADA has gone on record many times stating that BP, at the least, must be taken at every dental appointment. Since COVID, it has also been recommended to record temperature and oxygen level (pulse oximeter) readings.
- Review health history to include
    - Update and **record changes** since last visit.
    - Update and **document current medications** including OTC and supplements.
    - **Research medications** for potential dental contraindications and document. Discuss with patient.
    - If diabetic, may take a "**blood glucose level test**"(D0412). If, based on questions to patients that they present with diabetic symptoms, may consider D0412 or recommend HbA1c in-office point of service testing (D0411) if set up to do so.
    - If necessary, phone "**consultation with patient's medical health care provider**" (D9311).
    - If reviewing patient's vaccine and medical history and discussion of specifics are necessary, provide "**immunization counseling**" (D1301).
- Review and **discuss risk factors** to any medical and/or systemic condition(s) and **correlate to potential dental and or periodontal conditions.**
- Discuss and record any **chief complaint(s)** or concerns the patient may have.

It is not unusual for patients to have several health conditions as well as a "polypharmacy" of drugs which they are taking, even to the point of bringing all the bottles in a zip-lock bag! And if they don't know the name of their medications or why they are taking them, it takes time to research, document and discuss with the patient.

Now is the time to wash hands and don PPE according to CDC/office protocols.

- Perform an **extraoral/head and neck exam**. Unfortunately, this is one of the procedures which is eliminated by many

THE DENTAL HYGIENE CODING COACH
Kathy S Forbes
RDH, BS, FADHA

practitioners due to time constraints. But this is the time when suspected cancers of the skin, throat, thyroid and more can be detected and intervention provided.
    - This procedure is an element of the "comprehensive oral evaluation" (D0150) and is typically performed on new patients. With the public awareness of cancer in the region of the head and neck, the Standard of Care most certainly dictate to perform this at each recare visit.
- Perform an **intraoral/soft tissue/oral cancer exam**. This is a thorough oropharyngeal exam, not just a "grab the tongue" and look. If areas of concern are noted, this would be the time for "**adjunctive pre-diagnostic test**" that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures" (D0431) such as the VELscope™
    - **Oral cancer exam/evaluation is an element of**
        - D0150 "comprehensive oral evaluation" since 2021 [Prior to that, the language stated "if indicated"]
        - D0120 "periodic oral evaluation" since CDT2007-2008
        - D0180 "comprehensive periodontal evaluation" since CDT 4 (2004)
- Determine **necessary radiographs** based on the FDA/ADA standards. With all of the new technologies for diagnostic imaging, there are many different types and CDT procedure codes to choose from.
- If any chief mucosal/periodontal concerns would benefit from intraoral photos, now could be the time. (D0350).
- Complete **periodontal probing and charting**. "The American Academy of Periodontology states that a complete periodontal charting, including a description of periodontal conditions, includes:
    - Six points per tooth pocket depths
    - Recession
    - Furcations
    - Mobilities
    - Bleeding points
    - Minimal attached gingiva notations
    - AAP diagnosis (Using the 2018 Classification of Periodontal and Peri-Implant Diseases and Conditions, including Staging and Grading."
    - Standard of Care suggests this charting be completed yearly.
- **Periodontal screening** is an element of the "periodic oral evaluation" (D0120). "The American Academy of Periodontology states that a screening is "a charting containing only six points per tooth pocket depths."
    - Standard of Care suggests this to be done each time a D0120 is completed.

The above outlines what the hygienist is/and should be doing before she/he even starts the clinical portion of the appointment called the "cleaning". The hygienist does it because she/he cares about your patients and it's the right thing to do. It's the Standard of Care.

RDH Magazine published an article in November 2013 titled, "Top reasons hygienists are sued" by Dianne Glasscoe Watterson, RDH, BS, MBA. As the article points out, "Life in the dental office can be hectic at times. One reality is that hygienists fight a never-ending battle with the clock." The top four reasons hygienists are sued are ranked:

1. Failure to update medical history.
2. Failure to detect oral pathology.
3. Failure to detect periodontal disease.
4. Injury to patient.

Of the 817 CDT procedure codes in CDT2024, hygienists can perform between 60-120 procedures depending on their state practice acts and rules/regulations. Now, over 50 years later, dental hygienists are still expected to complete a continuing-care appointment in 60 minutes! There is so much more that can be done for our patients, but the time to complete those procedures needs to change when necessary.

