MDA NEWS
A Newsletter of the Montana Dental Association
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Premiums Raised for Group Health Plan

Trustees for MDA's self-funded health insurance plan met twice in October to determine the premium rates for the 2011 plan renewal. After reviewing claims experience for the past several years, plan assets, and other financial information, they determined that rates for the plan should be raised 11.9% for next year.

In discussing the renewal, MDA's health insurance consultant Jim Edwards of Mountain West Benefits explained that this has been the worst renewal in 10 years for the plans their company advises. Claims are up significantly in 2010 for most association health plans. MDA's claims for 2010 also have risen significantly. There are more shock (large) claims, claims at higher amounts. In 2010 the plan has had almost double the large claims than it had in 2009. In 2009 claims were down and the plan experienced a very good year. It posted a gain of nearly $600,000 for the year. In 2010 the plan, instead of adding the gain to plan reserves, has been using the gain to cover claims, in addition to injecting another $45,000 to date from plan reserves. The plan will probably be down $100,000 by the end of 2010. As one cost-saving device Edwards and his partner at Mountain West Benefits, Richard Miltenberger, are shopping the market for a better cost for stop loss insurance.

To assist the trustees in making their decision about the plan renewal for 2011, Miltenberger of Mountain West Benefits provided an update for trustees on the claims experience of the group health plan this year. He reviewed a rolling 12-month comparison of recent claims experience. Claims experience also has been higher the past several months. He commented that other group plans Mountain West Benefits provides consultation services for are experiencing a similar rise in claims costs this year. In general hospital inpatient claims are rising. The use of medical technology has increased in rural areas, thus driving up health care costs. This made MDA's renewal discussion more difficult this year than in past years.

continued on page 12

Denturists Seek Separate Licensure Board

At the request of Montana's denturists, Sen. Verdell Jackson of Kalispell will introduce a bill in the 2011 Montana Legislature to allow denturists to have their own licensure board. Currently denturists are licensed and regulated by the Board of Dentistry.

When denturists were originally licensed by the State of Montana they were governed by their own licensure board. However, the ballot initiative that allowed denturists to become licensed in Montana provided that if 30 denturists were not licensed by October 1, 1986, the denturists' licensure board would be terminated and denturists would become regulated by the Board of Dentistry. The required number was not licensed by that date and the denturists' board was merged with the Board of Dentistry.

In 1993 a bill was introduced in the Montana Legislature to reestablish the Board of Denturity. The bill did not pass. The Montana Dental Association opposed the bill primarily on the grounds that denturists sought to leave the purview of the Board of Dentistry to escape the expert scrutiny provided by the Board in regulating their activities. MDA's concerns remain the same regarding this proposal.

Congratulations!

Robert W. Wood, DDS has merged his practice with

Andrew C. Hyams, DDS, Billings West General Dentistry

"The transition was smooth…Just like doing a crown on a lower left 1st molar!"
-- Andrew C. Hyams, DDS

"When I met Consani Seims Ltd. at the MDA meeting several years ago, I decided right then they would be the ones to assist me with my practice transition. They are a first class team, and I recommend them highly." -- Robert W. Wood, DDS

Happy Holidays!

Wendy Hirai
Robert Hirai

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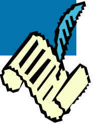
Across the Big Sky



Dentistry and the Law...

This column is offered to answer some of the queries frequently posed of MDA executive director/legal counsel Mary McCue about practice issues involving legal questions. If you have a legal question, e-mail MDA at mda@mt.net or call 800/257-4988.

Question: What issues should I be concerned with in insuring my dental practice?

Answer: Every dentist runs the risk of being named as a defendant in a malpractice lawsuit. For this reason a dentist should have professional liability insurance. There are two kinds of liability policies. An "occurrence" policy provides coverage for malpractice claims for dental services provided during the time the policy is in force. It does not matter when the claim is reported. A "claims made" policy provides coverage for incidents that occur and are reported while the policy is in force. Under a "claims made" policy, if the lawsuit is brought after the policy has terminated, there is no coverage. In this case a dentist should secure "tail coverage" which provides extended coverage for the period after the policy terminates.

A professional liability policy's "limits of liability" sets forth the total amount of losses for which the insurer will provide coverage. Generally there are two limits of liability under a policy. The first limit is the maximum the insurer will pay for a single claim. The second limit is the total amount an insurer will pay under the policy within a year. According to the ADA, most dentists carry policies that have $1 million per occurrence and $3 million aggregate limits of liability. In most cases these limits are more than adequate.

Another issue to consider in purchasing a professional liability policy is the "consent to settle" provision. This provision states the conditions under which the insurance company can settle a claim without the dentist's consent. In some cases the insurer may decide it is more economical to settle a claim without going to trial. This decision may be based on factors other than the merits of the case. There could be any number of reasons the insurer decides to settle the case without taking it to trial. A dentist's treatment records may be incomplete or the trial may take place in a venue that has been unfavorable to dentists accused of malpractice. The "consent to settle" provision will determine whether the dentist is entitled to refuse to agree to a settlement of the case.

Another kind of insurance a dentist should consider purchasing is business liability insurance which protects the practice against non-clinical losses sustained as a result of bodily injury or property damage to other persons. For example, a patient may slip and fall in the dental office and sustain an injury or damage may occur to the practice's premises. This insurance also covers personal injury that results from slander, false advertising, or invasion of privacy. Another kind of insurance, property and casualty, protects the dental practice from the replacement cost for damage to the practice. This coverage protects against the dentist's loss of livelihood and should be considered an essential cost of doing business. Life and disability insurance provide family income in the event of death or disability.

Letters to the Editor

MDA News invites feedback from our readers on material contained in the newsletter or otherwise of interest to dentists. Any communication intended for publication should be addressed to: Mary McCue, MDA, PO Box 1154, Helena MT 59624.

MESSAGE FROM YOUR PRESIDENT, DR. ANDY HYAMS

MDA's Comprehensive Oral Health Plan Takes Shape

Last year it became apparent that the MDA needed to develop a written plan to address a growing problem in the public's perception of the practice of dentistry in Montana. There are widening gaps that have developed along economic, geographic, and cultural barriers that block access to some of our citizens who need quality, oral health care. There is a concern at all governmental levels and in academic circles that the present private practice model of dental delivery is not addressing the needs of all of our citizens. At MDA, we feel that we need to provide strong leadership in finding solutions to some very complicated public health issues. For many years, we have worked on many individual fronts such as Medicaid, CHIP dental, Donated Dental Services, GKAS, etc. These are indeed noble efforts and must continue. However, access problems will not be solved by acts of charity or better program reimbursement rates alone. We recognize that we need to create a comprehensive plan to guide our strategy into the future.

The MDA is not alone at the table and if success is achieved it will be shared by many stakeholders and partners. Our partners include all the citizens of Montana and are not limited to: The Montana Department of Public Health and Human Services, The Montana Office of Medicaid, The Area Health Education Center, The Montana Society of the American Academy of Pediatric Dentistry, The Montana Chapter of the American Academy of Pediatrics, The Montana Dental Assisting Association, Montana Head Start, The Montana Women, Infant, Children program. These entities are supporting our effort. We have identified some objectives that our plan should address:

1. Create an adequately funded state oral health office that is led by a trained public dental health professional.
2. Support public policy that promotes the well -being of dental practices as small businesses.
3. Implement school sealant programs across Montana.
4. Promote fluoride programs in communities across Montana.
5. Increase the number of state insured children with a "Dental Home".
6. Advocate for fair and adequate Medicaid/ CHIP reimbursement of essential dental services that offer good value.
7. Enhance the dental team by expanding duties of current team members or creating new members if shown to be beneficial.
8. Improve distribution of dentists throughout the state to reflect population needs.
9. Promote cultural competency within the dental workforce.
10. Establish a state wide oral health education program to improve the public's understanding of the importance of oral health in relation to general health and well-being.

