2005 Meeting Features Three Great Speakers

MDA’s annual meeting for 2005 will again be held at the Red Lion Colonial Hotel in Helena. Dentists and staff will learn how to use new dental materials, successfully navigate relationships with their patients, and understand how to deal with a biologic terror attack.

Dr. Ed Swift will address the meeting on Thursday, May 5, on a wide range of dental materials. He received his D.M.D. degree from the Medical University of South Carolina and master’s degree in Operative Dentistry from the University of Iowa. He is currently professor and chairman of the Department of Operative Dentistry at the University of North Carolina School of Dentistry, Chapel Hill, North Carolina. Dr. Swift is actively involved in dental materials research, particularly in the area of dentin bonding and other aspects of adhesive and esthetic dentistry. He also maintains a part-time intramural practice devoted to restorative and esthetic dentistry.

Dr. Swift says, “When we were in school, most of us found dental materials to be one of the most boring subjects we were forced to take! However, most practicing dentists have developed a great interest in this topic. Unfortunately, the development of new materials has proceeded so rapidly that many clinicians are left confused by the wealth of new products that are available in many different areas.”

His course will present the latest information available on dentin bonding systems and composite resins, particularly those intended for posterior use. Newer categories of materials - such as self-etching adhesives, flowable composites, and micro-hybrid composites - will be included in the presentation. The presentation will also cover two of the less glamorous - but most important - areas of dental materials: cements and impressions. As most clinicians realize, getting these things right is important to the success of our routine indirect restorations and esthetic cases.

Finally, the presentation will provide an update and overview of tooth whitening. Although bleaching has become commonplace, new information and products are available at patient demand increases.

On Friday, May 6, Dr. Mark Hyman will present “Drill ‘Em, Fill ‘Em & Thrill ‘Em”, a fast-paced, humorous course designed to help dentist and staff focus on effective handling of patients.

Mark Hyman, DDS, a native of Greensboro, received his undergraduate degree from the University of North Carolina at Chapel Hill and his dental degree from the UNC School of Dentistry. Following an internship in Israel, he completed the two-year oral medicine/general practice residency at UNC Hospital in Chapel Hill. Dr. Hyman is on the surgical staff of Moses Cone Health System. He was elected president of the Guilford County Dental Society in 1991. He teaches at the Pankey Institute in Key Biscayne.
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**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, email MDA at mda@mt.net or call 1-800-257-4988.

**Question:** How do the new federal overtime regulations that became effective in August 2004 affect my dental office?

**Answer:** The new workplace regulations, adopted in a flurry of controversy, redefine the overtime exemptions. In general, depending on how the Department of Labor and courts interpret the new rules, the responsibility of dental practices to pay overtime in certain circumstances is narrowed.

As background, the Federal Fair Labor Standards Act has always required as a general rule that employees in the U.S. be paid at least the federal minimum wage for all hours worked. Overtime is paid at time and one-half the regular rate for hours worked in excess of 40 per week. The law has always exempted certain employees from this overtime rule. Under the new regulations, two tests must be met for an employee to be exempt from the overtime requirement. The first test examines the payment amount and the second examines the employee's duties and responsibilities to determine if the employee fits within the learned professional, executive, or administrative category.

The payment amount test provides that for an employee to be exempt he or she must earn not less than $23,660 per year on a salary basis. The second part of the test examines job duties: if an employee's duties are such they can't be categorized as a learned professional, executive, or administrative employee, they must be paid overtime.

For dental offices employees, dentist employees would be considered learned professional employees. Therefore, if paid at least $23,660 per year, they would be exempt. An office manager paid on a salary basis at least that amount would be exempt if the job duties put him or her in the executive or administrative employee category. Generally, the focus is on whether he or she exercises discretion and

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For answers to other legal questions, the ADA Legal Adviser is available free to members through ADA.org, the Association website. The Legal Adviser provides a broad range of information about how different laws apply to dentists and the dental profession. The articles are written by lawyers who understand the needs and concerns of dentists.
2005 Meeting continued from page 1

Florida, is an adjunct associate professor at the UNC School of Dentistry, and has lectured at many national and international dental meetings.

Dr. Hyman will offer insight on the critical issues involved in handling new patients, making certain the time you devote new patients is productive, and keeping your team focused and enthused—even when things go wrong.

Friday will also feature a second speaker, one familiar to MDA dentists and staff, Dr. Michael Glick, who will offer a course on bioterrorism. Dr. Glick is professor and chair Department of Diagnostic Sciences at the University of Medicine and Dentistry of New Jersey. He is the newly-appointed editor of The ADA News and is a diplomate of the American Board of Oral Medicine. Dr. Glick has authored numerous publications on the treatment of medically complex patients and has lectured extensively on this subject both nationally and internationally.

He states, “The tragic event of 9/11/01 propelled us into a new era of terrorism fought on our own soil. Worries about terror assaults with biologic agents quickly lead the federal government, together with both the medical and dental communities to proactively initiate educational campaigns to enable an appropriate response in case of an attack. Categories of potential agents were defined; literature was generated by professional organizations, federal agencies, and the military; and conferences were organized to gain and share information.” This seminar is designed to help dental healthcare workers to understand the effects of a biologic terror attack, the professional role of dentists during a potential attack, and how to prepare for such a scenario.

Dentistry and the Law continued from page 3

independent judgment in their job duties. Dental assistants are most likely not exempt from the overtime pay requirement. The typical job duties of an assistant do not fit within the executive or administrative employee category. The duties and responsibilities of a dental hygienist who have completed four academic years of pre-professional and professional study place him or her in the learned profession category. If your dental hygienist meets the education requirement of the law and is paid on a salary basis in an amount greater than $23,660 per year, he or she would be exempt from the overtime pay requirement. But many dental hygienists would not be exempt from overtime because they would not meet the four-year academic requirement.

Welcome to New Members

Justin D. Simmons, D.D.S.
Stacey L. Simmons, D.D.S.

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, Montana Dental Association, P.O. Box 1154, Helena, MT 59624.
In my 21 years of dentistry I have heard one subject discussed in many different ways. It seems to go round and round and has consistently caused griping, grumbling, and discourse among dentists in Montana. The subject I am talking about is provision of dental treatment for Medicaid patients across the Big Sky. There are rumors and misunderstandings that have caused some confusion among all dentists in Montana and this article is designed to stimulate conversation and continuity amongst us all. Ethically, this is an issue that affects all of us, whether we take part or not.

In the last issue of The MDA News, the column “Dentistry and the Law” addressed the issue of whether dentists may limit the number of Medicaid patients they serve. Traditionally, a lot of dentists thought that if they treated one Medicaid patient they had to throw open their doors for all Medicaid patients to be treated within their office. As you read in the column, this is not the case. You can customize your practice to accept and provide service for as many patients as you like so long as you do not discriminate based on one of the protected classes of Montana citizens. The healthy part of this legal principle is that it should stimulate more dental practices to provide treatment for Medicaid patients. It is good for the overall practice of dentistry. If everyone contributes a little of his or her time to serving Medicaid patients and spreads the load, the ultimate win-win for our profession is obvious. I challenge you all to do some part.

Our District Four Dental Society has a few examples of how different dentists have customized their practices. A few include:

- one Medicaid patient per day;
- four Medicaid patients per week;
- 5% of patient load, based on time;
- 5% of patient load, based on income.

Advantages of us all doing a little bit or as much as you like are to spread the load so that our city-county health departments and volunteer centers can truly treat their most needy. In addition, emergency rooms and emergency calls would not be overwhelmed with Medicaid patients. We would all feel better as a profession and provide treatment in a preventive and more aggressive manner. Finally, continuity among all dentists would be our ultimate win. For years I have heard talk, not only among dentists but especially staff between offices that develops into resentment. This concerns me.

The only excuse I can see for not providing treatment for your occasional Medicaid patient would be the proverbial “no show” appointment. This is an easy problem to handle. In my office we advise patients who miss appointments that they will not be seen in our practice again. It is done at the time the original exam or quick check is scheduled. This type of appointment has minimal time involved and only requires good verbal skills of your scheduling coordinator. So long as all patients are treated consistently, you may limit Medicaid patients in this manner.

We are lucky that we in the business of dentistry can still dictate how we prefer to handle certain situations. Others in healthcare are not so lucky. If we do a good job regarding the above issues then we can continue to map our own course. One last note is that as general dentists this is an easy hurdle and should be a “no brainer.” Specialists, such as oral surgeons, endodontists, and periodontists, have a more difficult situation, but do have the same freedoms customizing their roles within their specialty.

I would challenge you to take some role in treating Medicaid patients. Do a little on your part. Do not judge how much or how little others participate, but spread the load for all of us. It’s kind of like your January 1st resolutions in deciding to do things to better yourself, such as getting more exercise. If you do a little consistently, the impact on your overall body is healthier and you not have to exercise all the time. Let’s all do our part and the overall health of Montana patients and dentists within our healthcare system will be improved.
In 2003 Congress created a new opportunity for group health plans when it enacted the medical drug benefit law. A component of the bill created what are called High Deductible Health Plans (HDHP). A HDHP is simply a major medical insurance policy that has a high deductible. The Montana Dental Association group health insurance plan now offers a high deductible plan.