On a Personal Note:

I understand that there are dentists struggling with staffing and struggling with dwindling production. But they still have an obligation to their patients. The Centers for Medicare and Medicaid Services define a dentist as a Physician (www.CMS.gov). I prefer to call them Oral Physicians. They are so much more than "just a dentist".

As dental hygienists are considered the specialists in providing preventive and periodontal care to patients, they need to educate their employers and staff regarding what should and must be done during the appointment time. And if 60 minutes is not enough time, then they need to be given more time. It will probably not be an easy discussion, but it's one that must be done. Your patients deserve comprehensive care (Standard of Care) – after all, isn't that why you went to dental school? Understand that hygienists are more than just the "cleaning," ladies/men!

Resources:

Accreditation Standards for Dental Hygiene Education Programs, Commission on Dental Accreditation, American Dental Association, 2022

ADHA Standards for Clinical Dental Hygiene Practice, June 2016

"Top Reasons Hygienists are Sued" by Dianne Glasscoe Watterson, RDH, BS, MBA; *RDH Magazine*; November 12, 2013.

"The 60-minutes Hygiene Appointment: The procedures pile up; time allotted for them doesn't" by Kathy S. Forbes, RDH, BS; RDH; *RDH Magazine*; October 28, 2015.

CDT 2024: Current Dental Terminology, published by American Dental Association.

Kathy S. Forbes, RDH, BS, FADHA has been a dental hygienist, educator, speaker, author, consultant, seminar, and study club leader for over 40 years. She speaks frequently about the correct classification, documentation, treatment planning, and CDT procedure code selection for patients with periodontal disease. In addition, she holds a license with the ADA for Current Dental Terminology© which allows her to provide the most up to date understanding of current procedure codes.

Kathy has had articles published in *RDH Magazine, RDH eVillage, Dentistry Today, Dentistry IQ* and others specifically addressing dental hygiene treatment planning and correct CDT procedure code selection. Through her company, Professional Dental Seminars, Inc., she provides customized in-office, interactive workshops to address dental practices' specific concerns related to treatment planning, CDT procedure code selection and long-term management of periodontal patients.

For over 25 years, her faculty appointments have included the Dental Hygiene Program at Concorde Career College in Aurora, CO, the Dental Hygiene Programs at Pierce College in Tacoma, WA and Shoreline Community College in Seattle, WA. Through the University of Washington's Continuing Dental Education Program as well as the Pacific Northwest Dental Hygiene Institute, she has taught local anesthesia and restorative procedures for out-of-state hygienists seeking licensure in Washington state and the Teaching Practicum Series for Eastern Washington University's Degree Completion program for licensed dental hygienists seeking their Baccalaureate Degree.

Kathy currently serves as a Director for the DentalCodeology™ Consortium, reviewing and developing procedure codes relevant to dental hygiene practice which are presented to the Code Maintenance Committee of the American Dental Association each year. She has attended these hearings since 2017, providing verbal testimony and answering questions related to procedure code submissions.

Oral Surgery for the General Practitioner:

TIPS & TRICKS on how to make it FLOW in your CLINIC!

by Waji Khan, CD, BSc, DDS, MBA, MEd, FICOI, FPFA, FACD, FICD

The topic is oral surgery for the general practitioner and how to make it flow in your clinic. "In your clinic"…and the operative words here are *flow* and *clinic*. Many times, we go to the dental operatory, and there are procedures that are more suited to an operating room environment, compared to what we can do in our clinic. In the OR, you have advanced airway, resuscitation, blood pressure management, teams that are experienced in managing codes and emergencies, and fluid management capabilities. So always ask yourself, "Is this a procedure I want to be doing in my clinic operatory, not in a surgical OR?"

I'm focusing my comments on the young dentists. You are a vulnerable population. Surgery is not easy! I recall when I first started out that I'd be nervous all the time. I'd be working on Saturdays, and people would come in and need a maxillary molar removed, and my hands would start shaking. Patients would ask, "Sir, have you done this before?" and I was like, "Yes, ma'am, I've done this before. It was on a mannequin head, and I got a 64!" It's okay to be nervous. My goal is to teach you what you're going to be comfortable doing and how not to be nervous. What I do not want to do is give people blind confidence. I don't want dentists to become Paolo Macchiarini in that movie *Bad Surgeon* on Netflix.