These objectives are broad and encompass the scope of issues challenging the delivery of quality oral health care in Montana. The MDA recognizes its role in leadership in forging this plan. We believe our expertise and technical knowledge are paramount for success. However, we are but one of the stakeholders at the table. Proper funding and support will be necessary from our partners and stakeholders if we are to achieve success.

GET READY FOR THE MONTANA 2011 LEGISLATURE

In just a couple short weeks the Montana Legislature will convene the 2011 session in Helena. We already know that two bills will be introduced on issues of significant importance to our organization, and several bill draft requests have been submitted to modify the professional licensing process. It is essential that we begin to talk with our legislators about these issues before they move to Helena for the session, which will begin January 3rd. Your MDA Government Affairs Committee has met, and discussed strategies and talking points, which I would like to share with you.

The first issue is a request from the denturists to leave the Board of Dentistry. It is still unclear weather they will seek to have their own board or join some other board. In either case, our response will be the same. Here are a few talking points:

- Dentists and denturists perform some of the same dental procedures, and therefore should be governed by the same board.
- We have had disagreements with denturists in the past, and those are best resolved by a single board, and not by two separate boards.
- Members of the public are often confused by, and don't recognize the difference between, dentists and denturists. Should someone have a complaint, it is simpler and more efficient for them to deal with one entity. In order to best protect the public a single board should control both.

The second issue is Senate Bill 2 (SB 2), which would allow dental hygienists with a LAP permit to place sealants in any school, without any involvement by a dentist. We have opposed this idea since it was first brought to an interim legislative committee, which has proposed it. Here are a few more talking points:

- Tooth sealants are a dental procedure.
- Adequate diagnosis and treatment planning by a dentist is essential for the proper and safe performance of any dental procedure.
- Dental hygienists are not trained to diagnose and the law does not allow them to do so.
- Federal government agencies (HRSHA, CDC) recommend dentist involvement in school sealant programs.
- Proper sealant placement requires rubber dam isolation or a four-handed technique.
- It is not necessarily okay to place sealants over tooth decay. There is conflicting scientific evidence on this, but it appears that a new study by Gordon Christensen will support this point.
- Recent studies on sealant materials indicate that there may be adverse side effects from the material itself. (Academy of Pediatric Dentistry report) Therefore, the blanket placement of sealants on all teeth is unwarranted.
- This expansion of the LAP permit ignores the "need" requirement of the original LAP legislation. (The original LAP legislation includes the following: *The provision of services under a limited access permit is limited to patients or residents of facilities or programs who, due to age, infirmity, disability, or financial constraints, are unable to receive regular dental care.)*
- Placing sealants on all teeth in all children is an unwarranted waste of time, money, and labor. It is better to properly identify the problem (diagnosis by a dentist) and focus the resources where they are most needed.
- The placement of sealants on all students in a school program does not meet the federal requirements of the PHS act, or the recently passed Health Care Reform Act.
- The number of LAP hygienists is very limited (only 14 are currently licensed), and this drastic expansion will take away much of the service from where it is most needed - in nursing homes and other public health facilities.
- The Montana Dental Association is currently developing the *Sealants for Smiles Program* that will involve the whole dental team – dentists, hygienists, and assistants – in school sealant programs.

Please contact your local legislators to discuss these important issues before the end of the year. Without a doubt, that is the best opportunity to make the initial contact, and have a few minutes of their time. Talk about a couple of the points that are of particular interest to you and offer your personal experience and professional opinion. Tell them that you may be contacting them during the legislative session, and ask what the best method would be to do that, (phone call, email, fax, etc.) and get the contact information. Please also plan on coming to Helena on Friday, January 21st, for our MDA Dental Day at the Legislature.

Thanks in advance for your help,
Doug Hadnot and Kevin Miltko

LEGISLATOR INFORMATION OFFICE
BEGINNING JANUARY 3, 2011

406/444-4800	**8 am - 5 pm**
Montana House of Representatives PO Box 200400 Helena MT 59620-0400 fax: 405/444-4825	**Montana Senate** PO Box 200500 Helena MT 59620-0500 fax: 405/444-4875

You may also e-mail your legislator by utilizing their contact information at:
http://leg.mt.gov/css/Sessions/62nd/roster.asp?HouseID=0&SessionID=105

What is Evidence-based Dentistry

Article submitted by Dr. Jane Gillette, Bozeman

Periodontal therapy does NOT lower preterm birth.

Science News

Share Blog Cite

Study Finds Periodontal Treatment Does Not Lower Preterm Birth Risk

ScienceDaily (Nov. 3, 2006) — Scientists supported by the National Institute of Dental and Craniofacial Research, part of the National Institutes of Health, report in this week's New England Journal of Medicine that pregnant women who received non-surgical treatment for their periodontal, or gum, disease did not also significantly lower their risk of delivering a premature or low-birthweight baby.

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NO! Wait a minute. Periodontal therapy DOES reduce the risk of preterm birth!

Science News

Share Blog Cite

Successful Periodontal Therapy May Reduce the Risk of Preterm Birth, According to Dental Study

ScienceDaily (Sep. 15, 2010) — A collaboration led by a periodontal researcher from the University of Pennsylvania School of Dental Medicine has found a possible link between the success of gum-disease treatment and the likelihood of giving birth prematurely, according to a study published in the journal BJOG: An International Journal of Obstetrics and Gynaecology.

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NO! Wait a minute… what do you mean there is no association at all?! I'm so confused!!

Obstetrical & Gynecological Survey:
August 2009 - Volume 64 - Issue 8 - pp 513-514
doi: 10.1097/01.ogx.0000356747.26298.b2
Obstetrics: Obstetrical Complications

In contrast to several observational studies suggesting an association between periodontal disease and adverse pregnancy outcomes, these findings show no such association.