Under the law, for 2005 the deductible must be at least $1,000 for an individual but not more than $5,100, and at least $2,000 for family coverage but not more than $10,200. The only benefits that can be paid without imposing the deductible are a limited number of preventative or wellness benefits. The IRS and U.S. Treasury Department have provided guidance relating to the design and administration of qualifying HDHPs and in Montana, the state mandated health insurance benefits that might otherwise disqualify a policy from meeting the strict guidelines of a HDHP have been approved. Prescription drug coverage is available through the HDHP policy, but prescriptions can only be paid after the deductible has been met.

The intriguing component of the new HDHP coverage is not the uniqueness of the benefit coverage, but the fact that individuals covered under an HDHP policy may elect to open a Health Savings Account (HSA). For specific advice for your individual situation you should contact your accountant, but HSA contributions will be eligible deductions for most dentists, who previously could not participate in a Flexible Compensation Plan (Flex plan or Section 125 Plan).

Contributions to an HSA can come from either the employer, the employee, or both. HSA contributions are limited to the amount of the HDHP deductible subject to an upper limit. For 2005, the maximum annual HSA contribution for an eligible individual with self-only coverage is $2650. For family coverage the maximum annual HSA contribution is $5250. Catch up contributions for individuals who are 55 or older is increased by statute from $500 to $600 for 2005. Both the HSA contribution and catch up contribution apply pro rata based on the number of months of the year a taxpayer is an eligible individual, and, with respect to the catch up contribution, the number of months of the year that the taxpayer is age 55 and over.

The MDA Group Benefits Trust (MDAGBT) currently provides the medical coverage to almost 400 dentists and employees. In December, the MDAGBT granted all members a premium holiday. Members did not have to make their December premium payment to the plan.

The MDAGBT is also one of the few plans to make available a HDHP for members. To learn more about HDHPs, HSAs, and the MDAGBT, contact Jim Edwards of Mountain West Benefit Solutions. Edwards is the consultant to the MDAGBT and is available to explain these changes to MDA local dental societies. You may reach him at telephone 1-877-343-1060 or email jedwards@mwbs-insurance.com.

Sure-Way Handles Amalgam

MDA has learned that Sure-Way, in partnership with the State of Montana, has developed a program to handle small quantities of amalgam waste in amounts as small as one cup or in larger amounts, at a rate of $36.00 per pint collected. The new service will be coordinated with the company’s medical waste services. The wastes will be manifested separately to show compliance with disposal recommendations. For information about the new service, contact the company at email address: garywayyn@aol.com.
In Memoriam

Dr. Harry Yunck

Long-time MDA member Dr. Harry Yunck of Great Falls died recently as the result of injuries received in an auto accident. He was 90. Dr. Yunck was born in Cut Bank on October 14, 1914, to William and Marie Yunck, the youngest of three boys. He graduated from Cut Bank High School and earned his DDS degree from the University of Minnesota. During World War II he served as a caption in the United States Army Dental Corps and was stationed in the Aleutians and Europe.

Harry and his wife, Joy, met in Cut Bank and were married in 1942. In 1946 they moved to Conrad where he practiced dentistry for more than 40 years and was an active member of the community. In addition to his membership in the MDA and ADA, Dr. Yunck was a member and former director of the Conrad Chamber of Commerce, past president of the St. Mary's Hospital Board, member and past president of the Pondera Golf Club, and a 50-year member of the Mason Lodge of Conrad. He also was a member of the Great Falls Shrine Club, Cut Bank Elk Lodge, and trustee and elder of the First Presbyterian Church of Conrad.

Dr. Yunck was preceded in death by his wife, Joy. His survivors include his daughters and sons-in-law Judy and Bob of Anchorage, Alaska, and Vicki and Mel Fullerton of Green Valley, Arizona; his son and daughter-in-law John and Moreen Yunck of Tucson, Arizona; and several grandchildren and great-grandchildren.
The MDA Board of Directors and Executive Committee met in Helena on October 15. The following is a summary of the issues discussed and actions taken. If you have questions on any of the items, please contact your local dental society representative to the Board.

1. **Continuing Education:** Dr. Dan O’Neill reported on recent meetings of the MDA Continuing Education Committee. The Committee seeks to contract with the best speakers at the most economical rate. They also try to determine the most beneficial locations for the speakers. Dr. O’Neill inquired whether Board members would recommend that a cap be placed on the amount MDA is willing to spend on a speaker’s honorarium. Board members did not recommend a specific cap.

2. **Dental Benefits:** The Dental Benefits Committee, chaired by Dr. David Dachs of Kalispell, has recommended that MDA retain Jim Edwards of Mountain West Benefit Solutions to market the MDA direct reimbursement program. The Board approved this recommendation. Edwards is the insurance consultant for the MDA group benefits health plan.

3. **Government Affairs:** MDA Delegate at Large Dr. Doug Hadnot reported on activity of the ADA House of Delegates at the 2005 Annual Session. He stated that the financial status of the ADA is positive; they have 41% of the amount of their annual operating budget in reserves. As a result, there will be no ADA dues increase for 2005. Also, the ADA House of Delegates passed a full dues waiver for members temporarily called to active duty in the federal service. House delegates also discussed the development of a standardized national clinical examination for licensure. Mutual acceptance by state licensure boards will have to occur for this to be successful. Dr. Hadnot also related the discussion at the national level regarding the Alaska dental health aide program. ADA leadership is seeking ways to help the Alaska native population access dental care for persons in remote villages.

   Board members reviewed a letter from MDA member Dr. Bert Winterholler, a member of the Montana Tobacco Use Prevention Advisory Board. He encourages MDA member dentists to take a leading role in the development of dental-based strategies against tobacco use. Executive Director McCue stated that the Alliance for a Healthy Montana has asked MDA to join other health care provider groups in supporting the ballot initiative to increase the tobacco tax by $1 per pack. At an earlier meeting Board members voted to not support the initiative. Further discussion of the issue was deferred until Dr. David Johnson is available to participate in the discussion.

4. **Medicaid Funding and Reform:** MDA president Dr. John Smith led discussion of Medicaid funding issues. He asserted his hope that the ADA would develop viable ideas for reform of the program. The proposal prepared by ADA describes changes to several other state Medicaid programs that have had mixed results. Board members expressed consensus that the problems with the state Medicaid program were long-standing; parents ultimately must be responsible for ensuring their children properly care for their teeth and get needed dental treatment. Following discussion Board members recommended that the MDA seek an increase in funding for the state Medicaid dental program. Members also voted to form an ad hoc subcommittee to address long-term Medicaid reform within the state.

5. **Ethics:** Dr. Chris McDonald led discussion on the need for MDA to encourage and promote high ethical standards for its members and maintain dentistry in high regard with the public. He voiced concern about the lack of truth in some dentists’ business advertising. The Board discussed the fact that advertising is permissible and legal; however, the ADA Principles of Ethics and Code of Professional Responsibility prohibit dentists from advertise that their services are superior to other dentists unless they can produce proof of superiority. If an MDA member dentist violates the ADA Principles and Code, other members could discuss the issue with the offending dentist, report the problem to the MDA Ethics and Peer Review Committee, or file a complaint with Board of Dentistry.

   Following the discussion of ethics issues, board members agreed that MDA will: periodically review members’ advertising; ask MDA-sponsored continuing education speakers to include discussion of ethics in their course topics; publish articles on ethics issue in the MDA newsletter: encourage the ADA to urge dental school to
include discussion of ethics in core curricula; encourage dental schools to assess applicants’ ethics when determining eligibility for admission; monitor disciplinary action of the Montana Board of Dentistry regarding disciplinary that has ethical implications; and have the Ethics and Peer Review Committee meet more frequently.

6. **Dental Assisting:** Following discussion of the need to encourage persons to consider dental assisting as a career, Board members directed MDA to promote high school dental assisting work-study programs and educate high school guidance counselors on the dental assisting profession. Ad hoc committees were formed to promote these issues and to explore alternative methods of training dental assistants.

7. **The 2005 proposed budget** was adopted as submitted.

8. **RIDE Program:** Following discussion, Board members voted to introduce legislation in the 2005 Montana Legislature to appropriate $10,000 for study of the University of Washington’s proposal regarding a regional dental education program.

9. **Non-dues Revenue:** The Colorado Dental Association has reported that 10% of MDA members have inquired about Cardservice-MDA, the endorsed credit card processing program and numerous dentists has enrolled. CDA also offers an NSF check collection service. Members agreed NSF checks are not a significant problem; they will revisit the issue in the future. Mary reported that a Missoula-based telecommunication bill monitoring service has approached MDA for possible endorsement. The company examines telecommunication systems and makes recommendations on possible savings. Dr. Smith asked for several Missoula-area dentists to try the service to determine if they could realize significant savings and report back to the board.

10. **ADA Product Endorsement:** Executive Director Mary McCue reported that the ADA has unbundled their endorsement package and no longer requires a constituent society to endorse all products as a package. Members voted to endorse the ADA-sponsored products that members are currently using.

11. **National Museum of Dentistry:** Following discussion centered largely on the cost involved, members voted to decline an offer to participate in the museum.

12. **Future Annual Meeting Sites:** Board members voted to host the 2006 annual meeting in Kalispell and directed staff to explore Missoula as the site for 2007.

**Help Line for Dentists Insured by Cincinnati Insurance**

For MDA members who contract for their professional liability insurance from Cincinnati Insurance, the company endorsed by MDA, help with potential liability questions is available from the company and insurance agency that markets the product in Montana.

Dentists with questions about their professional liability in specific circumstances may seek help by calling Mike Terrell of Cincinnati at 1-513-870-2361 or Nate Allie of Payne Financial Group in Billings at 1-800-877-0115. Before you allow a situation to develop into a legal claim, seek expert advice on how to proceed. Mike Terrell and Nate Allie can advise on the best course of action to pursue.