Let's start with how to extract teeth with confidence. Rule #1: You need the right weapons. If you look at the Special Forces, they are not a bunch of lemmings. Oral surgery is like Special Forces. Some people are right-handed, some people are left-handed. Some people are tall, some are short. Some people take a short shot, some shoot from far away. No, I'm not with the NRA. My point is that everyone looks different, and you need to procure the tools that are best suited to you and which work in your hands. I can show you what I use, but I need to remind you that my favorite tools are all attached to my elbow.

Let's go into emergencies. If you review a paper by Stanley Malamed in 1993[1,2], we can handle 95% of dental emergencies. Only 5% are going to kill a patient, and we can reliably screen for these. The big one is the patient's cardiac history, and everyone gets the "deer in headlights" look. Is this patient going to be fit to do the procedures we want to accomplish? What question do you need to ask? It could be something as simple as, "Can you walk up a flight of stairs, or can you walk two city blocks?" This is 4 metabolic equivalents[3], and I am comfortable with that.

Which is safer, oral sedation or IV sedation? If your answer is "oral sedation," you're wrong. The reason oral sedation is not safe is because everyone thinks it safe. There's no titration. You have no IV access. No doubt, the patients are dehydrated, and you're not even giving them fluid. I do IV sedation and I've done a ton of anesthesia training, but I do 99% of my surgery with just local anesthesia. I firmly believe in iatrosedation, sedating a patient with your personality. You must convince your patient. Say "Yes, Ma'am/Sir, you're not going to feel a thing. If you do, please let me know, and we will stop." Sedation is not safe, and a 2017 literature review found that nearly half the deaths in dental offices resulted from "anesthesia/sedation/medication-related complications"! [4,5]

Next, what instruments do I use? 95% of the time, I use a 701 or 702 surgical length drill, 16mm long. The 701 is a great bur for creating either a small trough or a purchase point to place your elevator or if you're doing a socket shield. The 702 is my go-to for sectioning teeth. Why the 702 and not the 701? The main reason is the width of the shank. You can drive it its full length of 16mm. The other reason I like the 702 is that it allows the sections to implode on each other. This is a trick I've learned from the late Dr. David Stanley Precious, who was an oral surgeon in Halifax, Nova Scotia. Everything you're removing as you section is creating more room for that tooth to implode on itself.

When I first started practicing oral surgery in my clinic, I would have around 80 instruments to choose from. Now I use about five (Fig. 1): retractor, a Woodson elevator (Fig. 2), a 77R elevator, a 34S elevator, some type of a curette, plus usually a lower or upper forceps.

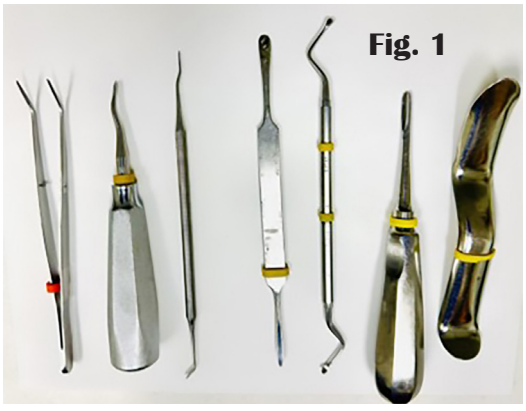


Fig. 1

Another trick is how you use the elevators and forceps. I see folks on Instagram treating instruments like precision guided missiles and applying forces in Star Trek photons. The secret is light continuous forces for at least 5-10 seconds to allow the bone to expand and not snap the tensile strength of the tooth. If you are impatient, sing a song in your head like Taylor Swift or Maroon 5.

In terms of retractors, everyone knows the Minnesota retractor, invented at the University of Minnesota. However, I'm going to share with you one I learned about when I was in Halifax, the Bishop retractor. The main difference between these retractors is that the Bishop retractor has a little S hook that places your fingers into a different position and makes third molars appear much closer than using the Minnesota retractor (Fig. 3). I also like the fact that it doesn't gouge the tissue compared to the Minnesota. Another retractor, the Weider, is great for keeping the tongue out of your way.