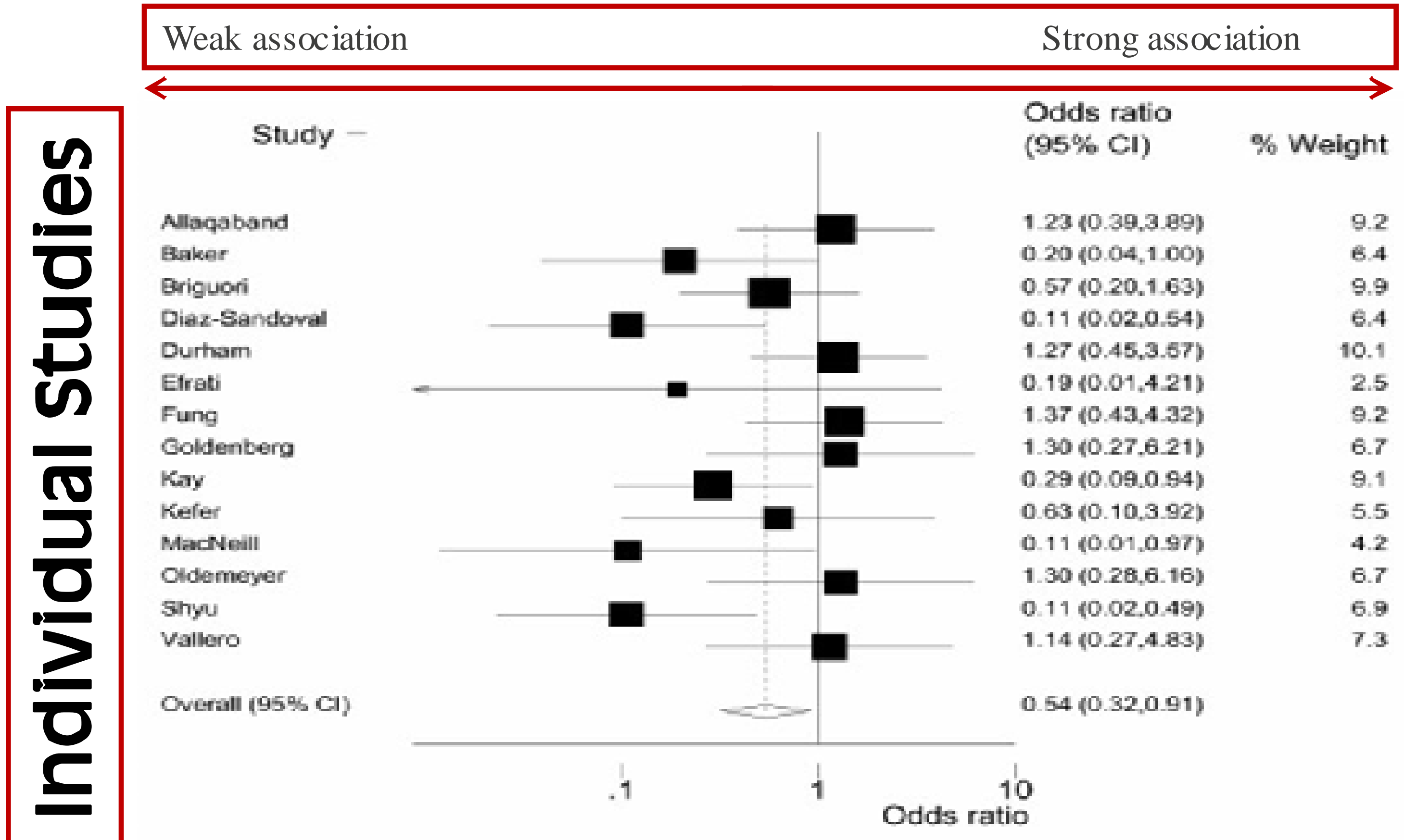
Periodontal Disease and Adverse Pregnancy Outcomes: Is There an Association?

As practitioners we are confronted almost daily with an exhausting amount of often conflicting health information. Evidence-based dentistry (EBD) is an approach to dental healthcare that utilizes *high-quality and reliable evidence*, along with *professional expertise* and *patient's values*.

The example above in which research findings vary greatly from study to study is all too common. There are many reasons science sometimes fails us including:

1. Lack of an *a priori* question
2. Lack of a proper control
3. Lack of randomization
4. Bias:
    a. Lack of blinding (both investigators and/or subjects)
    b. Selection bias: only selecting studies that support the topic of interest
    c. Publication bias: the fact that more studies with positive results get published
    d. Conflict of interest
    e. Measurement bias: observer, responder and instrument bias
5. Lack of statistical "power"
6. Small sample size
7. The use of surrogate outcomes (i.e. using "attachment loss" instead of tooth survival as an end point of a study)
8. Confounding: when the association of an exposure (i.e. smoking) and the outcome (i.e. cardiovascular disease) is mixed up with the real effect of another exposure (i.e. periodontal disease) and the same outcome (i.e. cardiovascular disease)
9. Even the way statistics are presented in a study can make a finding appear more significant than it really is!

Because researchers are evil (that's a joke), we cannot consider the results of just **one** study to be enough to base decisions regarding our patient's health. Instead we must look at the **total body of evidence** on a particular subject. Clearly busy dentists do not have the time (and sometimes expertise) to critically appraise every relevant study published on a particular topic of interest. Luckily, there is a very rigorous scientific technique by which researchers can combine results from many individual studies. This process is called a "systematic review" (sometimes accompanied by "meta-analysis") and is considered to be the *very highest quality of scientific evidence available.*



Systematic reviews often use "forest plots" of weighted odds ratios to describe the combined results of multiple individual studies and are a wonderful efficient, visual and descriptive tool.

Since even accessing and reading systematic reviews can be burdensome in modern life, there are many organizations that specialize in producing short summaries and quality assessments of systematic reviews. Examples of free internet sites that specialize in this are:

- The ADA: EBD.ADA.org
- The Cochrane Collaboration: www.cochrane.org
- The DARE database: www.crd.york.ac.uk/crdweb/
- The TRIP database: www.tripdatabase.com/

Additionally, the ADA's Center for Evidence-based Dentistry has many quality membership services including multiple courses in EBD and low-cost original text publication's available from the library.

The utilization of the most current high-quality and unbiased evidence is not a substitution for professional expertise or patient autonomy, but simply a complement and enhancement to the delivery of high-quality, value-based healthcare.

Share Your Volunteer Dentistry Story

If you've had an opportunity to participate in volunteer dentistry in Montana, across the United States or abroad - please share the location, the organization you worked with, and any other details or stories associated with your experience. We are collecting this information for statistical purposes and possible newsletter stories.

Thank you for your help on this project, and for all you do for organized dentistry and people in need across Montana, the Unites States, and the world.

Friday, January 21, 2011

Dental Day at the 2011 Montana Legislature

Join Your Fellow Dentists in Helena and Support Your Profession

Come to Helena for "Dental Day" at the Legislature. MDA members will be in Helena on Friday, January 21 beginning at 10 am with a **free** 2 hour CDE class followed by lunch. From 1 pm to 5 pm dentists will visit with their legislators at the Montana Capitol. A reception and dinner will be held beginning at 6 pm.

"Evidence-Based Dentistry"

presenter: Dr. Jane Gillette

Dr. Gillette graduated from the University of Washington School of Dentistry in 2002. She served three years in the U.S. Air Force at Malmstrom AFB in Great Falls. During that time she was the lead dentist on a humanitarian mission, and was a member of the Forensic Identification Team. After her military service she became the dental director at the Community Health Partners in Bozeman. Currently, she has a private practice in Bozeman.

Dr. Gillette is the MDA Board of Directors representative for the Sixth District, she is a member of the Government Affairs Committee, and is very active in her local dental society. Dr. Gillette has lectured for the American Dental Association on the topic of Evidence-Based Dentistry.

2 CDE hrs-Great Northern Hotel

Points of Interest:

- CE Class, **10 am to 12 Noon**, meet in the Great Northern Hotel lobby - you will walk to the CE meeting room
- Lunch for class attendees immediately following at Great Northern
- Meet with Legislators at State Capitol, **1 pm to 5 pm**
- Reception and Dinner **6 pm**, Great Northern Hotel

Great Northern Hotel
835 Great Northern Blvd.
406/457-5500

Please detach and return.

MDA Legislative Contact Network & Legislative Events

1. ____*Yes,* I will attend the **CDE** "Evidence-Based Dentistry" class at the Great Northern Hotel (register below)
2. ____*Yes,* I will participate in MDA's Grassroots Contact Network
   I will contact………………. House______________________ Senate________________________
3. ____*Yes,* I will attend the Dental Day at the **State Capitol** from 1 pm to 5 pm
4. ____*Yes,* I will attend the **free** Legislative **Reception and Dinner** beginning at 6 pm at the Great Northern Hotel

*YOUR NAME*____*ADDRESS*_____________________________

*CITY, ST, ZIP*_______________________________________*PHONE* ______________________________

*E-MAIL*____

NAMES OF THOSE ATTENDING RECEPTION:

____

____

Contact MDA for further information: 800/257-4988 or mda@mt.net fax:406/443-1546

In Memoriam

Dr. John C. Kall

Dr. John C. (Bud) Kall died of natural causes on November 18, 2010. He was born in Butte on June 15, 1933, to John Joseph and Anna (Seman) Kall and later moved to Helena in 1935, when his father became the golf professional at the Helena Town & Country Club.