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**Jonathan D. Morgan, D.D.S.**

has joined the practice of

**Steven J. Burt, D.D.S.**

_Evanston, Wyoming_

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Montana’s 2005 Legislature Convenes

On the first Monday in January the 2005 Montana Legislature convened in Helena. One hundred fifty lawmakers, including MDA member dentists Dr. Don Roberts of Billings and Dr. Bill Jones of Kalispell, will address the business of the state for 90 legislative days. The Montana Dental Association also will be there to represent the interests of members of the dental profession and their patients, to improve the health of all Montanans.

MDA has several priority issues this 2005 legislative session.

**Funding for Medicaid dental services:** At the top of the list is increased funding for the state Medicaid dental program. Over the past two years the program has suffered reductions in services due to the Legislature’s past failure to fully fund the program. For a period during the past biennium the adult dental program was suspended, except for emergency care. MDA, along with other health care advocates, will urge the 2005 Legislature to fully implement I-149, the 2004 Healthy Kids Healthy Montana tobacco tax increase. A portion of the tax increase is intended to fund increases in the Medicaid program and MDA will advocate that part of the tax be spent on increases for dental services.

**Funding for the Donated Dental Services Program:** Since the inception of the Montana Donated Dental Services Program the state has helped to fund the administrative costs of the program. So far this fiscal year Montana dentists and dental labs have donated $12 worth of care for every dollar spent by the state. This is the highest ratio of donated dental care among the 34 DDS programs nationwide! MDA again will urge the Montana Legislature to appropriate $25,000 per year for the administrative costs of the program so that Montana dentists can continue to serve the most vulnerable among Montana’s citizens.

**Funding for dental hygiene education program:** MDA will monitor the state’s university budget to ensure it includes adequate funding for the dental hygiene education program.

2005 Legislature ... continued on next page
program at the MSU-Great Falls College of Technology. Last biennium Montana legislators appropriated $470,000 for the program.

**Appropriation of $10,000:** MDA will support a bill to help fund a study of the University of Washington’s proposal for a regional dental education program.

In addition to these funding issues, the Montana Dental Association will monitor other bills of interest to dentistry. These include proposals to reform medical malpractice laws, regulate Blue Cross Blue Shield, offer tax incentives for health insurance plans, and regulate licensure of the professions.

As a member of MDA you can help support the association’s priority issues by contacting your legislators when called upon to do so. You are also invited to visit the 2005 Legislature on Friday, January 21st and Saturday, January 22nd, during MDA Dental Days at the Legislature. On Friday afternoon MDA members will tour the Capitol to visit with legislators. That evening MDA dentists will host a reception and dinner for legislators at the Helena Red Lion Colonial Hotel. On Saturday morning MDA will also host a breakfast at the Colonial for legislators and present a program to inform them about the progress dentistry has made this century and explain MDA’s issues for 2005.
We all know that our population is aging. With an aging population, we are becoming increasingly aware of the many health conditions that affect our senior patients. One of the more-commonly recognized problems is that of Alzheimer’s disease and other late-life dementias.

Just how big is this problem? It has been stated that over 4.5 million Americans will be afflicted with some form of dementia in 2004.\(^1\) In Michigan, an estimated 220,000 persons suffer from dementia.\(^2\) And, seven out of 10 individuals with dementias live at home, where friends and family provide nearly 75 percent of their care.\(^3\)

There is a very high probability that some of our patients will develop dementia, and that families and friends of demented persons will seek our help in providing care for them. Therefore, being knowledgeable about the management of patients with dementias is important to the dental profession.

Consider the following case. Harriet is a 73-year-old with Alzheimer’s disease. She has been regular in her visits to the dental office until 18 months ago, when she entered an assisted living facility. About three months ago, she lost the ability to brush her own teeth. The loss of a crown precipitated an emergency, because she was so uncomfortable that she refused to eat. A panoramic X-ray revealed extensive decay in a heavily restored dentition.

What questions come to mind as you consider this X-ray? You may ask: What teeth can be salvaged? Should all remaining teeth be removed in favor of complete dentures? Should the salvageable teeth be restored with endodontics and fixed prosthodontics? Can I manage this patient’s behavior in my office? To whom can I refer this patient for care?

A similar patient may present to your office tomorrow. Therefore, it is incumbent on dentists and their staffs to be knowledgeable about current treatment approaches and recommendations regarding the provision of oral health care. The purpose of this article is to provide an overview for dental professionals to encourage successful management of these patients in their practices.

**JUST EXACTLY WHAT IS DEMENTIA?**

Dementia is not a disease in itself, but a group of symptoms that often accompanies a disease or condition. Dementing conditions represent diseases and illnesses that are some of the most prevalent, serious and expensive health problems facing society.\(^4\) There are over 70 different disorders that can cause dementia, some of which are treatable or curable, while others are less responsive to treatment.\(^5\) Table One lists dementias that are treatable and those that are less-responsive to treatment or are incurable.

The exact prevalence of people with dementia in the United States is difficult to determine. Many diseases or conditions that cause dementia have an insidious onset and may be confused with normal aging changes. The affected person and/or family may be unaware that there is a disease, so no medical attention is sought. Even when health care providers examine patients, without extensive testing many of the reversible causes of dementia can be overlooked. In some cases, the disease is not even noted.\(^6\)

Alzheimer’s disease (AD) is the most prevalent form of dementia and is considered progressive and incurable. Evans and colleagues in the East Boston region of Massachusetts have studied the prevalence of AD.\(^7\) Their study determined that 10.3 percent of the persons aged 65 and older met the clinical criteria of probable AD. The prevalence of the disease increased with age of the group: 3 percent for persons age 65-74, 18.7 percent for those 75-84, and 47.2 percent for those age 85 and older.

The cost of caring for a patient, either at home or in a

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<tr>
<th>Dementias (Incurable/progressive)</th>
<th>Table One</th>
<th>Treatable Causes of Dementia</th>
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<td>Alzheimer’s disease</td>
<td>Medication side effects</td>
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<td>Vascular dementia</td>
<td>Depression</td>
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<td>Frontotemporal dementia (FTD)</td>
<td>Vitamin B12 deficiency</td>
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<td>FTD with Parkinsonism linked to chromosome 17 (FTDP-17)</td>
<td>Metabolic imbalances, including thyroid, kidney, or liver disorders</td>
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<td>Pick’s disease</td>
<td>Certain tumors or infections of the brain</td>
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<td>Supranuclear palsy</td>
<td>Blood clots pressing on the brain</td>
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<td>Corticobasal degeneration</td>
<td>Chronic alcoholism</td>
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Treating Patients ... continued on next page
The human costs for caring for individuals with dementing conditions are incalculable and include both health care personnel and family members who often act as the primary caregivers. Emotional burdens can be tremendous for caregivers, who struggle with symptoms from diseases that have no cure and get progressively worse. The Alzheimer’s Association (www.alz.org) estimates that for every person with AD at least two to three family members see their lives significantly affected by caring for that person.8

On the positive side, new modes of therapy are constantly being developed that can slow or ameliorate the symptoms of AD (and other progressive dementias). The Food and Drug Administration recently approved the drug memantine, which is a new line drug to slow memory loss in moderate to severe state of AD, and will be discussed later in this paper.

DIAGNOSING DEMENTIA

Dementia results from the death or disability of nerve cells that store information in the brain. Since nerve cells are unable to reproduce, unless the damaged nerve cell can be repaired, the information stored on the cell is lost. Dementia patients lose memory (amnesia), communication skills (aphasia), daily living skills (apraxia), and the ability to recognize faces or things (agnosia).9

Since many diseases that can cause dementia can be treated, a comprehensive assessment should be done to evaluate patients with neurologic changes. This evaluation should include a complete health history, thorough physical examination, neurological and mental status assessments, and diagnostic tests including blood studies, urinalysis, electrocardiogram and chest X-rays. Other studies often recommended include: computerized tomography (CT scan), electroencephalography (EEG), discontinuation of medication(s), formal psychiatric assessment, neuropsychological testing, and occasionally, examination of the cerebrospinal fluid by spinal tap.9, 10 All of these tests are done to detect for possible causes of a patient’s dementia.

If all of these tests are normal, than a clinical diagnosis of progressive dementia is typically made. Depending on the type of symptoms, one of the diagnoses of progressive/incurable dementia will be given. Diagnostic accuracy for AD using clinical criteria and the tests described above is approximately 90 percent.9 An important point regarding patients with progressive dementia is that the symptoms of dementia will continue to change over time. Since no two patients are completely alike, differences in symptoms will be inevitable. However, because AD is the most-prevalent form of progressive dementia, some generalities do exist and can be studied. The remainder of this paper will discuss dental management of progressive dementias using AD as the most prevalent example.

DIAGNOSING ALZHEIMER’S DISEASE

Six primary criteria for the clinical diagnosis of AD have been established.11 These are: 1) dementia established by the clinical examination and documented by neuropsychological testing; 2) deficits in two or more areas of cognition; 3) progressive worsening of memory and other cognitive function, such as abstract thinking, judgment, problem solving, language, perception, praxis and ability to learn new skills; 4) no disturbance of consciousness; 5) onset between ages 40 and 90; and 6) absence of systemic disorders or other...
brain diseases that could account for the progressive memory and cognitive changes.