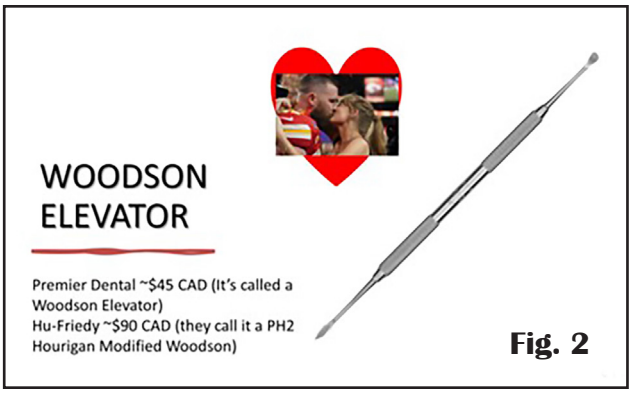


Fig. 2

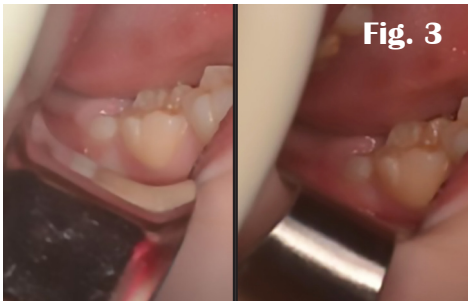
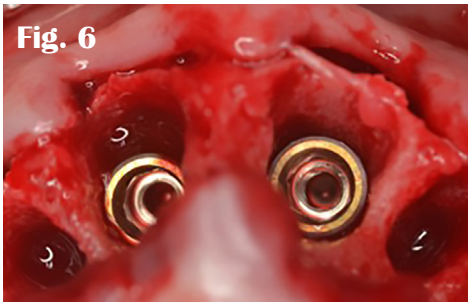


Fig. 3


Fig. 4


Fig. 5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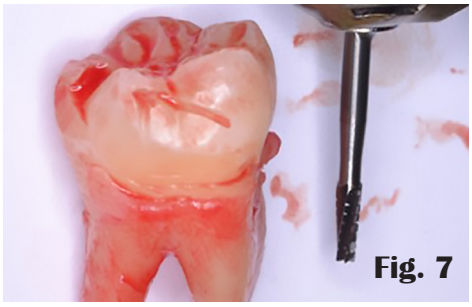
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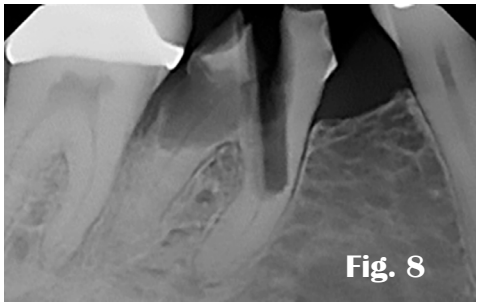
Fig. 8

Which needle holder do I like? (Figs. 4 and 5) We're not doing belly surgery here. Remember, the shorter it is, the more dexterity and control you'll have. I like the square head of the 5-inch Ryder, but anything 5 inches is going to be suitable for dentistry. I find the Castroviego needle drivers a little bit annoying because of the position you're in when you're using them, but if you're suturing a fine graft or using fine 5-0 or smaller sutures, the Castroviego drivers are great. Also, make sure that you suture on your forehand and not your backhand, and you'll have far more control with the suture.

That's it for equipment. How about techniques?

Rule #1: Always raise a flap (Fig. 6). Some dentists are hesitant and say that their flaps are crap. Do you know what my first flap was like? It looked like a scene out of *Psycho*, like I took a rusty machete or something like that. Your first one is going to look like crap, but you're not going to get to your hundredth until you do your first. So, you've got to do your first.

Rule #2: Section your tooth properly (Fig. 7). In dentistry, we grow accustomed to drilling 2-3mm, and beyond that, we intuitively get scared. When you are sectioning a tooth or placing an implant, you are at a depth of 8-16mm at times. You need to develop the confidence to do this. You are not going to hurt the tooth; it is heading for the garbage bag.

Rule #3: Use light forces. If you hit it in the right spot, light continuous forces are all you need. You don't need to be He-Man or She-Ra.

Rule #4: Take a radiograph, if the extraction is not going well (Fig. 8). Perhaps you did not flap enough; perhaps you did not section enough or in the right direction. Perhaps this is why your light continuous forces are not working.

