THE DENTAL SOCIETY OF GREATER ORLANDO

Journal

SPRING 2021

DELEGATED DUTIES

A Brush Up for Your Team Members

Live! In-Person Meeting

- DR. TRAVIS CAMPBELL
- CRYSTAL MAY

Sink Your Teeth Into This

PLANDEMIC

President's Message

STAYING ALIVE IN 2021

UCF Pre-Dental Student Association

MEET YOUR FUTURE ASSOCIATES

Spring

Who We Are

Shepherd's Hope is a faith-based organization of volunteers that exists to provide access to healthcare for uninsured patients. Shepherd's Hope has provided over 300,000 primary care and specialty care patient visits to uninsured men, women and children since 1997.

With our new dental program, we are hoping to fill a void for dental care in our community for the underserved.

We Are Seeking

Licensed dental providers and technicians to volunteer in the West Orange Health Center (Winter Garden) and/or to offer more intensive services to patients by case-managed appointments in their offices.

Volunteer licensed providers and in-office donated services are covered under a **sovereign immunity** contract with Shepherd's Hope and the state of Florida.

Interested providers should contact Ashleigh Perkins, Operations Intern
E: Ashleigh.Perkins@ShepherdsHope.org P: 407-876-6699 ext. 226
West Orange Health Center: 455 9th Street, Winter Garden, FL 34787
www.shepherdshope.org/volunteers

What's Inside

MEMBERSHIP UPDATES

ASSOCIATE MEMBERSHIP

Dr. Anthony Graham
13809 County Road 455
Ste 106
Clermont, FL 34711
407-930-4659

Dr. Herb Bennett
120 East Dixie Ave.
Leesburg, FL 34748
352-787-7890

ACTIVE MEMBERSHIP

Dr. Ivan Montijo
10429 Moss Park Rd.
Orlando, FL 32832
(407) 277-1779

Dr. Jesse Edwards
2815 Corrine Dr.
Orlando, FL 32803
(407) 894-5061

Dr. Troy Gessner
429 N. Fern Creek Ave.
Orlando, FL 32803
(303) 402-1625

Dr. Mikal Baaquee
2677 Maguire Road
Ocoee, FL 34761
(407) 293-3002

Dr. Aaron Goodwin
3025 Aloma Avenue
Winter Park, FL 32792
(407) 671-2306

Dr. Frankie Gomez
201 North Lakemont Ave.
Ste 2200
Winter Park, FL 32792
(407) 629-0075

Staying Alive *in 2021*

March 2021 marked the one-year anniversary since the start of the global pandemic known as COVID-19. What a wild ride it has been. In Florida, most of the restrictions have been lifted, dental offices are open, and a majority of our patients seem to be returning to for their routine dental care. DSGO leadership has worked tirelessly together with the Florida Dental Association and American Dental Association to obtain and disseminate information to help our members during this time of uncertainty. With the rapid development and release of a vaccine it feels as if we can start to see the light at the end of the tunnel.

On May 3 we converted back to live membership meetings. Our membership meetings will be hosted at the Winter Park Community Center. The facility is able to safely accommodate our members with proper social distancing guidelines. Our speaker was Dr. Andonis Terezides who gave a very informative update on Bisphosphonate Related Osteonecrosis of the Jaw (BRONJ). We also have our annual CE meeting scheduled for Friday June 11th at the Winter Park Community Center from 10am – 4pm. The guest speaker will be Dr. Travis Campbell. Dr. Campbell is a full-time practicing dentist. He started his practice from scratch after graduating from Baylor College of Dentistry and has grown this single dentist practice to be in the top 1% in the country. He is the author of a book titled *The Practice Whisperer.* His lecture topics will include *Understanding Insurance and Discounts & Marketing Cycle and Media*. It will be a great meeting and I encourage you to bring your team members.

The Florida Dental Convention is also back this year at the Gaylord Palms. FDC2021 will feature a comprehensive scientific program offering 130+ courses for the entire dental team, opportunities to meet 350+ leading dental vendors to learn about new products and technologies, and networking opportunities to build morale and come together as a dental community.

I hope that you remain healthy and safe during the coming months and I look forward to seeing you and your team soon!

Sincerely,

Clay

Dr. Clay Miller
DSGO PRESIDENT
2020-2021
407-834-0330
claymillervb@gmail.com

DENTAL SOCIETY OF GREATER ORLANDO (DSGO) CALENDAR OF EVENTS 2021-2022

THURSDAY, JUNE 17, 2021
Central Florida District Dental Association Caucus

SATURDAY, JUNE 26, 2021
Florida Dental Association House of Delegates

THURSDAY, JUNE 24, - SATURDAY, JUNE 26, 2021
Florida Dental Convention

JULY 1, 2021
Dr. Caroline Gordy-McHugh becomes President of DSGO

MONDAY, JULY 12, 2021
Board of Directors meeting
800 North Mills Avenue, Orlando
6:00 p.m.