In order to make the diagnosis of probable AD these six criteria must be met. A diagnosis of definite AD can only be made post-mortem by a neuropathologist who identifies specific cerebral changes characteristic for this condition (neurofibrillary tangles and neuritic plaques). Although the cause of Alzheimer’s disease is not known, risk factors include being of advanced age (85 or older), having trisomy 21, having a previous history of severe head trauma, or having a first-degree relative with the disorder.

CLINICAL FINDINGS: SYSTEMIC

The clinical course of AD is usually divided into three stages: an early or mild stage, middle or moderate stage, and late or severe stage.

The early stage is characterized by a gradual and steady deterioration in short-term memory, such as difficulty remembering names, recent events, and conversations; misplacing items; missing appointments; and repeating questions or answers during conversation. Because these mild memory difficulties are often present in older adults in the absence of disease, many of them worry that they are developing Alzheimer’s disease. However, older adults develop an age-associated memory impairment that is generally believed to be a normal aging change. Where pathologic changes apparent in Alzheimer’s disease begin is still not clear, but they tend to be based on a person’s ability to function in society.

In addition to memory loss, someone in the early stage may be unable to tell what day it is, what time of day it is, or where they are. Patients may display less sparkle in the personality, and appear emotionless or less energetic or willing to begin something. In this stage, patients are likely to make errors in judgment, such as making a mistake when driving or getting lost when going to or from familiar places (such as the home of a relative, a store, or doctor’s office). Patients in this stage also have problems with orientation, emotional stability, language capacity, abstract thinking, motor skills, and ultimately, self-care. Patients in the first stage may not be able to think of certain words to use when speaking, have difficulty learning new things, and become easily angered.

More rapid declines in intellectual capacity occur during the middle stage and are characterized by problems with language, abstract thinking, motor skills, and self-care. Patients in the middle stage are less likely to get lost while driving or going to familiar places and are less likely to make mistakes in judgment. However, they may have trouble understanding complex ideas or abstract concepts, and their motor skills may be impaired. Patients in the middle stage also have problems with orientation, emotional stability, and language capacity.

In the late stage, patients are likely to have significant problems with memory, language, and motor skills. They may have difficulty understanding complex ideas or abstract concepts, and their motor skills may be impaired. Patients in the late stage are also likely to have significant problems with orientation, emotional stability, and language capacity.
the moderate or middle stage. Continued progressive cognitive losses may advance from the early stage in as little as a few months or as long as a few years. Patients may develop perceptual problems, such as an inability to recognize themselves in a mirror or images on television. They may find it difficult to carry out purposeful movements such as eating or walking. They also may lose the ability for self-care, such as dressing, bathing, or eating independently. They may hoard items, such as napkins or pencils. Attention may turn increasingly inward, with less interest in or sensitivity toward others. In many cases patients become restless and pace continuously during waking hours. They are easily agitated and may become anxious or tearful. Wandering, especially late in the afternoon or evening, puts the individual at risk of becoming lost if left unsupervised.

AD patients in this stage begin having problems recognizing friends and family members, and have difficulty organizing thoughts and thinking logically. Many AD patients in the middle stage also develop personality changes, such as becoming physically violent or displaying verbal outbursts over minor daily situations.

In the severe or late stage, a person can no longer survive without assistance. Patients have great difficulty understanding instructions or simple language. Eventually they will completely lose the ability to remember and speak, uttering only meaningless phrases or repeating words or phrases endlessly. If asked questions, most patients are unable to respond appropriately and often will respond with the first thing that comes to their minds. An AD person in this stage may become apathetic, disoriented, and unable to walk. Significant body wasting may occur, and there is a tendency for the patient to touch and examine objects with the mouth (hyperorality) as well as a tendency for forced grasping and gripping (hypermetamorphosis). In addition, patients tend to become more anxious, and will display aggressive behavior, develop hallucinations and/or delusional episodes.

Complications from AD in this stage include malnutrition, aspiration pneumonia (due to increased problems with swallowing), pressure necrosis of the skin, and oral/odontogenic problems. In the late stage, patients...
need total care with activities of daily living, such as dressing, bathing, eating, and using the bathroom.\textsuperscript{17}  

To classify AD patients into early, moderate, or late stages, mental status tests are typically used. The best-known and most widely used test is the Folstein Mini-Mental Status Exam (MMSE),\textsuperscript{19} which contains 10 items and a maximum possible score of 30 points. A person is considered mildly impaired (early stage AD) with a score of 18 to 24. If the score is less than 18, this indicates moderate to severe dementia (AD). The MMSE does not require administration by a psychology practitioner. Dental personnel may employ the exam for referral purposes when dementia is suspected.  

The course of the disease varies between people afflicted, but generally there is a gradual progression through the three stages over a period of 15 or more years. For many AD patients, symptoms may seem to plateau for an extended time, but death eventually occurs, typically as a result of an infection that is not identified or cannot be controlled due to a weakened immune system. In 1996, there were 20,900 deaths recorded from AD in the United States, making it the ninth-leading cause of death that year for persons 65 years and older.\textsuperscript{20}  

**MEDICAL TREATMENT**  

Medical treatment of demented patients is managed with the patient’s family’s input and based on thorough psychiatric, neurological, and general medical evaluations.\textsuperscript{21} Although there is no cure for AD, there are several guidelines that outline specific steps in managing patients with AD. These include nonpharmacologic approaches as well as medications used in managing AD patients.\textsuperscript{21,22,23}  

Nonpharmacological therapies include modification of the environment and memory aids. Modifying the environment to provide a calm, non-stressful atmosphere may help reduce agitation. Maintaining a predictable, structured routine is also helpful. In the early stage, dementia patients may benefit from memory aids that provide clues that can help them remember important information. Memory aids can be as simple as a list of important telephone numbers or putting up pictures and names of family members and friends.\textsuperscript{20}  

Another important aspect of management is educating the patient and family about the illness, its treatment and available sources of care and support, including the...
Treating Patients with Alzheimer’s ... continued from previous page

Alzheimer’s Disease and Related Disorders Association (ADRSA). Education will help patients and their families plan for financial and legal issues, available sources of care and support, such as local support groups, and alternative living situations, including respite care, nursing home, and other long-term care facilities.

The goal of medications in treating AD is three-fold: retarding disease progression, preventing further deterioration, and/or reducing symptoms. Much of the memory loss and cognitive deficits associated with AD are linked to a lack of acetylcholine, an important neurotransmitter that helps nerves communicate with each other. Currently, four existing drug treatments increase cholinergic function and retard disease progression. These are Cognex (tacrine), Aricept (donepezil hydrochloride), Exelon (rivastigmine tartrate), and Reminyl (galantamine hydrobromide). They are categorized as “acetylcholinesterase inhibitors.” Cholinesterase inhibitors are approved only for use in patients with mild to moderate AD, as studies in patients with late-stage AD have not shown significant clinical improvement. Adverse events associated with these drugs are mainly due to cholinergic effects: urinary incontinence, diarrhea, myalgia, anorexia, ataxia, postural hypotension and bradycardia. Tacrine has also been associated with hepatotoxicity, has a short half-life, cannot be taken with food, and has frequent gastrointestinal (nausea and vomiting) side effects, which makes this drug difficult to use.

The FDA has recently approved a new drug for patients with AD, which works by a different mechanism than the cholinergic drugs listed above. Axura (memantine) blocks the transmission of glutamate, a chemical that is overstimulated in the brains of AD patients. Memantine blocks the N-methyl-D-aspartate (NMDA) receptor and prevents the overstimulation of glutamate. The approval of this drug is significant because it has been effective in reducing the symptoms of AD patients, even of those in the moderate to severe stages. In addition, this drug seems to have very few harmful side effects. Finally, since memantine has a different mechanism, it is thought that use of this drug with AD patients already on cholinesterase inhibitors may be able to provide additional benefits.

Other therapies used for treating cognitive decline in AD patients and other dementias include vitamin E, Selegiline (l-deprenyl) and Hydergine (ergoloid mesylate). Vitamin E has been shown to slow nerve cell damage and death in animal models and cell culture thought to be a result of its antioxidant properties. Vitamin E has been widely used clinically in moderately impaired AD patients in order to delay the progression of the disease. Vitamin E has not been studied in mild or severe AD patients, but given the lack of toxicity, some physicians are also recommending similar doses as for moderately demented patients from 200 to 3,000 IU/day (the typical recommended dose is 1000 to 2,000 IU/day). At high doses, vitamin E has sometimes been noted to worsen blood coagulation defects in patients with Vitamin K deficiency.

Selegiline is a selective MAO-B inhibitor licensed in the United States for the treatment of Parkinson’s disease. It is approved as a dementia medication in some European countries and is used by some physicians in the United States for this indication. The action of Selegiline is unclear, but in several studies it appears that Selegiline may act as an antioxidant or neuroprotective agent. Because it also has effects on catecholamine metabolism, it could also act in other ways. The principal side effect of selegiline is orthostatic hypotension, which has been reported to interfere with some patients’ tolerance of the medication. The dosage is 5 to 10 mg/day that is relatively selective for MAO-B and does not fully inhibit MAO-A, so avoidance of sympathomimetic agents (epinephrine in local anesthetics) is not required. More importantly, adverse effects of medication interactions, including changes in mental status, seizures, and even death have been observed with meperidine (Demerol), SSRIs, and tricyclic antidepressants, and selegiline is contraindicated for patients taking these agents.