Dr. Kall attended St. Helena grade school and graduated from Cathedral High School in 1951. He then attended Carroll College for one year before serving as a corpsman in the U.S. Navy. He returned to Carroll and subsequently was admitted to St. Louis University Dental School, graduating in 1961. He began his practice of dentistry in Helena that summer and practiced for 33 years until his retirement in 1994.

He married Marie Retz on July 19, 1956. They enjoyed 54 years together, raising four children: Scott, Val, Tori and Jasyn. Over his lifetime he was a member of the Jaycees, Elks Club, Montana Club, Mended Hearts, Fifth District Dental Society, and St. Helena's Cathedral Parish. He served as a dental consultant to the Intermountain Children's Home and the state of Montana. He was an avid golfer and longtime member of Green Meadow Country Club, having served on the board of directors, and a term as club president. He was on the board of directors of the Montana State Seniors Golf Association, also serving a term as president. In the winters, he and Marie would enjoy golfing in Hawaii, and when he could no longer play golf he enjoyed his Wednesday "crib" bunch.

According to family, friends, and staff Bud's gregarious personality will be greatly missed. He did not need an intercom at the office and held court over family functions, making sure everyone was taken care of, especially his grandchildren.

Dr. Robert E. Danskin

Dr. Robert E. Danskin died April 14, 2010. He was born in Glendive in 1924 and adopted at 2 weeks by Dr. Melville and Minnie Danskin. According to his family, he considered this to be one of the best things that happened to him and greatly admired his rural physician father and homesteading mother. He always was proud of being a Montanan.

Dr. Danskin graduated from Dawson County High School in 1941. He served two years (1944-1946) in the U.S. Navy during WWII, advancing from Apprentice Seaman to Pharmacist Mate 2nd Class, spending much of his time at the NOB Hospital in Norfolk, Va. After the Navy, he returned to Bozeman, completing his college degree and graduating from MSC (now MSU) Bozeman in 1948.

Dr. Danskin graduated cum laude from Chicago College of Dental Surgery, Loyola University School of Dentistry in 1953. He practiced general dentistry for two years in Illinois before returning to Montana. He practiced in Billings from 1955 until his retirement in 1987 due to heart trouble.

In 1951, he and Alice Hintz were married in Illinois and raised four children. Dr. Danskin was active in several local organizations, including serving a number of years on Mayor Frazer's Public Health Committee. He was the dental health consultant for Western Manor Nursing Home for 25 years, and also served as President of the 9th District Dental Society. He was a member of Billings Boat Club, Kiwanis Club, and a patron of many local and national charities.

He was a life member of the MSU Alumni Association and the National Rifle Association. He also was a lifelong member of the First United Methodist Church in Glendive and then in Billings. He was a member of several Masonic bodies.

After retirement, Dr. and Mrs. Danskin spent several winters in a home they built in Sun Lakes, Arizona. An avid traveler, Dr. Danskin enjoyed driving, exploring, and cruising the Caribbean, Mississippi River, Panama Canal, Hawaii, and Alaska. The Danskin family also enjoyed many summers at their lake place on the shores of Flathead Lake.

Dr. Danskin is survived by his wife Alice; two daughters Judith (Craig) Miller of Alexandria, Ontario, Canada, and Laura (Brian) Golphenee of Kettle Falls, Wash.; and two sons, Wesley (Linda Scott) and Greg (Wendy) of San Diego and Escondido, Calif. A third son James died in infancy. He is also survived by five grandchildren.

Consulting Editor for the *MDA News*

MDA staff, executive officers, and members of the board of directors thank Dr. Kevin Miltko of Missoula who serves as consulting editor for the *MDA News*. We are seeking other dentists who are willing to serve as consulting editors for the newsletter. If you are interested, please contact Dr. Miltko at email miltko5@msn.com or MDA executive director, Mary McCue, at email mda@mt.net or phone 1-800-257-4988.

One Method to Deal With a Bolton's Discrepancy

Article submitted by Dr. Christian Kenworthy, Missoula

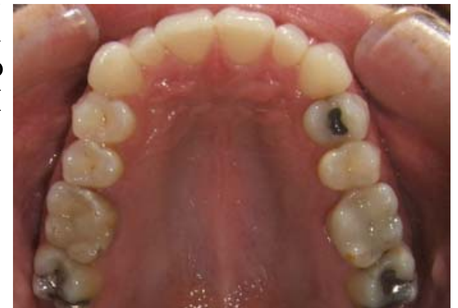
All of us have seen a patient who has beautifully aligned maxillary anterior dentition, nicely interdigitated Class I buccal segments, normal overbite, and crowded mandibular incisors. Welcome to the world of tooth size discrepancy.

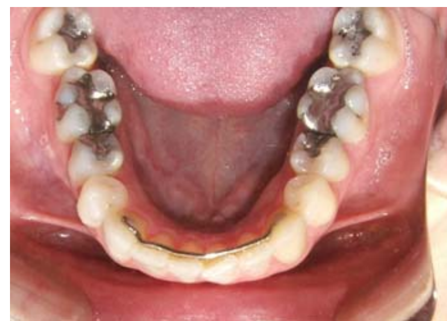
There are many tooth size discrepancy formulas and models that have been presented since 1909 but the most widely used and studied is Bolton's work published in 1958 in the journal Angle Orthodontist titled, "Disharmony in tooth size and its relation to the analyses and treatment of malocclusion". To determine if the teeth will be able to be placed in a Class I occlusion with correct overjet and overbite and without diastemata, one can calculate either an Overall Bolton's Index (first molar to first molar) or an Anterior Bolton's index (canine to canine). This is done by measuring the mesiodistal widths of the teeth and obtaining a percentage by dividing the maxillary width by the mandibular width. The percentage for the Overall Bolton Index should fall between 87.5 and 94.8 and for the Anterior Bolton's Index between 74.5 and 80.4. Tooth size discrepancies are not the only reason for Class I misalignment. Arch form and curvature as well as thickness of the anterior teeth may allow the occlusion to work when it falls outside the Bolton Index norms and conversely might result in misalignment when the teeth fall into the Bolton Index norms.

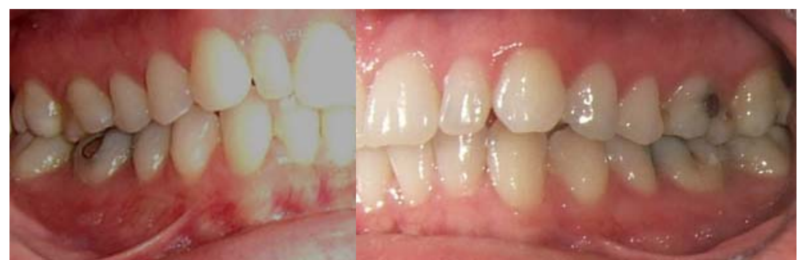
So we have all seen the results of Bolton's discrepancy and now you know how to calculate one, but how do you treat it? First, it is helpful to determine which teeth are relatively too wide or too thin. Levin published an article in the Journal of Prosthetic Dentistry in 1978 titled, "Dental esthetics and golden proportion" where he proposed ratios of height and width of the anterior teeth. For example, he stated that a central incisor's width should be approximately 80% of its height. But with tooth wear in a 50 year old or incomplete eruption of an 11 year old those ratios should be used with expertise. Sometimes it is easy to tell because the patient has a peg lateral or one very wide central and the treatment can be focused on that tooth. But if it was always that easy Bolton would not have had much to write about in his article.