THURSDAY, JULY 22, 2021
Membership Meeting
6:00 p.m.
Location to be determined

MONDAY, AUGUST 16, 2021
Board of Directors
800 North Mills Avenue, Orlando
6:00 p.m.

MONDAY, OCTOBER 4, 2021
Board of Directors
800 North Mills Avenue, Orlando
6:00 p.m.

THURSDAY, OCTOBER 21, 2021
Membership Meeting
6:00 p.m.
Location to be determined

MONDAY, NOVEMBER 8, 2021
Board of Directors
800 North Mills Avenue, Orlando
6:00 p.m.

TUESDAY, FEBRUARY 1, 2022
Dentist Day on the Hill
Tallahassee

MONDAY, FEBRUARY 7, 2022
Board of Directors
800 North Mills Avenue, Orlando
6:00 p.m.

THURSDAY, FEBRUARY 24, 2022
Membership Meeting
6:00 p.m.
Location to be determined

MONDAY, MARCH 7, 2022
Board of Directors
800 North Mills Avenue, Orlando
6:00 p.m.

MONDAY, APRIL 4, 2022
Board of Directors
800 North Mills Avenue, Orlando
6:00 p.m.

THURSDAY, APRIL 28, 2022
Membership Meeting
6:00 p.m.
Location to be determined

FRIDAY & SATURDAY APRIL 22-23, 2022
CFDDA Annual Meeting
Champions Gate

MONDAY, MAY 2, 2022
Board of Directors
800 North Mills Avenue, Orlando
6:00 p.m.

Stepping Forward

We have made it through Quarter 1 of the year and I can hear the applause! I'm sure you can see the light at the end of the lengthy Covid-19 tunnel. I sure can! Although the release and availability of the CoVID Vaccine was concerning for some, it has been a necessary answer for others. I am simply thankful that through the uncertainty, we've been able to take a step in a different direction: that step being *forward*. If I had to guess, I would even go as far to say that despite the diversity of opinion, I firmly believe forward movement is the desire for us all.

As we enter the second quarter of this year, let us continue to forge ahead in our practical, yet comprehensive approach to Clinical Dentistry, while also making strides in combatting the progression of CoVID, collectively. In this edition of the journal, we have a special segment from several local specialists who've contributed to our clinical advancement through their written work. While CoVID-19 may have temporarily impaired our freedom to gather for common meetings, CE courses, and dinners, thankfully we are surrounded by group of innovators who can and will keep us well-informed.

As you enjoy the information included in the journal, don't forget to mark your calendar for all upcoming events. If you are interested submitting an article for the next edition, please submit them at arnellewrightdmd@gmail.com. I am always excited to display your contributions to our ever-evolving field.

ArNelle Wright, DMD, MS
EDITOR

DENTISTS' DAY ON THE HILL 2021

By Daniel J. Crofton, D.D.S.,M.D.

On Tuesday, March 16, 2021 the Florida Dental Association (FDA) celebrated 25 years of advocacy by hosting its first virtual Dentists' Day on the Hill. Dentists from around the state were able to meet virtually with legislators, participate in a panel discussion and receive special presentations. This year the Florida state legislative session convened on March 2nd and is scheduled to end on April 30th.

This year's virtual event was well-organized by our FDA Governmental Affairs Office (GAO) featuring our chief legislative officer Joe Anne Hart and governmental affairs coordinator Alexandra Abboud.

FDA President Dr. Andy Brown began by welcoming the participants. Next, Florida's lieutenant governor, Jeanette Nunez (R), gave a special message of encouragement. Joe Anne and Alexandra then gave a legislative update and took questions from participants.

The first legislator participants met was Senator Aaron Bean (R-Jacksonville). Next, Jimmy Patronis (R) who is Florida's chief financial officer spoke. Meetings were then held with Rep. Nick Duran (D-Miami-Dade), Rep. Michael Grieco (D-Miami-Dade) and Rep. Ralph Massullo (R-Citrus), Rep, Evan Janne (D-Hollywood) and Senator Gary Farmer (D-Fort Lauderdale).

Special presentations were given by Mrs, Jerilyn Bird of the Florida Dental Alliance and former State Senator Dr. Alan Hays. These presentations were followed by a grassroots panel discussion moderated by Alexandra Abboud with panelists Drs. Bernie Kahn, Zack Kalarickal, George Kolos and Beatrice Terry who answered questions about their experiences with legislators and past Dentists' Days on the Hill. Dr. Cathy Bridges who is the executive director of the Department of Health gave an overview of the state of dentistry in Florida.