A mixture of ergoloid mesylates, known by the trade name Hydergine, is currently marketed in the United States for the treatment of nonspecific dementias. Hydergine has been available for at least 40 years and has been studied in at least 150 clinical trials. In general, these studies suggest that any improvement observed is in behavioral rather than cognitive (mental) measures. However, for patients with vascular dementia, there was better evidence of improvement on both neuropsychological and behavioral measures. Due to the questionable efficacy of Hydergine found by extensive studies, it is not recommended for routine use in treating dementia. However, it may be appropriate to offer a trial of this agent for patients with vascular dementia. Occasionally, ergoloid mesylates cause mild nausea or gastrointestinal upset, but no significant side effects or
toxicity have emerged during long-term use. Hydergine is contraindicated for patients with psychosis.35

Other agents including aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), estrogen replacement therapy, the hormone melatonin, and ginkgo biloba (a botanical agent), have been proposed for the treatment of dementia on the basis of epidemiologic data or pilot studies, but have not been recommended for routine use for dementia or AD patients at this time.39,40,41,42,43

AD patients who experience psychotic symptoms or disruptive behavior are also frequently prescribed antipsychotic agents, such as haloperidol. While moderate doses of haloperidol improve psychotic or disruptive behavior, the risk of extrapyramidal effects or tardive dyskinesia is high.24 Other symptomatic problems such as anxiety, depression, insomnia, and systemic problems prevalent in this age group are also commonly treated with medications, which may lead to drug/drug, and drug/disease interactions. A summary of the medications commonly used in treating patients with dementia, their impact on the oral condition, and precautions for dental providers are presented in Table Two. Oral health providers should always take a detailed medical history and review the medications AD or dementia patients are taking to prevent adverse drug reactions or treat the sequelae of drug side effects in their practices.

## Table Two

<table>
<thead>
<tr>
<th>Category of Medication</th>
<th>Impact on Oral Condition or Oral Treatment Plan</th>
<th>Precautions for Dental Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetylcholinesterase inhibitors (tacrine, donepezil, rivastigmine, galantamine)</td>
<td>Bradycardia; increased gastrointestinal acid; may decrease function of local anesthetics and vice versa</td>
<td>Awareness that bradycardia may be related to medication; nausea and vomiting may occur; caution in administering local anesthetics.</td>
</tr>
<tr>
<td>Glutamate blocking agent (memantine)</td>
<td>None known</td>
<td>None known</td>
</tr>
<tr>
<td>Vitamin E</td>
<td>At high doses (2000 IU/day or greater) may worsen coagulation defects in patients with vitamin K deficiency</td>
<td>Be prepared for possible bleeding in patients with vitamin K deficiency or on warfarin.</td>
</tr>
<tr>
<td>Selective MAO-B Inhibitor (Selegiline)</td>
<td>Orthostatic hypotension; risk of hypertensive crisis if dose &gt;10mg/day; adverse drug reactions: mental changes, seizures and even death</td>
<td>Slow recovery (3-5 min. of sitting up) after laying back in dental chair; if dose &lt;10mg/day, no change in epinephrine needed. If &gt;10mg/day, avoid local w/ epinephrine. Avoid use of meperidine (Demerol) if providing IV sedation.</td>
</tr>
<tr>
<td>Ergoloid mesylates (Hydergine)</td>
<td>Mild nausea or GI upset.</td>
<td>Nausea and vomiting may occur.</td>
</tr>
<tr>
<td>Antipsychotics and behavior-altering drugs (butyrophenones i.e., haldol, benzodiazepines, phenothiazines, tricyclic antidepressants)</td>
<td>Extrapyramidal symptoms (EPS) associated with antipsychotic agents: xerostomia, orthostatic hypotension, cardiac effects, and possible tardive dyskinesia with long-term use.</td>
<td>Recognize risk for orthostatic hypotension and prevent falls by sitting chair upright for 3-5 min; use of fluorides and salivary substitutes if no aspiration risk; when possible, ask physician to change to least-xerostomic drug.</td>
</tr>
</tbody>
</table>
infections, difficulty in mastication (chewing), swallowing, speaking, and taste dysfunction. Demented patients with psychotic symptoms or disruptive behavior are frequently prescribed antipsychotic agents such as haloperidol or antidepressants that have xerostomia as a significant extra-pyramidal effect. This further contributes to increased caries, periodontal disease, oral mucosal pathology (i.e., denture stomatitis) and difficulty with denture retention.

**ORAL CARE RECOMMENDATIONS**

The goal for oral care for AD patients is similar to that for other patients with neurological impairments: “to maintain oral health function and comfort and to prevent and control oral diseases.” As with other patients, dentists should thoroughly assess the patient, develop a treatment plan, initiate dental treatment, and develop a prevention plan. Due to the nature of dementing conditions, each of these steps may require some modification. This will be discussed in the following sections.

**Assessment.** Most patients with dementia will already have been diagnosed with a specific condition or disease such as AD. Patients who present to the dental provider with neurologic changes such as a decline in recent memory, inability to follow directions, or obvious personality changes, should be referred to an appropriate physician, neurologist, psychiatrist or a tertiary medical center depending on availability or expertise in the area. Medical providers should be able to run diagnostic tests that can differentiate reversible from progressive, non-reversible dementias.

In many cases, a patient with a dementia (such as AD) will present to the dental office with a number of existing dental problems, undiagnosed and unreported because of prolonged length since the last visit to a dentist. The first objective is to diagnose existing problems and eliminate any sources of pain or infection.

Diagnosis should begin with a careful medical and dental history including a thorough review of medications. Regardless of the stage of dementia a patient presents with, communication should always take place in the presence of a family caregiver (spouse, children or responsible adult). If the patient is able to understand and respond to questions, the dental provider should address the patient directly. Verbal directions should be presented in short, simple phrases, giving only one direction at a time. It is important to remember that the adult with a dementing condition has a disease and should be spoken to with appropriate respect, not as a child. In moderate- to late-stage AD, it may be appropriate to address the patient by his or her first name instead of the surname, because some dementia patients will forget their own last name, but usually will not forget their first name.

The presence of a family member or caregiver will often alleviate a dementia patient’s anxiety. Because dementia interferes with the patient’s ability to communicate, it is important to have the caregiver’s input, as well as other sources of information (such as a registered nurse, nursing assistant, or medical record if from a nursing home) to verify reported symptoms. For example, perception and localization of dental pain may be distorted in dementia patients. Symptoms of dental pain which are well-known to dental care providers may be manifested instead by a sudden worsening of behavior; moaning or shouting, refusal to do certain things; or increased restlessness. Clinicians, who are trying to determine if there is a dental cause for agitated behavior, must use the AD patient’s baseline behavior as a gauge. The caregiver who knows the AD patient best (spouse, child, nurse, etc.) is the ideal person to elicit specific symptoms that may be an indicator of the presence of dental pain.

Even though dementia patients may be confused, dental providers should avoid speaking about the patient in his or her presence to the caregiver or staff member, as if the dementia patient does not exist, hear, or understand. Even in late-stage AD, patients may have moments or windows of lucidity, when they may understand briefly, with amazing clarity, what is said or done. In addition, nonverbal communication techniques can also have a comforting effect on a dementia patient’s responsiveness. A message of calmness, confidence, and kindness, especially in cases of bizarre or difficult-to-manage behaviors, should be consistently communicated verbally and non-verbally. Some suggestions include maintaining eye contact, firm but gentle touching on the person’s arm or shoulder as a sign of encouragement, and using positive facial expressions with a smile and good sense of humor. Other communication techniques are described in Steps to Enhancing Communication: Interacting with Persons with Alzheimer's Disease, published in 1997 by the Alzheimer’s Disease and Related Disorder Association.

A complete oral assessment should minimally include the following 10 areas: face and neck, lips, inside cheeks and lips, roof of mouth, tongue, floor of mouth, gums, teeth,
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saliva, and dentures/partials. To successfully complete an exam an extraoral mouth-prop (surgical Molt) may be essential to help control the patient’s head position and maintain the oral opening. Panoramic radiographs should be possible in mild-stage dementia patients, but will not be in moderate or severe patients. Dentists who treat patients with progressive dementias should consider purchasing an additional lead apron and a pair of lead gloves to protect the extra person that may be needed to hold a patient’s head still during the exposure of dental periapical or bitewing radiographs.

Treatment planning. In patients with progressive dementia, treatment planning should be done with the expectation of deteriorating oral hygiene and declining ability to maintain natural teeth or complex restorations. The progressive deterioration of cognition can cause agitation, disorientation, and inappropriate behavior, especially in such unfamiliar surroundings as a dental office, and can interfere with the patient’s ability to tolerate most therapeutic interventions. If a patient is seen in the early stage, definitive treatment should be done as soon as possible because of diminishing oral self-care and ability to cooperate. Appointment times should be scheduled when the dental office and waiting room are not busy, so as not to distract and disorder the AD patient. In general, late afternoons are not good appointment times, especially toward dusk, because many AD patients may show signs of “sundowning,” an exaggerated confusion and disorientation that occurs as light levels change and fatigue sets in. To the extent possible, background noise and activity level should be kept to a minimum to reduce agitation.