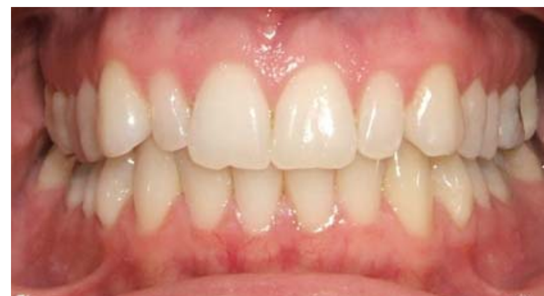
Second, once you have determined the culprit teeth, you and your patient must decide whether it would be best to widen the thin tooth or thin the wide one. If the teeth that are too wide are in relatively decent alignment, interproximal reduction (IPR) can be performed prior to orthodontic alignment. Similarly, if there is excess space around the thin tooth/teeth they can be built to ideal size prior to orthodontic space closure. If these two conditions do not exist, the orthodontist and restorative dentist should consult to decide whether tooth reduction or prosthetic addition is the treatment of choice and to determine the eventual widths of the teeth. This way the teeth can be positioned so that the final result achieves maximum esthetics.

Let's look at a case. This female was referred to me with the complaints of headaches and orthodontic relapse with an intact bonded lingual retainer. The previous orthodontic treatment resulted in closed spaces, but some compromises due to the Bolton's discrepancy. You will notice the narrow maxillary laterals, non-coincident dental midlines, lower crowding, and more wear on the left cuspid than the right due to the mild Class II occlusion on that side.

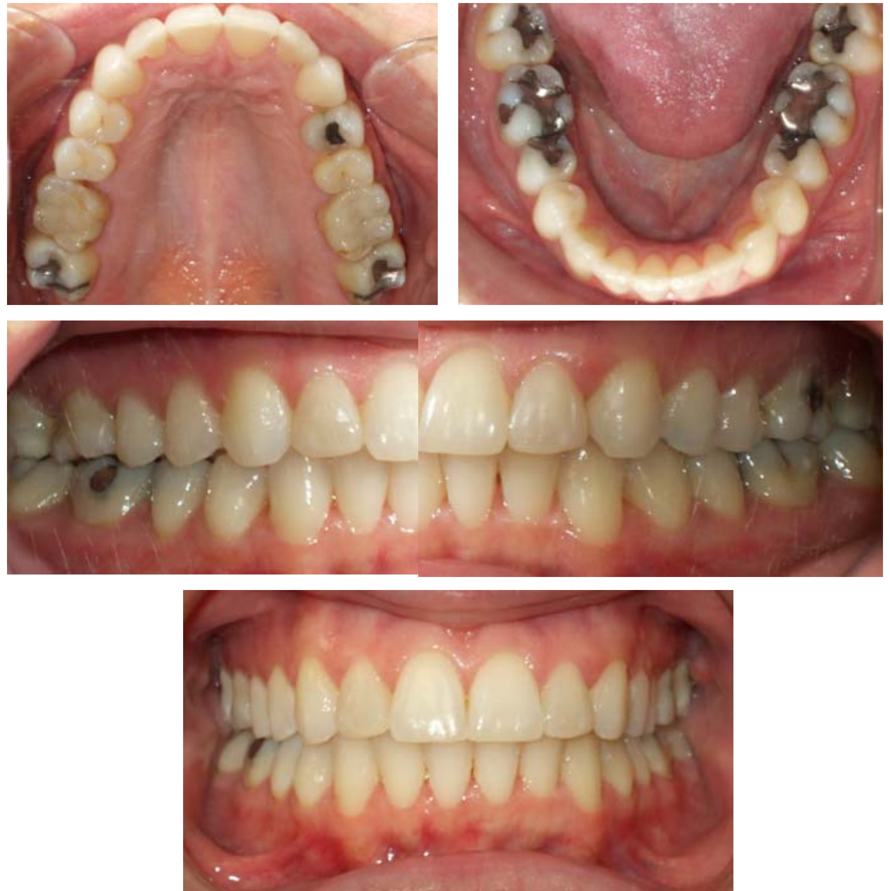








So it is pretty easy to see why the Bolton's Index for this patient falls outside the norms – the maxillary laterals are too narrow. The goals of orthodontic treatment were to establish bilateral Class I cuspids, remove non-working interferences, and create space for the restorative dentist to create ideally sized laterals. I used a bone screw to distalize the maxillary teeth into Class I buccal segments and then positioned the peg laterals so that 1/3 of the space was on the mesial and 2/3 distal to preserve embrasure form. Once the restorative dentist accepted the final tooth positions the brackets were removed and composite build-ups were placed resulting in a normalized tooth size ratio and a more esthetically pleasing smile.



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Practicing Dentistry in a Community health Center in Montana

Story submitted by Dr. Joanna Wales, Bozeman

Earlier this year, I made the monumental decision to leave private practice in order to work for Community Health Partners and practice dentistry in Livingston. I had been in private practice for nine years, seven of which were spent in Bozeman building a practice of great patients whom I enjoyed. I felt frustrated, however, at the confines of the for-profit, production driven model of dentistry and wanted to work in a non-profit, community health center setting. As you can imagine, the past five months have been filled with both challenges and rewards.

Thinking about an underserved population in theory is much different than actually working with them. I have been awakened to the prevalence of mental illness in our society. I am continually shocked at how rampant dental disease is among the underserved. I was simply unaware of the numbers of people with chronic periapical and periodontal infection who have just learned to deal with pain. I have met teenagers who are already missing several of their permanent first and second molars and young adults who are missing maxillary anterior teeth. I have heard countless stories of job loss, death of spouses, catastrophic injury or illness, or simply retirement and the subsequent inability to pay for dental care.

Much of how I practice dentistry is the same as when I was in private practice. I encourage people who come in for an emergency to return for a comprehensive exam. I perform risk assessment during comprehensive exams and educate patients of their biomechanical (caries, structural compromises), periodontal, and functional (occlusion, TMJ disorders) risk factors. I encourage patients to complete their treatment plans. (In the past six months our clinic has averaged an 80% completion of 6-month treatment plans.) Just as in private practice, our goal is to help patients attain a functional, stable dentition.

Some of what I do, however, is very different. Quadrant dentistry has become much more difficult because the complexity of direct restorations is increased. I have placed more 4 and 5 surface fillings in the last five months than in all of my nine years of private practice. I have also extracted what for me is a great number of teeth. Three hundred teeth in five months is definitely more than I either extracted or even referred for extraction in my previous nine years of private practice. Dental emergency appointments are a daily occurrence. It is difficult to balance how to provide the best care for the greatest number of patients.

What do I love about my job? What do you love about yours? The patients! While I was hoping for a sense of contribution to my community, I didn't expect the inspiration I feel at many of my patients' stories. To see the many adversities that my patients face has been a daily reminder to be grateful for what I have and deepens my sense that "To those whom much is given, much is expected."

If you have a Community Health Center in your area and haven't done so already, I would encourage you to meet and talk with the clinic's dentist. Our practices share many similarities as well as differences. It is my hope that Community Health Centers can work in partnership with local private practice dentists and not be seen as adversaries. We can work together to address the many problems facing both our profession and our communities.

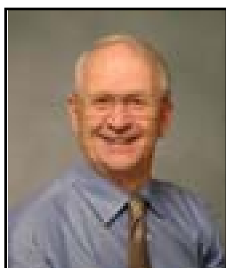
"Premiums Raised" continued from front cover

Effective January 1, 2011, there also will be a 3-4% increase in costs to the plan due to measures enacted in federal health care reform. These include increased preventive benefits, removal of dollar limits, and increase in rehabilitation and physical therapy benefits. Health care reform measures will apply to most health plans, including MDA's. That increase was also considered by trustees in making their decision about the 2011 renewal.

MDA members covered by the health plan were be notified of the renewal in early November. They then have to make a decision about renewing their coverage effective January 1.