The issues of interest included the dental student repayment program and the

Donated Dental Services (DDS) program. The FDA is trying to secure funds of approximately $773,000 for these two programs. Both of these programs were approved by the legislature at their last session in 2019, but no funds were allocated for these programs.

The FDA also continues to support community water fluoridation and the state allocating $200,000 in state funds that would enhance the efforts of the Department of Health. These state funds would supplement federal funds allocated for statewide fluoridation efforts. The requested funding would be used to assist local communities wanting to start community water fluoridation efforts and could be used for updating and maintaining water treatment facilities. For every $1 invested in water fluoridation, $43 in future dental treatment costs are saved.

The FDA is asking the state to allocate $580,000 to fund the Florida Mission of Mercy (FLA-MOM). House Bill 2171 sponsored by Rep. Allison Tant (D-Leon) promotes this effort. The FDA Foundation has generated approximately $9.43 million in donated dental care since the first FLA-MOM event in 2014.

In Florida currently, insurance companies can recover an overpayment 30 months from the date of overpayment. This is known as a clawback. Long clawback terms may be destabilizing to dental practices when funds are requested years after services have been delivered. Many other states have shorter, more reasonable clawback provisions than Florida. House Bill 1109 sponsored by Rep. Michael Grieco (D-Miami-Dade) and Senate Bill 1386 sponsored by Sen. Gayle Harrell (R-Stuart) if approved would reduce the present clawback term in Florida from 30 months to 12 months.

The FDA supports legislation that provides liability protection from frivolous lawsuits during national disasters, such as the COVID-19 pandemic. HB 7005 sponsored by the Health and Human Services Committee and Senate Bill 74 Sen. Jeff Brandes (R-St. Petersburg) would offer such liability protection to health care providers.

The FDA opposes lowering the standard of care by creating a new licensed dental provider called a dental therapist. House bill 961 sponsored by Rep. Melony Bell (R-DeSoto) and the companion Senate bill 604 sponsored by Sen. Jeff Brandes (R-St. Petersburg). These bills would allow dental therapists with only three years of education beyond high school to perform irreversible dental procedures such as extractions and pulpotomies under the general supervision of a dentist. The FDA adamantly opposes this legislation in favor of allowing only licensed dentists to perform these procedures. Dental therapists have been touted as a solution to the access to care problem, however, even though such a model has existed in Minnesota, the less than 100 dental therapists practicing there have not solved that states access to care problem.

The Western Regional Examining Board (WREB) is promoting another dental exam in Florida. Presently, Florida offers the American Board of Dental Examiners

(ADEX) exam which is the only dental exam offered and accepted in Florida. The ADEX exam is offered in 48 other states as well. The WREB exam allows a candidate to fail a section of the exam which they may not be proficient in, but to still pass the exam if their overall score is high enough to pass. House Bill 497 sponsored by Rep. James Buchanan (R-Sarasota) and Senate Bill 1366 sponsored by Sen. Jason Brodeur (R-Lake Mary) promotes the WREB exam. The FDA opposes adding another dental licensure in Florida, especially the WREB exam.

It was evident during our virtual meeting that one of the main issues that the legislators in both the Senate and the House will be grappling with again this session is the state budget. The state budget this year is over $96 billion. Both the Senate and the House are working on their own budgets and a conference committee will most likely be required to iron out their differences over the next several weeks. Given Florida's mandatory balanced budget provision, difficult decisions lay ahead for lawmakers who will have to decide which programs will receive funding.

During DDOH 2021, your FDA members met with a number of legislators. The membership should rest assured that dentists have an excellent reputation among the legislators and that our concerns will be given serious consideration.

Our DSGO legislative affairs chairman, Bernie Kahn and I will be following all of the above issues and continue to inform you about important events taking place. Advocacy has been one of the most valuable benefits that organized dentistry has provided to members over the past 25 years and advocacy should remain important throughout our careers. For more information on these topics I encourage you to check out the FDA website at www.floridadental.org. The Capitol Report can be found there and it is a very informative publication by the FDA. Also, I encourage you to contact Bernie Kahn at bkahn32751@gmail.com or me at djcrofton1@gmail.com if you have any political questions or concerns. If anyone is interested in attending our next DDOH, then please contact Bernie, Kahn, our DSGO executive director Sharon Hamilton or me. We would love to have more DSGO members join us when we return to in person meetings in Tallahassee next year!