Caregivers need to be involved at the first visit an AD patient is seen, and every visit thereafter. Whoever the caregiver maybe — spouse, son, daughter, or nurse — should be asked to accompany the patient into the operatory, to sit and converse, or to hold the patient’s hand(s) if needed. The importance of caregiver participation cannot be overstated. As mentioned previously, in most cases, loving caregivers alleviate stress and anxiety experienced by the patient and may also be able to, if necessary, translate the patient’s needs or wants to the dentist. An indirect benefit of having the caregiver present is that the family member recognizes the dentist’s caring approach as well as appreciates the dentist’s struggles when trying to provide good dental care. The caregiver soon becomes another member of the dental team and does all he or she can do to ensure treatment is successful. This becomes extremely important when the caregiver is asked to assume responsibility for the AD patient’s oral health care program.

Another role caregivers play in treatment planning is acting as the legal authority who will sign permission for their loved one to undergo dental treatment. Caregivers of dementia patients in moderate to late stages should be legally appointed (adjudicated) to act as “guardians” who can sign consents for whatever treatment is needed. Note that the consent for an examination, dental prophylaxis, and minor treatment may differ from consent required for more invasive procedures, such as surgery, sedation, and general anesthesia. A review of the applicable state dental laws should be done prior to the appointment.

In many cases, AD patients may not be adjudicated incompetent by the courts, yet clinically they exhibit obviously impaired decision-making capability. Caregiver involvement is critical, particularly when the patient verbalizes difficult, sometimes contradictory wishes. For example, an abscessed tooth requires extraction but what should be done if the AD patient who has not been adjudicated incompetent clearly refuses treatment? Ethical issues involving competency, informed consent, and decision-making capacity are common with AD patients and their families. Each dental situation must be dealt with individually, but should include a careful review of the severity of the oral-dental problem, consultation and communication with all concerned parties (i.e., family members and others on the health care team), and determination of the risk and benefit of the proposed treatment.

Some general guidelines for treatment planning for the most common dental procedures are discussed next.

General Dentistry. In general, time-consuming and complex dental treatment should be avoided in persons with severe dementia. The emphasis should be on keeping patients pain-free and able to maintain adequate nutritional intake, particularly if the patients are no longer able or willing to wear their dentures.

Oral surgery. As long as the patient’s dentition does not compromise physical well-being, oral surgery should be the last resort. Dentists should consider all available conservative techniques, before resorting to oral surgery procedures. Prophylactic extraction of teeth for the convenience of caregivers is not appropriate.
Restorative. Composite restorations for anterior teeth and amalgam restorations for posterior teeth are the accepted norm.63 There is apparently no correlation between the number of amalgam restorations and brain concentrations of mercury.69 Other options that are beneficial for patients at high risk for caries, especially for root surfaces, include resin-modified glass ionomer or compomer (composite/glass ionomer material such as Dyract/Dentsply/Caulk), restorative materials. These materials leach fluoride and also help to protect the tooth structure adjacent to the restorations.63

For dementia patients with extensive loss of tooth structure, the use of stainless steel, polycarbonate, or resin composite crowns may be appropriate. These alternatives allow the retention of teeth with guarded prognosis for a finite period of time or it may provide long-term management solutions in patients in the debilitated final stage of the disease.63

Periodontics. Frequent recall, including scaling and root planing, is the cornerstone of nonsurgical treatment and is appropriate for periodontal maintenance in the dementia patient. For patients who have pocket depths greater than 4 mm, corrective periodontal surgery is usually not an option, since the patient cannot control plaque pre- or post-operatively. Systemic antibiotics, such as metronidazole, may be justified for the treatment of acute episodes of generalized periodontitis if the disease cannot be controlled by home care, scaling and root planing, and if surgical treatment is contraindicated.61 In patients with one or a few sites of deep pocketing, local antimicrobial treatment (doxycycline hyclate; Atrigel, Atridox; Atrix Laboratories) as an adjunct to scaling and root planing may be beneficial.

Dementia patients who have gingival hyperplasia are candidates for gingivectomies but may not be able to tolerate periodontal packs. The use of electrosurgery or laser surgery done in an operating room setting may be an appropriate alternative.

Endodontics. If the indicated tooth is restorable and essential to maintain function, endodontic treatment may be appropriate. If patients are irradiated or are immunocompromised, root canal therapy may be the only alternative therapy to extractions.64

In all patients being treatment-planned, swallowing water or fluids during treatment can lead to aspiration pneumonia, particularly in later, moderate-severe stage dementia patients.21 Procedures involving high volumes of water, (i.e., Cavitron, high-speed handpiece/restorative with water spray) should be avoided, or minimized.

Initiating dental treatment. Dementia patients frequently display symptoms of restlessness, anxiousness, or become uncooperative in an unfamiliar environment. Ideally, the patient should be seen during his or her most-relaxed time of day, and when the clinic is the least hectic (this may be first appointment of the day, or the first appointment of the afternoon). The dental office staff and clinicians should convey a genuine sense of caring and make an effort not to act hurried or rushed. They should use a familiar operatory, or one in which the surroundings look comfortable (such as pictures or home-like decorations), along with decreasing the time the patient spends in the waiting room. If the patient is especially anxious, the dentist should try to determine the cause of anxiety. It may mean the person needs to urinate, or is hungry.6,70

If demented patients become angry or are evaluated as likely to become angry or uncooperative at the evaluation appointment, the dental team should first understand that the anger results from the confusion and manifestation of the underlying disease. In some cases, the dentist may be able to distract the patient in order to change the direction of the anger. The idea behind distraction is to refocus the patient’s energy long enough to allow the completion of the exam or treatment. Demented patients who remain angry or uncooperative are best managed by rescheduling for a time when they can be sedated or during a time of day when they are calmer.70

Physical and/or chemical restraints may be necessary to control voluntary or involuntary movements to prevent injury in dementia patients. Guidelines for physical restraint use, developed by Shuman and Bebeau, are listed in Table Three.67 These 10 guidelines are appropriate for dementia patients to preserve safety and dignity when physical restraints are needed.

For most dental practitioners, oral sedation will be the preferred method to manage anxiety or control undesirable behavior seen in demented patients, particularly those in moderate to late stages. Oral sedatives should be used only after reviewing the patient’s medication and medical history or in consultation with the patient’s physician.64 Consultation with the physician will help identify sedatives currently in use and the best agent and dose to use. All oral sedatives are unpredictable, in that the pharmacokinetics...
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(absorption, distribution, metabolism, and excretion), vary from person to person, and what works for one person, may not work for another. Given this constraint, Table Four summarizes a recommended approach for oral sedation use in the management of behavior problems seen in dementia patients.44

In general, benzodiazepines are the best choice for oral sedation in dementia patients who do not have a standing order for an anxiolytic medication. They have very predictable sedative effects in most patients; they have skeletal muscle relaxant properties, are anticonvulsants, and have a wide safety margin between therapeutic and toxic doses. Finally, benzodiazepines do not produce clinically significant hepatic microsomal enzyme induction and do not interact with other drugs, as do many other drug classes.71 For any sedative drug given, pre-and postoperative vital signs should be taken and the patient and caregiver should be cautioned about drowsiness after the sedation and dental appointment as well as the increased risk of the patient falling.70 Monitoring, training, and licensure will impact the utilization of oral sedation in clinical dental practice.44

Intravenous conscious sedation is the best alternative available to treat uncooperative demented patients in the moderate to late stages if trained personnel and monitoring equipment is available.44,70 Advantages include the most rapid onset of action, ability to titrate the drug to effect, predictable blood levels, shorter duration of effects, and immediate access to treat complications.71 The disadvantages are obvious in that venipuncture is necessary, venipuncture complications can occur, more-intensive monitoring is required, reversal of intravenous agents is not instantaneous, and more expensive malpractice insurance may be required. In addition, complications associated with intravenous sedation can also occur, such as respiratory depression, cardiac rhythm disturbances, and possible nausea or gastrointestinal disturbances.71 The techniques for IV sedation are beyond the scope of this article. Readers are encouraged to become certified/licensed in their state if they are interested in providing dental care to dementia patients using intravenous sedation.

For some moderate- to late-stage dementia patients, intravenous sedation may not be enough to control the movements or agitation that occurs. For these patients, general anesthesia or deep sedation may be needed. Training and hospital privileges are needed before dentists can see these patients in the operating room in the hospital, surgical centers, or ambulatory care facilities where these patients can be managed with the help of anesthesiologists and trained medical professionals.

Table Four
Recommendations for Oral Sedation

For patients already taking oral sedatives for anxiety or cooperation problems:
- schedule dental treatment to coincide with the regularly scheduled drug dosage;
- if scheduled drug is a PRN (take as needed), order this before dental treatment;
- consult with physician about increasing the dosage of the scheduled drug prior to dental procedure if you have tried the drug at regular dose without success.

For patients not taking an anxiolytic/antiagitation medication, a short acting benzodiazepine can be used. The two recommended benzodiazepines are:*
- Triazolam/Halcion — Dose: 0.125-0.5mg; onset: 0.5-1.5 hours; half-life: 2-3 hours;
- Lorazepam/Ativan — Dose: 0.5-2 mg; onset: 1.5-2 hours; half-life: 10-20 hours.

For those who are allergic or have an adverse reaction to benzodiazepines, an alternative drug which has the same effect as Triazolam, but works by a different mechanism is recommended:
- Ambien (Zolpidem) — Dose: 5.0-10 mg; onset: 1.5 hours; half-life: 2.5 hrs.

*Oral sedation agents should be tried at the lowest dose. If not effective, then the dose can be adjusted upwards at another visit after consultation with the patient’s physician, until the desired effect is achieved. If oral sedation is still not effective after a number of visits, then parenteral (intravenous) conscious sedation may be indicated.
In general, management approaches should be attempted using the least-restrictive and least-invasive techniques first. Not only are less-invasive techniques generally effective, but also they are more widely available to general dental practitioners, and they can be used long-term for general dental treatment as well as recall appointments.