The Montana Dental Association

Presents



Dr. William Costerton

Biofilm and Dental Diseases

Friday – March 25, 2011

Holiday Inn

400 10th Avenue South
Great Falls, Montana

Registration, 8 am **Class**, 8:30 am – 5 pm

ABOUT THE CLINICIAN

Dr. William Costerton earned both his Bachelor and Master of Arts degrees in Bacteriology and Immunology from the University of British Columbia, and completed his doctoral at the University of Western Ontario. Early in his career, Dr. Costerton was the Dean of Science at the Baring Union Christian College in Punjab, India. For eleven years he served as Director of the Center for Biofilm Engineering at Montana State University, and at the present time, he is the Director of the Center for Biofilms, Dentistry, at the University of Southern California.

Dr. Costerton is the recipient of numerous awards including Honorary Professor of Wastewater Management from the University of Queensland, the Leveraging/Collaboration Award in Antimicrobial Testing from the Food and Drug Administration, and the Procter and Gamble prize in Environmental Microbiology. He has served as Editor of the Biofilms Online journal and Springer Series on biofilms estimated at 20 books. Dr. Costerton has published many articles on biofilm and has lectured nationally and internationally.

ABOUT THE COURSE 7 CE Hours

Presentation is designed for clinicians, dental assistant and dental hygienists

In this class participants will:

- Examine the biofilm concept of bacterial growth, as opposed to the traditional "planktonic" concept that is taught in most microbiology courses
- Relate this concept to a whole range of dental diseases
- Begin with caries, in which the biofilms are the site of acid generation, and the means of focusing this acid on the hydroxyapatite of the tooth
- Consider periodontitis, in which biofilms develop in the gingival space, and persist in spite of host reactions and antibiotic therapy, because they are protected by the biofilm mode-of-growth
- Examine the pivotal role of biofilms in the failure of root canals, and of dental implants
- Evaluate possible technologies that may make these foreign bodies less amenable to bacterial colonization and more robust.

Thank you for pre-registering

Lunch and breaks are included in the cost of tuition. No refunds will be issued after the course date.

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MDA Dues Structure Explained

Your tripartite membership in the American Dental Association, Montana Dental Association, and your local dental society plays an important role in the continued success of organized dentistry in Montana and across the nation. More than 157,000 ADA members ensure essential "strength in numbers' when lobbying the U.S. Congress. ADA and MDA offer many benefits for members including up-to-date information affecting your profession, access to free tools to help your practice more effectively, and opportunities for you to share your talent to benefit the association and your colleagues. And now at ADA.org, you can update your profile for free and help potential patients find you – 20,000 patients search the ADA website each month.

The tripartite membership can be confusing for some with the various levels available. MDA staff is well versed in membership issues and works diligently to ensure you are well informed and placed in the optimum category. For the most part, MDA and the local dental society mirror ADA at all membership levels. One difference that affects some dentists is the "retired" category. ADA assesses 25% of full active dues. MDA and the local dental society do not charge retired dentists any dues.

The most frequently asked questions regarding membership are answered below:

- **Recently graduated dental students** pay no dues their year of graduation. The first year out of dental school is 0% of full active dues, second year out is 25%, third year out is 50%, and fourth year out is 75% of full active dues. Only in the fifth year do you pay full active dues. If you received a specialty certificate or continued your education in some other fashion and did not pay the $30 graduate student fee, ADA will most likely allow you to "catch up" by paying the past dues which will allow you to take advantage of the significant savings those first years in practice.
- **Life membership** is attained when a dentist has 30 years consecutive or 40 non-consecutive years as a member and is 65 years of age. Active life members are assessed 50% of full active dues and retired life members pay $0. These savings are not realized until the year immediately following your 65th birthday.

MDA staff has spent the last five months switching over to the ADA membership database. This move has allowed us to ensure your information at the national level is current. If you have any questions regarding membership or your 2011 membership statement, please don't hesitate to call the MDA central office at 1-800-257-4988.

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Senior Consultant

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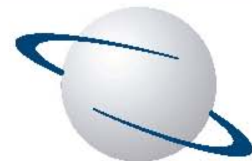

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TREATMENT OF A PATIENT WITH A PARTIALLY FAILED DENTITION AFTER INTRAVENOUS BISPHOSPHONATE THERAPY

Article submitted by Joe Meng, DDS, MS, Missoula

Bisphosphonate-induced osteonecrosis (BON) of the jaws has received a lot attention by the dental world for nearly the last decade, due to the widespread use of bisphosphonate drugs. It is a condition characterized by exposure of bone in the mandible or maxilla persisting for more than 8 weeks in a patient who has been/is taking a bisphosphonate, and who has no history of radiation therapy to the jaws. Clinically, the disease is usually seen to present as spontaneous exposure of necrosed alveolar bone that occurs following an invasive surgical procedure such as extraction, periapical surgery, periodontal surgery, or implant placement; however, it may also occur in patients with poor oral hygiene or an ill-fitting denture. Dr. Robert Marx, Oral and Maxillofacial Surgeon, University of Miami, originally discovered the association, and is currently respected as the chief expert on the issue.

Bisphosphonate drugs come in both intravenous and oral preparations. The IV drugs have been paramount in the management of bone related malignancies such as multiple myeloma and hypercalcemia related to breast and prostate cancers. The less potent oral forms are primarily used to treat osteoporosis and osteopenia. The IV preparations include Aredia, Zometa, and Bonefos; oral drugs include Fosamax, Actonel, Boniva, Didronel, Skelid, and Reclast. The American Dental Association reports that 94% of documented BON cases have occurred in patients having taken intravenous preparations, while 6% of cases occurred with the oral preparations. Additionally, Marx reports that the successful management and long term sequela associated with the IV preparations is much worse, and can occur with as few as 5 to 6 doses of a given drug. The best possible scenario is to avoid treatment interventions which may predispose these patients to the occurrence of BON.

The dilemma in dentistry is how to manage these patients when surgical treatment would conventionally be indicated for a given dental condition. In general, if an otherwise healthy patient has been treated with oral bisphosphonates for a duration of 3 years or greater, Marx suggests suspending the bisphosphonate treatment (drug holiday) for 4-6 months, and then assessing the general risk of BON with a serum CTX test, before providing the invasive treatment. If the patient has received IV treatment however, the risk of developing BON is high, and therefore all surgical intervention should be avoided for the rest of the patient's life (at least for now). If a tooth is unrestorable due to caries, then non-surgical root canal treatment and crown amputation is preferred over extraction. Restoration with removable prostheses is acceptable in compliant patients, according to Marx.

Figure 1 demonstrates an example patient who had been receiving high doses of an IV bisphosphonates for a malignancy, received a routine extraction for a second molar, and subsequently developed an osteonecrotic lesion associated with the first molar, 1.5 years later. This lesion is chronically infected and draining, has caused morbidity to the point of continuous pain management with narcotic patches, and has only worsened in the last 4 years.