Important issues that influence the way we practice dentistry are being addressed in Tallahassee and it is important that we pay attention to what is happening there or else there may be consequences for our profession. I encourage any and all DSGO members to be attentive to these issues, to support candidates who support our Tooth Party and to plan on attending DDOH 2022. There is strength in numbers. Please plan on joining us next year in Tallahassee for this important, interesting and informative event.

LIVE! IN PERSON MEETING

The Dental Society of Greater Orlando Presents

Dr. Travis Campbell

with guest speaker Crystal May

Friday, June 11, 2021, from 10:00 a.m. – 4:00 p.m.

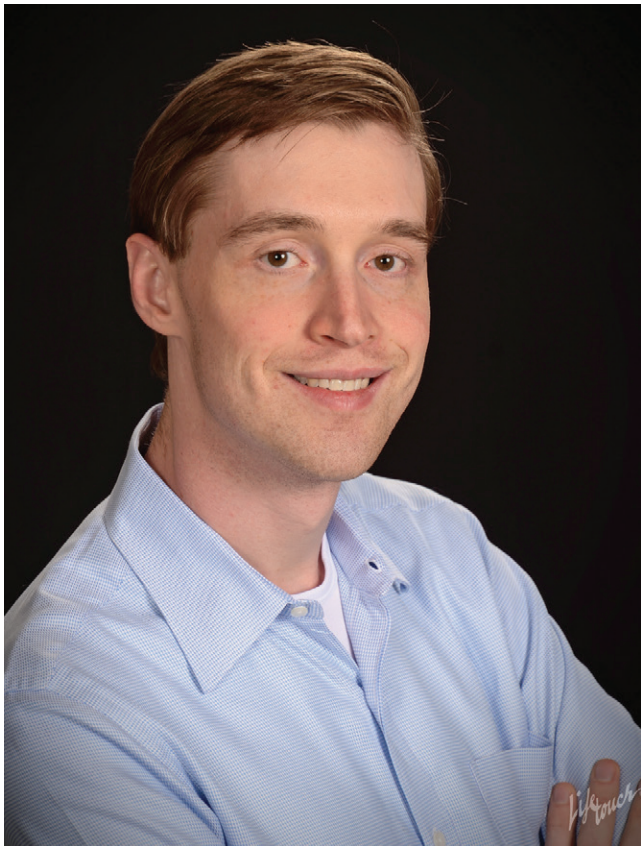
Lunch included

Winter Park Community Center

721 W New England Ave, Winter Park, FL 32789

FEATURED SPEAKER: Dr. Travis Campbell is a full-time practicing dentist. He started his practice from scratch after graduating from Baylor College of Dentistry (2009).

As a result, Dr. Campbell has become well known for his knowledge/experience in dental business management, efficiency, and dental insurance.



Understanding Insurance and Discounts

Synopsis: Does insurance drive you and your team crazy? Are you getting denied for legitimate claims on common services like crowns and SRP? Do you ever have patients upset because they owe more money after their EOB comes in?

Marketing Cycle and Media

Synopsis: How would you like to double the effectiveness of ALL your marketing efforts, without spending a dime more on marketing?

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GUEST SPEAKER: Crystal May is the co-founder and COO of Devdent. She is dedicated to helping dental practices be successful in dental sleep medicine and medical billing. She has over 17 years of medical billing experience, 15 years with an emphasis on dentistry, and 10 years on airway and sleep. Crystal is a leading educator and has presented at hundreds of events for major corporations and organizations.

She owns and manages multiple dental practices, holds multiple US and international patents, has developed several software products specifically designed for dental offices, and has started companies that help practices with the successful implementation of dental sleep medicine and medical billing. Crystal's mission is to educate every dentist in the country about their opportunity and obligation to help identify sleep disorders in their patients.

Understanding Medical Billing Possibilities for Dentistry

Synopsis: Join Crystal May as she explores the medical billing possibilities for dentistry. She will break down dental procedures into six easy-to-understand categories and discuss the procedures that are most commonly covered. Crystal will also identify some of the most common obstacles offices may face, and how to overcome them. By offering another form of payment, medical billing can help more patients afford the care that they need.

To Register for these courses or for more information 407-894-9798 or email kellymillett@dsgo.org

Return the form below to DSGO scanned to email or 800 North Mills Ave. Orlando, FL 32803, or fax 407-895-9712

Registrant Information – For additional registrants, photocopy this page and list requested information or list them on a separate sheet.

Team Members cost: $75.00 each. Non-Members: $125.00 (Dentist). DSGO Members may choose this to be their prepaid meeting for the year.