**Prevention.** Since the most-significant dental problems of patients with dementia result from a progressive decline in oral self-care ability, there is an increasing dependence on caregivers to provide oral hygiene. For this reason, during the time when the patient is in the early stages of the disease, the caregiver (whether family member or nurse) should be trained to provide daily oral hygiene.7 2 The dental team needs to explain to the primary caregivers that as the dementia progresses, the caregiver will eventually need to assume the oral hygiene role completely.

Initially, the caregiver may have a very small role in treatment planning or oral care.

A number of specially adapted products are available for patients with disabilities, and two are particularly useful in neurologically impaired or dementia patients. A foam mouth prop called the Open-Wide Plus (Specialized Care Col, Edison, N.J.; 800/722-7375) is designed for caregivers to use to keep the mouth open during oral hygiene or for lengthy procedures. The prop has a unique design of high-density foam that is safe and comfortable for the patient. Although disposable, one mouth prop can last for 50 to 100 uses, is dishwasher-safe, and inexpensive.

A specialized toothbrush, called the Collis Curve (Collis Curve, Inc., Brownsville, Texas, 800/945-6665) has been designed with three rows of bristles that, when placed correctly, can clean the lingual, facial, and occlusal surfaces at the same time. The technique required with this brush is a simplified scrub motion, and caregivers may find this brush simpler to use than either conventional or electric brushes.

Electric brushes such as the Rotadent (Pro-Dentac, Batesville, Ark.), Sonicare (Sonicare, Snoqualmie, Wash.) and Interplak (Bausch and Laumb, Eatontown, N.J.), are helpful for patients who have limited dexterity. Unfortunately, AD patients are generally unable to use these brushes effectively in moderate to severe stages, although caregivers may still find them helpful.

Other conventional products (see Table Five), may be helpful for the caregiver in maintaining oral hygiene and preventing dental diseases. For cleaning between the teeth, an interproximal cleaner such as a proxybrush (Butler, Chicago, Ill.) may be easier to use by caregivers than floss or even floss-holding devices, since proxybrushes do not require fingers to be placed intraorally.

The use of fluorides through toothpaste should be part of the daily oral hygiene protocol, although only a small

### Table Five

**Preventive Products Useful in AD Patients**

<table>
<thead>
<tr>
<th>Product category</th>
<th>Indication</th>
<th>Example of product</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mouth-prop</td>
<td>Help hold mouth open</td>
<td>Open-wide Plus</td>
<td>Specialized Care Co.</td>
</tr>
<tr>
<td>Modified tooth brush</td>
<td>Removes plaque on teeth</td>
<td>Collis-curve Brush</td>
<td>Collis Curve Inc.</td>
</tr>
<tr>
<td>Electric brush</td>
<td>Removes plaque on teeth</td>
<td>Sonicare sonic toothbrush</td>
<td>Sonicare</td>
</tr>
<tr>
<td>Interproximal brush</td>
<td>Removes plaque between teeth</td>
<td>Proxy-Brush</td>
<td>Butler, Inc.</td>
</tr>
<tr>
<td>Fluoride rinse</td>
<td>Prevents dental caries/decay (must be able to swish/spit)</td>
<td>Fluorigard (0.5% NaF) (OTC)</td>
<td>Colgate</td>
</tr>
<tr>
<td>Fluoride gel</td>
<td>Prevents dental caries/decay</td>
<td>Prevident (1.1% NaF) (prescription)</td>
<td>Colgate</td>
</tr>
<tr>
<td>Fluoride varnish</td>
<td>Prevents dental caries/decay (applied by dentist/clinician)</td>
<td>Duraphat (5.0% NaF) (prescription)</td>
<td>Colgate</td>
</tr>
<tr>
<td>Topical agents</td>
<td>Prevents gingivitis and periodontal pathogens</td>
<td>Peridex (0.018% Chlx Gluconate)</td>
<td>Procter and Gamble</td>
</tr>
<tr>
<td>Saliva substitute-rinse</td>
<td>Keeps mouth moist (must be able to swish and swallow)</td>
<td>Mouth Kote</td>
<td>Unimed, Inc.</td>
</tr>
<tr>
<td>Saliva substitute-gel</td>
<td>Keeps mouth moist</td>
<td>Oral Balance Gel</td>
<td>Laclede</td>
</tr>
<tr>
<td>Saliva stimulant-gum</td>
<td>Stimulates salivary glands</td>
<td>Biotene gum (Laclede)</td>
<td>Laclede</td>
</tr>
<tr>
<td>Saliva stimulant-pill</td>
<td>Stimulates salivary glands (radiation &amp; Sjorgen’s only)</td>
<td>Salagen (pilocarpine tabs) (prescription)</td>
<td>MGI Pharma</td>
</tr>
</tbody>
</table>
amount (pea-sized) is recommended, due to likelihood of patients swallowing the paste. Fluoride rinses may be appropriate for patients with xerostomia, a high risk or incidence of dental caries, and if the patient is able to rinse and spit without risk of aspiration. One brand, Fluorigard (Colgate, Canton, Mass.), contains 0.05 percent NaF and can be obtained over-the-counter (OTC) for use as a daily rinse. Topical fluorides in the form of a gel such as Prevident (Colgate, Canton, Mass.) may be brushed on for AD patients with the same risk for caries but who cannot rinse and spit. The use of gels minimizes ingestion, but such gels cannot be obtained OTC and must be prescribed by a physician or dentist. The application of fluoride varnish, such as Duraphat (5 percent NaF, Colgate, Canton, Mass.) at the close of dental visits is highly recommended as an effective preventive therapy for patients at high risk for dental decay.

Antimicrobial agents such as chlorhexidine gluconate are useful to combat gingivitis and periodontal pathogens. Once again, these products, (Peridex, Procter & Gamble, Cincinnati, Ohio), must be prescribed, and patients must be able to swish and spit to use them effectively. However, in some situations, caregivers could apply the product to the patient’s teeth with a toothbrush, a sponge applicator, or a cotton swab while suctioning the mouth to remove the excess.

Patients who have oral xerostomia should first be evaluated for adequate fluid intake. Drinking water can prevent dehydration and correct dry mouth and related problems. Assuming fluid intake is appropriate, oral dryness can be treated by salivary substitutes or salivary stimulants. Substitutes include MouthKote (Unimed Inc, Buffalo Grove, Ill.) and Xerolube (Scherer Laboratories, Inc., Dallas, Texas) and may provide symptomatic relief for some patients. Due to the fluid viscosity there is a risk of aspiration, particularly with the moderate to severe AD patient.

Another salivary substitute, Oral Balance (Laclede, Rancho Dominguez, Calif.), comes in a gel. Increased viscosity permits its use to coat the mouth of severely xerostomic patients (mouth-breathers, denture wearers) with diminished risk of aspiration. A small amount can be applied with a gloved finger to the affected areas. Patients with xerostomia whose salivary glands can respond to stimulation can benefit from oral stimulation, such as eating carrots or celery, chewing sugarless gum or candy. The use of a pilocarpine hydrochloride (Salagen, MGI Pharma) as a salivary stimulant is currently approved for use only in patients with radiation-induced xerostomia and those with Sjogren’s syndrome.

Throughout the life of a patient with dementia, a caregiver will need to continue to help provide preventive mouth care. While the focus here has been for those patients with natural dentition, oral care is also important for those who are edentulous wearing dentures, or partially edentulous with or without replacements. Some suggestions for the caregiver include:

- establishing a regular time each day for mouth care;
- breaking up the steps for cleaning into small simple steps for the patient, reminding the person one step at a time;
- explaining what you are doing in a gentle, calm manner;
- placing a simple list of step-by-step instructions on a piece of paper and posting it in the bathroom, if the person can still read;
- keeping labeled mouth care supplies in the same place all the time;
- not assuming that the person will remember the next day what he or she did today.

CONCLUSIONS

Because progressive dementia patients have cognitive and behavioral changes that are different from typical healthy, ambulatory, and cooperative adults, seeing these patients in a traditional dental practice can be a challenge. However, as the number of patients with dementia increases, the need for dentists to evaluate and treat these patients will also increase. In some cases, patients with AD or other dementias may have acute needs, or may need to be managed with sedation or general anesthesia. In these cases, oral surgeons or dentists who have hospital privileges, should be contacted.

For most dentists, treating patients with dementing conditions like Alzheimer’s disease will be a difficult situation, particularly for the first time and without knowledge of what to expect and what can be done. As with other complex, medically compromised patients, working together with the patient’s family (and primary caregiver), primary care physician, psychologist, pharmacist, and social worker as a member of the patient’s health care team will undoubtedly provide the best outcome for the patient and...
increase the chance for continued collaboration with demented patients in the future.

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REFERENCES
ABOUT THE AUTHORS

Robert G. Henry, D.M.D., M.P.H., is director for geriatric dental services and assistant chief of dental service at the Department of Veteran's Affairs Medical Center in Lexington, Ky. He is also a clinical associate professor at the University of Kentucky College of Dentistry, a research associate at the Sanders-Brown Research Center on Aging, and the assistant director of the Kentucky Public Health Dentistry Department. Dr. Henry is the past president of the American Society of Geriatric Dentistry.