Third molars: The key is to ensure you have completed a proper examination of the patient and diagnosis of the case. The Pell & Gregory classification system (Fig. 9) is probably the most ideal for this:

https://exodontia.info/impactionclassification/#:~:text=Inverse.-,Pell%20%26%20Gregory's%20Classification,distal%20to%20the%202nd%20molar). It classifies a case based upon the position of the wisdom tooth in relation to the second molar from an occlusogingival perspective, and in the case of mandibular third molars, how much mesiodistal crown room there is for the tooth to be removed. You need to have a clinical reason to extract it. The surgical risks must be outweighed by the benefits of surgery. The patient must be somewhat symptomatic in order to accept the surgical risks. A deep probing depth, caries, or a history of pericoronitis are some examples. Some suggest a CBCT is the gold standard in these cases. However, how does this change your surgical management of the case? Your two hands still need to do the work.

I'm going to share some other third molar secrets. Treat one side at a time. Everyone comes in and says, "I want to take all four of my wisdom teeth out now." Your reply: "Let's just do one side at a time. We'll do the right side today. We'll bring you back in two weeks and we'll do the left side." Unless you are being deployed, or you are Taylor Swift and you're flying from Japan to watch your boyfriend play in the Super Bowl, no one is really in that much of a hurry. The benefit is fewer incidences of post-op complications. While one side is healing, the patient can enjoy chewing on the other side. Another tip is to give them a syringe on Day 1 and ask them to start irrigating the socket on Day 2. Food impaction is the number one cause of patients having to come back. What people think is a dry socket is really food impaction most of the time.

Having an ability to understand bloodwork is also something we as dental surgeons need to become more familiar with in the future. We're no longer just doing restorations in practice. As we provide more surgery, competence in lab-based studies is recommended when we are screening our patients. There are all types of blood tests, but the most relevant pertain to bone healing and healing in general, such as testing for vitamin D, calcium, phosphorus, bleeding, and control of diabetes (Fig. 10). The more surgery we're doing in practice, the more reliant we are going to be upon the medical health of our patients, and simply sending them to the physician for interpretation doesn't meet the standard, in my opinion. I think that we can offer our patients more.

Local anesthesia: Practice all the techniques. Infiltration is easy; it is usually blocks like the standard Halstead IAN block which are the most challenging for most dentists. The Gow-Gates and Akinosi techniques have a higher rate of success[6]. The main challenge is the position

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Dr. Khan has a keen interest in implant dentistry and dental education. He is committed to improving oral health and boosting the confidence of his patients. In addition to his work as an international lecturer and clinical instructor for dental students at Dalhousie University and the University of Toronto Faculty of Dentistry, Dr. Khan is dedicated to his profession through his previous and present efforts in dental research and dental education. He enjoys spending time with his wife and two children, in addition to trying to play golf while also trying to play baseball.

of the mandibular canal in relation to the lingula on the medial aspect of the ramus. Always review your anatomy so you can say the steps for the technique in your head: locate the external oblique ridge, internal oblique ridge, and the pterygomandibular raphe; approach from the opposing canine at the level of the mandibular plane; bisect your index finger and pierce through the buccinator lateral to the pterygomandibular raphe; contact bone; aspirate; and inject. Most of the time, it is the lingula that you may hit first. If you bend your needle 45 degrees, and approach from the ipsilateral side and rotate it over the lingula, you can avoid this lingula issue. It's like the Fosbury Flop[7] Fig. 11). Some will cite the chances of the needle breaking, but this will not happen if you use a metal hub needle and avoid the temptation to bend the needle back. If it deforms, get another needle and metal hub.