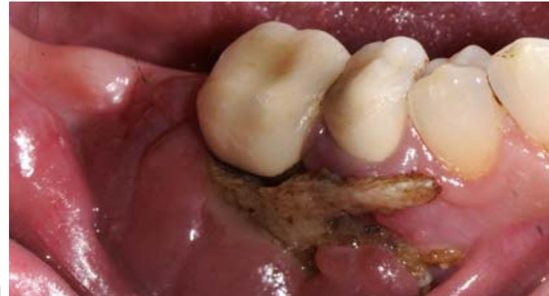
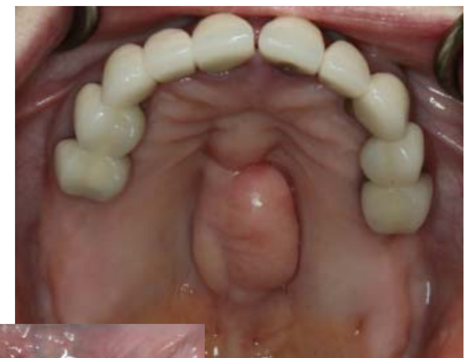


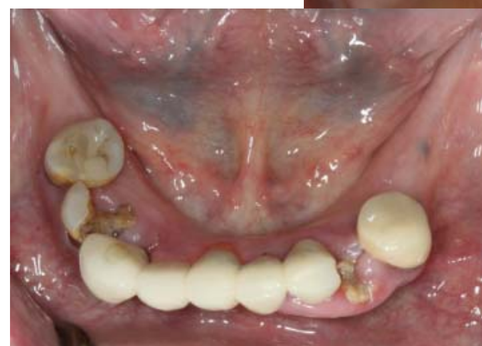
fig 1

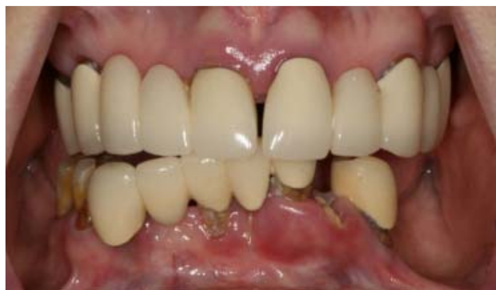
The following is case study illustrates comprehensive treatment of a patient with a near hopeless dentition due to caries, and a 2-year history of treatment with IV bisphosonates for multiple myeloma.

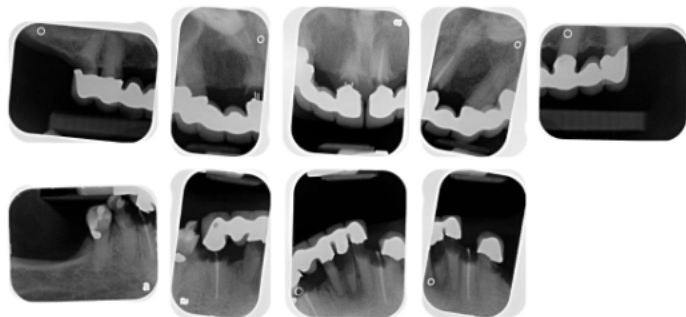
The patient is a 70 year old female who has previous bridge restorations and endodontic treatment which has all failed. Endodontic lesions are also present. View of the maxillary arch demonstrates a very large torus. The ideal conventional treatment in a normal and healthy patient would be full mouth extraction, and prosthetic replacement with conventional or implant retained dentures. If a conventional maxillary denture were to be considered, torus removal would be indicated. In light of this patient's history of IV bisphosphonate therapy, extractions, implant therapy, and torus removal are absolutely contraindicated.

The following photographs and radiographs illustrate the patient's presenting condition:







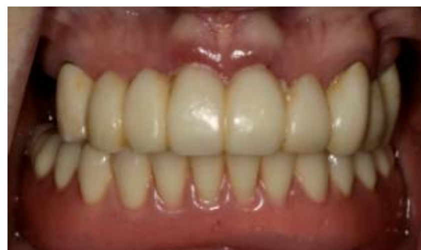


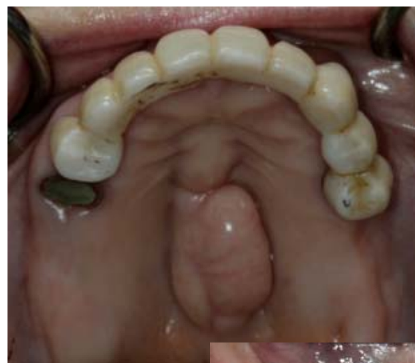
Because conventional treatment was contraindicated, an alternative plan was executed which avoided any surgical intervention. The first step of treatment was disassembly of the failed restorations and removal of all caries. After caries removal, only teeth #5, 11, and 13 were able to be salvaged for potential bridge abutments; all lower teeth were unrestorable for future fixed prosthodontics. The patient received non-surgical root canal treatment for all mandibular teeth which had not previously been endodontically treated, in addition to one upper premolar, by an Endodontist. After RCT was completed, amalcore buildups were placed in all lower teeth slightly coronal to the gingiva.

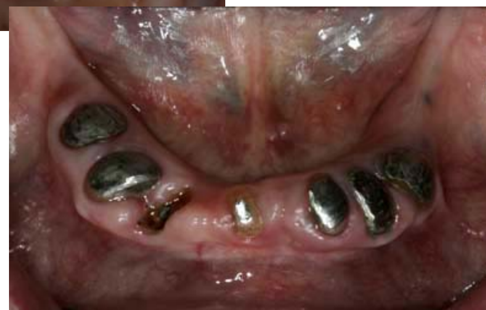
The maxilla was restored with a long span bridge fabricated with heat cured acrylic resin and reinforced with a glass fiber rope. Teeth #5,11, and 13 were used as abutments, and the bridge was luited with a zinc-polycarboxilate cement. Because the patient had experienced such a catastrophic failure due to caries in the past, and still has severe xerostomia from medications, this particular treatment was elected to see if caries control is feasible long term. The bridge span in this situation is longer than ideal, but is the most reasonable option given the circumstances. A porcelain-metal bridge may be considered in the future depending on the patient's ability to control caries. A conventional denture was fabricated for the lower arch, with a cast metal base, to provide the most intimate fit to the teeth and tissues.

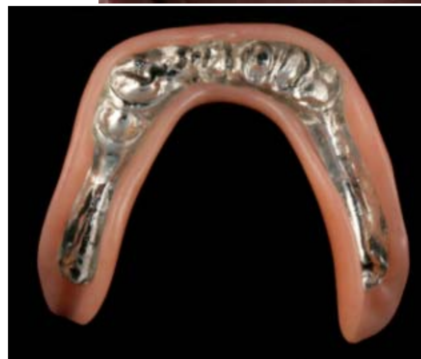
The patient has currently been restored for 6 months with successful esthetics and function, and without any additional breakdown from caries. An aggressive home care protocol has been prescribed for caries control including daily fluoride tray use, intermittent use of Chlorhexidine rinse (per ADA protocol for high caries), and regular use of xylitol products. A recall interval of 3 months is currently being followed.

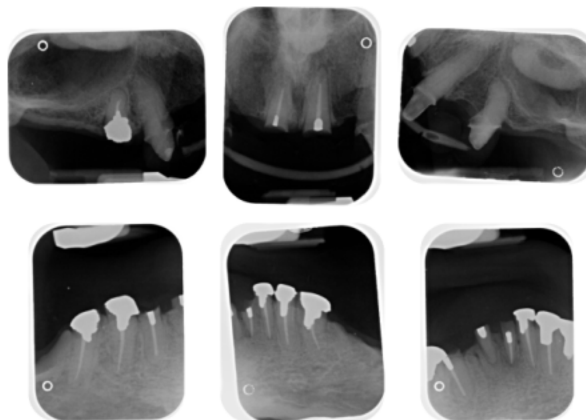
The following photographs and radiographs demonstrate the final treatment:











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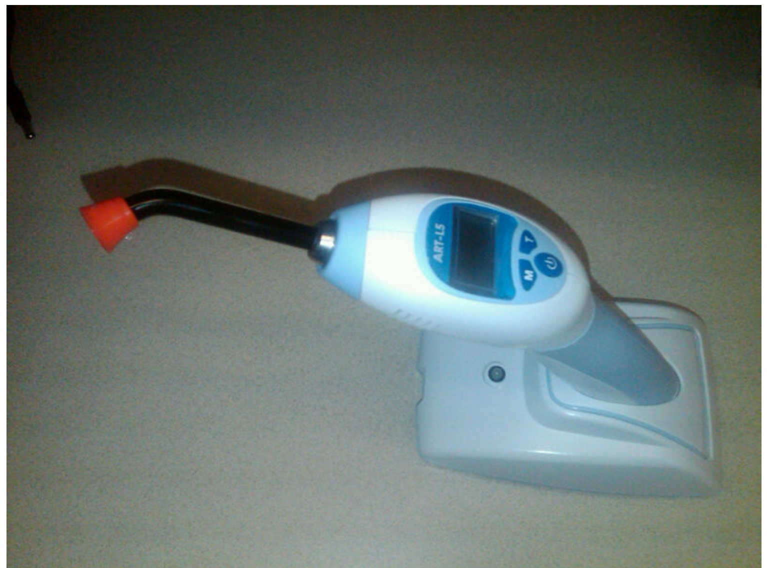
Dental Product Review: ART-L5 Curing Light by Bonart Medical

Story submitted by Dr. Kevin Miltko, Missoula



Every once in a while a product comes out that changes the game. The cordless LED curing light ART-L5 is a game changer. It is priced at $299 and has been recommended by the Clinical Research Foundation (Dr. Gordon Christensen's group) as one of four highest rated curing lights. Its light intensity of 1200mWcm2 allows for 5 seconds of curing time for up to 4 mm depth of A2 composite.

I have used this light for about a month and it is excellent. The light is very light weight and portable. Its eye shield protection works quite well. There are three curing modes: Fast, Pulse, and Ramp. Curing times of 5, 10, 15 and 20 seconds are available. The only part I had to get used to was the button to activate the light is on top of the light and not trigger-style but this was easy to get used to.

This light may be difficult to find as the big supply houses try to unload their stock of $1000-$3000 lights. As stated above, the CR Foundation ranks this inexpensive light equal to better than its pricier competitors. You can see the light at www.bonartmed.com. I purchased mine online and I love it.

Classifieds

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Northwest - Practice for Sale: Experience mountains, rivers and a beautiful valley. This is a quality, fee for service, Family Practice. It is committed to excellence and provides all facets of patient centered care including fixed and removable Prosthetics, Surgery, Endodontics, Pediatric Dentistry and a quality Hygiene program. The growing, active community, has excellent schools, a hospital and is close to a University and International airport. Hunting, fishing and floating provide a recreational paradise. Contact: Dr. Don Hanson (406) 862-6260 www.qualitytransitionsdds.com

Northwest - "Paradise." That is where you will think you are when you see the beautiful setting for this practice. NW Montana is legendary for its beauty and outdoor recreation opportunities. Practice is just minutes from lakes, hiking, skiing, hunting, etc. And, the 100% fee for service practice is wonderful too! Four ops, with digital x-rays, laser, and newer chairs – on track to collect $600,000 this year. Doctor refers out pedo, endo, advanced perio, and most extractions, so there's room to grow by keeping these services in-house. For detailed information about this opportunity and others contact Wendy Hirai at ADS Northwest/Consani Seims Ltd. (866) 348-3820. www.mydentalbroker.com

North Central – Low overhead – high bottom line! 100% fee-for-service, exceptionally well-priced, solo practice collecting $485,000. Beautiful area with immediate access to big game and bird hunting, fishing, hiking, golf and water sports. Rural area readily accessible to larger community and good shopping amenities. Three ops with opportunity to expand. For detailed information contact Wendy Hirai at Consani Seims Ltd. (866) 348-3820. www.mydentalbroker.com

Western Montana - A great opportunity in the surrounding beauty of the Rocky Mountains. This family Practice offers a wide cross section of dental care plus a well trained, versatile staff with many years of experience. A perfect setting for the outdoor enthusiast (rafting, hiking, hunting, fishing and golfing nearby). The community has excellent schools, hospital, museum and public library. East, Interstate drive to a large University, international airport, cultural and sporting events. Reply in confidence to Dr. Don Hanson (406) 862-6260 www.qualitytransitionsdds.com

Helena - Associate wanted in well-established very active, six operatory practice in new facility. Accepting curriculum vitaes of dentist to associate with intention to buy. Helena, located in Western Montana , is home to some of Montana's finest outdoor sports, including fishing, skiing, and hiking. It is a great family-oriented community with excellent schools. Contact Dr. Eddy Crowley at 406-459-6141 or 406-442-0282. Email maryc@bresnan.net.

Southwest - New Listing in area of high demand. Solo practice is collecting $600,000 and has 3 ops with room for 4. The atmosphere is fun and friendly, with a highly cohesive staff and a high number of new patients each month. Owner refers out very little and has computerized ops and digital radiography. Walk away sale – available immediately. For detailed information contact Wendy Hirai at Consani Seims Limited – 866.348.3820.

Billings - Oral Surgery Practice. **Flexible opportunity to associate, lease or purchase.** State-of-the-art oral surgery practice in the economic hub of Montana. The 5,000 square foot building was built and equipped just four years ago and is located in a highly visible medical/dental business park. The practice is in a high traffic area which is experiencing tremendous commercial and retail growth. Collections for 2009 were $1.2 million with a strong, loyal referral base. For detailed information about this opportunity and others contact Wendy Hirai at ADS Northwest/Consani Seims Ltd. (866) 348-3820. www.mydentalbroker.com

Eastern Montana - A $1.3 million practice opportunity. Incredible return on investment - great schools and community activity. Fund your retirement early in your career. AFTCO - Ed Butcher, 406/462-5615. www.aftco.net

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For Sale: Sirona Orthophos XG3 digital panoramic machine. Barely used. Works beautifully. Crated and ready to ship. $13,000. Phone 406/437-1294, Jason Fleishmann

Wanted to Purchase: A used digital panoramic machine for our community clinic, or can take a film panoramic machine for conversion. Phone 406/922-0881 or 406/587-2779. Dr Joanna Wales.

Both winter scenes were submitted
by Shawn Modula
who is the husband Missoula dentist,
Dr. Annette Dusseau.
Above is a Bighorn Sheep
and on the right is Snowbowl ski area.

Dental Datebook

2011

January

13-14 Billings Mid-Winter meeting.
Thurs. Dr. Lorne Lavine, and Friday Dr. Duane Shafer

March

11 Montana Board of Dentistry Meeting

25 MDA sponsored CDE, Dr. Bill Costerton, "Biofilm", Great Falls - Holiday Inn

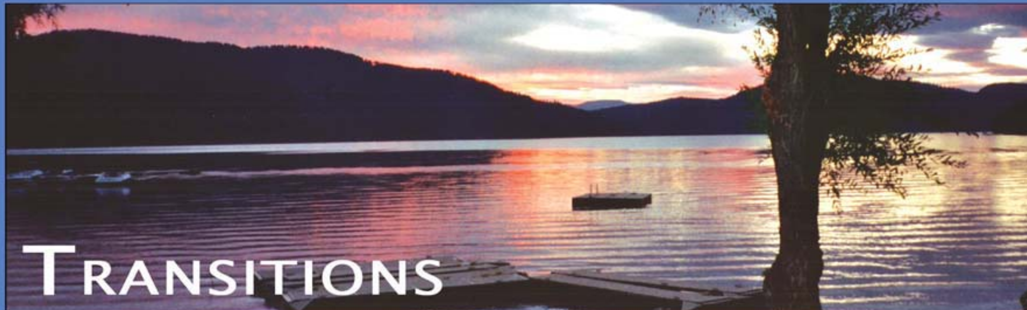
May

5-6 MDA annual meeting, Helena, Red Lion Colonial Hotel, Featured Speaker, Dr. Stanley Malamed, "Medical Emergencies in Dental Practice". Further details TBD.

2012

April

25-27 Montana Dental Association annual meeting. Missoula, Montana.
Thursday, April 26 - Dr. Gordon Christensen "The Christensen Bottom Line"



Do you have a plan?

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