Barbara Smith, RDH, M.P.H., Ph.D., is director of geriatric dental programs and assistant professor at the University of Michigan School of Dentistry. She also provides care to veterans at the Ann Arbor Veterans Administration Health System. She has been involved in geriatric dental education and clinical administration for over 20 years. Before coming to Michigan, she administered the University of Minnesota School of Dentistry’s graduate training program in oral health services for older adults.
The Montana Dental Association’s political action committee, MoDePAC, and the Alabama Dental Association (ALDA) will jointly host a Ski ‘n Learn Seminar at Big Sky Resort on March 19-26, 2005. Several other state dental associations will also co-sponsor the trip including Colorado, Idaho, Kentucky, North Dakota, South Dakota, Oklahoma, Tennessee, Maryland, Missouri, Pennsylvania, Virginia and West Virginia.

As you know, Montana is known for its vast, beautiful landscapes and at Big Sky, there’s no exception. Big Sky Resort is Montana’s largest destination resort, featuring uncrowded skiing on 3,600 acres with a vertical rise of 4,350 feet. World-class skiing and riding is spread across three interconnected mountains with 150 trails and 400 inches of annual snowfall. With two terrain parks, a half-pipe, and the Lone Peak Tram whisking skiers and riders to 11,150 feet, Big Sky is the choice of many winter enthusiasts from around the globe.

CONTINUING EDUCATION

The Ski ‘n Learn Seminar offers 16 hours of continuing education held Monday, March 21 through Thursday, March 24. A morning session will be held from 7:30-9:30 a.m., with an afternoon session from 4:30-6:30 p.m. A full breakfast will be served to seminar attendees at the morning sessions and snacks and beverages are offered during the afternoon sessions. Speakers and topics include:

DR. MIKE EDWARDS
- “Update on Dental Materials” 2 CEUs
- “Multimedia and Patient Education” 2 CEUs

DR. RICK HARRELL
- “Contemporary Extraction Practices in Orthodontics” 4 CEUs

DR. JIM ROBERTS
- “Relationship of Periodontal Disease to Systemic Diseases” 2 CEUs
- “When Is It Appropriate to Refer Patients with Periodontal Disease?” 2 CEUs

DR. MIKE O’BRIEN
- “Practice Transition – What to Do and When to Do It!” 2 CEUs
- “The O.B. – 5 Crown and Bridge Technique” 2 CEUs

LODGING

Huntley Lodge - This three-story hotel was part of the late NBC news broadcaster Chet Huntley’s original vision. With recent remodeling, it is as tasteful as it is convenient. The Huntley complex includes a fine dining room, lounge, coffee cart, concierge, shops, ski storage, meeting rooms and Solace Spa.

Shoshone - Shoshone combines the service of a hotel with the comforts of a condominium. This recently remodeled seven-story landmark is attached to the Yellowstone Conference Center and Huntley Lodge. Solace Spa, shops, espresso cart, and Kids Club are located in the lobby.

The Summit - This 10-story luxury complex combines the convenience of a hotel with the amenities of a condominium. Flexible lock-offs allow for many sleeping configurations. The Summit melds European sophistication with Western style with three high capacity lifts within 100 yards of the entry.
ABOUT THE CLINICIAN

Professor Karen A. Baker has been on the Dental College faculty at the University of Iowa for 22 years and occupies a unique role in dental practice and education. She is a clinical pharmacist with a Master's degree in clinical pharmacology and therapeutics and is focused on patient-specific dental drug therapy. She has given nearly 500 programs nationally and internationally and holds memberships in the American Dental Association, the American Dental Education Association, the American Pharmaceutical Association, the American College of Clinical Pharmacy, and the Omicron Kappa Upsilon Dental Honor Society. Ms. Baker is on the editorial board of the Journal of the Academy of General Dentistry. She directs the operation of an in-house pharmacy and drug consultation center that serves dental students, staff, faculty and patients every clinic day. She has authored more than 50 articles and abstracts and lectures 100 hours per academic year in 10 College of Dentistry courses.

ABOUT THE COURSE

7 Credit Hours

The range of drug therapy options available to dental practitioners has greatly expanded over the past ten years. This expansion has opened the door to unprecedented therapeutic successes as well as disastrous drug misadventures. This course will update the dental team on recent developments in dental pharmacotherapy while providing strategies for prescribing to ensure therapeutic success. Drug therapy and alternative medicine reference sources will be listed.

The Montana Dental Association
Presents
What’s New in Dental Pharmacotherapy
Karen Baker, M.S.

GREAT FALLS
Friday – March 4, 2005
Registration: 8 am • Class: 8:30 am - 5 pm
Hampton Inn
2301 14th St. SW, Great Falls MT 59404 • 406-453-2675

MISSOULA
Saturday – March 5, 2005
Registration: 8 am • Class: 8:30 am - 5 pm
Best Inn Conference Center
3803 Brooks St., Missoula MT 59804 • 406-251-2665

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Thank you for pre-registering.

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

Total CE credit hours are 7.

MDA Member Dentist ................................................ $190
With CE Credit Sticker ............................................... $165
ADA Member/other than MT ...................................... $250
MDA Retired Volunteer Dentist.................................. $ 15
Non-Member Dentist ................................................. $340
Hygienist/Staff Attending with Dentist ...................... $ 70
Hygienist/Staff Attending without Dentist ................. $ 80

Total ________________

Attendee’s Information

Name __________________________________________
Address ________________________________________
City, State, Zip __________________________________
Phone _________________________________________
Additional Attendees _____________________________
______________________________________________
❑ Great Falls    ❑ Missoula

Method of Payment

❑ Check made payable to MDA       ❑ MasterCard       ❑ VISA
Credit Card # ____________________________
Signature___________________________________
Expiration Date ____________________________

Mail Payment and Registration to:
MDA, PO Box 1154
Helena, MT 59624
Or call 800-257-4988
Or fax 406-443-1546 with Credit Card

The Montana Dental Association is an ADA CERP recognized provider. AGD accepts MDA courses for Fellowship and Mastership credit.
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If you enjoy a high income potential and outdoor activities in a beautiful state, then this is the perfect opportunity for you! We are seeking a dentist to join our fast-paced office as an associate in our beautiful, newly built office featuring high tech dental equipment. Possible relocation assistance available. Give us a call for more information at 907-490-0127, 907-490-4649 fax, nldc@gci.net.

Belgrade/ Big Sky Associate Needed
Associate needed for fun, fast-growing family practice in beautiful southwest Montana. Future partnership or purchase possible. Oral surgery and endo emphasis helpful. Call 406-388-0550 or email bigskydoc@aol.com.

For Sale
Cerec II with cart, software, and accessories for $14,995. Can use it for a $30,000 trade-in toward a new Cerec III from Patterson Dental. Call Dr. Bryan Finn at 506-535-7787 (work) or 509-448-1863 (home).

CLASSIFIED & DISPLAY ADVERTISING INFORMATION
Classified ads are available at no charge to MDA members (limited to 50 words; 50 cents/word above 50 words). Non-member rates: $29 per insertion up to 30 words; 50 cents/word above 30 words. Payment by check or credit card must accompany ad copy. Deadline is the 10th of the month preceding publication (publication months are January, March, May, July, September, November).

Send classified ads to:
MDA News, P.O. Box 1154, Helena, MT 596254 or fax to (406) 443-1546

For rates and information about display advertising, please call 406-443-2061 (toll free in Montana at 800-257-4988).

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Kalispell: HELP!
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Missoula
Fantastic opportunity for dentist to establish own private practice without the high expense of purchasing new equipment. I am building a new dental office in Missoula for my practice and want to sell my present modern, 4-operative office turnkey. Includes everything: computers, fiber-optic handpieces, chairs, etc. Just move in and assume building lease. George M. Olsen, DDS, 406-549-5869.

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## Dental Datebook

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>21-22 MDA Dental Days at the 2005 Montana Legislature, reception and dinner January 21 and breakfast January 22</td>
</tr>
<tr>
<td></td>
<td>February</td>
<td>25 Montana Board of Dentistry meeting, Helena</td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>4 Karen Baker, “Pharmacology”, Great Falls 5 Karen Baker, “Pharmacology”, Missoula 31 MDA Executive Committee meeting, Helena</td>
</tr>
<tr>
<td></td>
<td>April</td>
<td>1 MDA Board of Directors meeting, Helena 29 Dr. Frank Spear: Update 2005, Missoula, Montana. Sponsored by Montana Study Group. Contact Bobbie at 406-644-2340 for more information.</td>
</tr>
<tr>
<td></td>
<td>May</td>
<td>4-6 MDA Annual Meeting, Red Lion Colonial Hotel, Helena, Dr. Ed Swift, Jr., “Modern Dental Materials: A Practical Review”, Dr. Mark Hyman, “Drill Em, Fill Em &amp; Thrill Em”</td>
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<tr>
<td></td>
<td>June</td>
<td>3 Montana Board of Dentistry meeting, Helena</td>
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<tr>
<td></td>
<td>September</td>
<td>9 Dr. Gordon Christensen, Red Lion Colonial Hotel, Helena</td>
</tr>
<tr>
<td></td>
<td>October</td>
<td>6-9 ADA Annual Session, Philadelphia</td>
</tr>
</tbody>
</table>

### Practice Opportunities

If you are trying to sell your practice or seeking an associate or partner and want the information shared with dentists who inquire at the MDA central office, please let us know. MDA will list your practice opportunity on their web site and will provide details about the opportunity to any interested party who contacts the central office. Call 1-800-257-4988 with information about your practice and needs or log on to the MDA web site at www.mtdental.com.