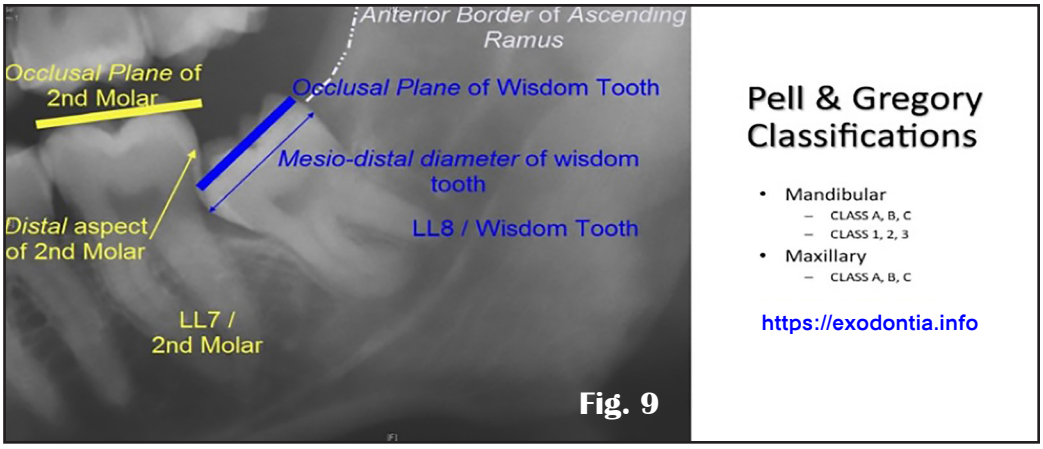

Fig. 9

X-Tip and Stabident are forms of intraosseous anesthesia that are useful if you cannot achieve profound anesthesia. You can also use a 701 bur, drill through the cortical bone, and inject into the bone using a conventional 30-gauge needle, if you don't have these items routinely in your office.

"In the OR, you have advanced airway, resuscitation, blood pressure management, teams that are experienced in managing codes and emergencies, and fluid management capabilities... So always ask yourself, "Is this a procedure I want to be doing in my clinic operatory, not in a surgical OR?"

Management of infections is another area that we must be well versed in. The most important thing to remember is that "the sun never sets on pus." If you suspect pus in a patient, you need to see them that day. Pus is an avascular collection of dead cells and bacteria that antibiotics will not clear, as it is avascular. It needs to be drained that day. In drainage, you want to remove the cause, irrigate the site ("the solution for pollution is dilution"), and maintain drainage with a Penrose drain, rubber dam, or some other item that you can later retrieve.

We will discuss many of these concepts in more detail at the lecture workshop in June at the FDC. Thank you for taking the time to read this article.

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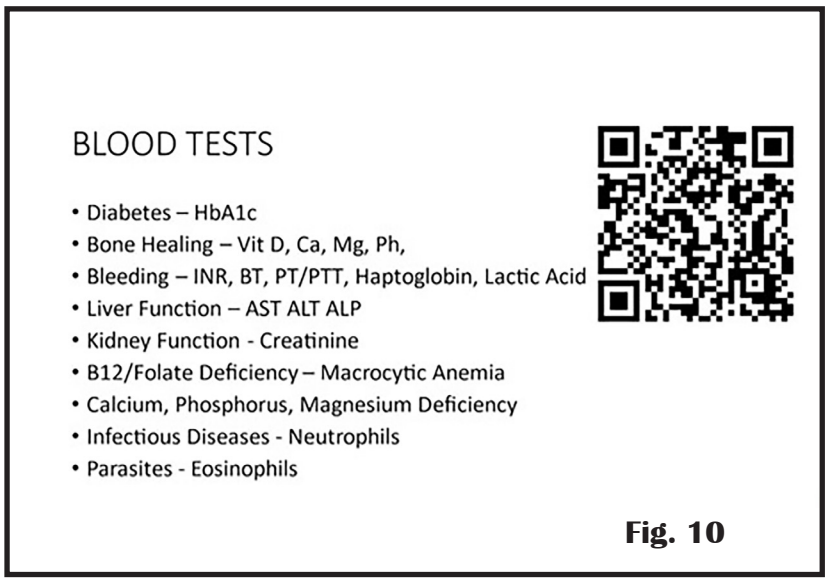
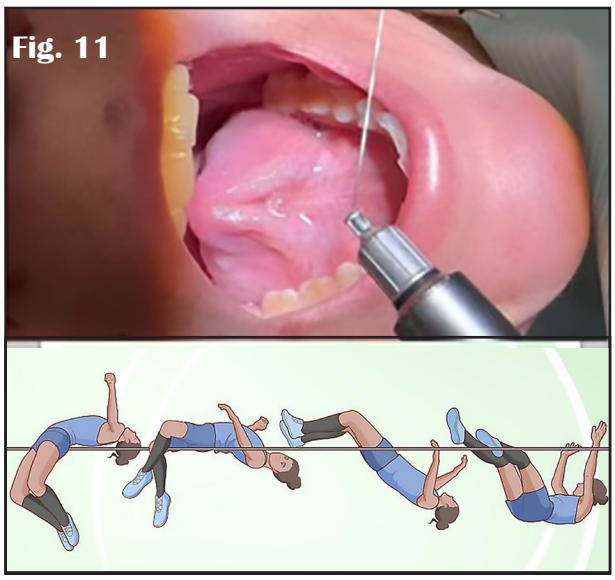


Fig. 10



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