Name_____ DSGO Member ___ Yes ___No

YOUR FUTURE ASSOCIATES – UCF PDSA

By Matt Hall, Diana Rodriquez, Michelle Lawton

Pictured from left to right: Daniel Orozco, Kayley Loerop, Victoria Molina, MaKayla Bender, Diana Rodriguez, Rehana Koilpillai, Tatyana Chowbay, Ashlie Infante

You would be impressed with a select group of pre-dental students at the University of Central Florida (UCF) who are members of the Pre-Dental Student Association (PDSA).

We all know that it's not easy getting accepted to dental school. Dental school and medical school are essentially equal in difficulty as it relates to admissions, and for some years over the last two decades the average GPA for entering dental students has been higher than medical students. For a lot of reasons today, a dental career is more desirable than a medical career, and this has increased the competitiveness for admission to dental school. Undergraduate students know what numbers are required for GPA and DAT scores. The Director of Pre-Health Careers at UCF advises pre-dental students that to be considered a viable applicant they need a GPA in the range of 3.5-3.7 or above, a DAT score of 18 plus (20 is better), and a minimum of 150 hours of shadowing and/or assisting in a dental office, and 300 hours is better.

Many students, who initially felt dentistry seemed like a good profession, eventually decided not to apply because of trouble with science classes, GPA and DAT scores, or feeling dentistry is not right for them after being exposed to dentistry by shadowing in a dental office. The national acceptance rate for those who actually apply, and feel they have a chance to be accepted, is 50%.

The testing ground at UCF, for those students who initially feel that dentistry may be their profession, is the Pre-Dental Student Association (PDSA). This PDSA officially was founded in 2008, although a less formal group had existed prior to that year. It presently has 210 members covering all four undergraduate years who

signed up and paid dues of $55 for a shirt with a UCF PDSA logo, access to a yearly banquet, and emails about event opportunities. The number who actually end up in a position to apply, and get accepted to dental school, is a small percentage of this group. Those who do make it are truly dedicated and talented.

To exist as a UCF student association, the PDSA requires three sponsors, a local dentist, a UCF faculty member, and a Community Sponsor. These sponsors are:

1. Peter Lemieux, DMD, a private practice dentist who is, and has been, an officer and representative of organized dentistry in Florida (DSGO, CDDSF, FDA);
2. Professor Erin Myszkowski, Director of the UCF Pre-Law and Pre-Health Program;
3. Michelle Lawton, Director of Dental Operations at Grace Medical Home in Orlando, and a Certified Dental Assistant, and has been a sponsor since 2012.

Dr. Lemieux puts on a yearly workshop on the UCF campus in which he teaches dental anatomy and has students do wax restorations on dental casts. This workshop is limited to the first 20 students to sign up when the event is posted. Professor Myszkowski advises and coordinates the students' application process. Michelle Lawton has two main functions. She allows select students (typically 5-8) to observe (shadow) and help in the Grace Medical Home dental clinic as volunteer "interns." And she teaches several voluntary seminars on her own time after hours and weekends on various practical topics in dentistry, e.g., Introduction to the Dental Office, Instrumentation, OSHA, Medical and Dental History taking, Patient Management, Chart Notes, Chairside Assisting. Michelle teaches these seminars every semester both at Grace Medical Home and at the Dental Clinic on the UCF campus.

The PDSA has a Board of Student Officers who are elected, President, Vice-President, Secretary, Treasurer, Media Relations, and a Sergeant-at-Arms. Each has its own special duties, but the Sergeant-At-Arms responsibilities relate most importantly to the student events that allow for clinical shadowing and seminar opportunities, and thus this officer is typically the busiest on a daily/weekly basis. The present Sergeant-At-Arms is Diana Rodriguez, a junior majoring in Biomedical Sciences.

Diana, like the 30 or so members who are very active, is determined to be a dentist. Her mother is a dentist from Ecuador, and as a young child Diana remembers going to the dental school and clinic with her mother. The family moved to the U.S. when Diana was 11-years old. Diana was thinking about medical or dental school, but after joining PDSA as a freshman, she became convinced that dentistry was right for her.

Diana, as Sergeant-At-Arms, coordinates the scheduling of events, shadowing, seminars, and workshops, and follows up to document what each student has done using Excel Spread Sheet. The Vice-President posts shadowing opportunities with private practice doctors (there only 6-10 who consent to do this), and has the Secretary send out the emails. The Sergeant-At-Arms posts the seminars, workshop, and clinical opportunities for shadowing and helping at the Grace Medical Home. Again, it is the Secretary who sends out the emails. It is the Sergeant-At-Arms who must check what students sign up, give them reminders, and document their attendance. The documentation is important so that each student has a record of their clinical and didactic exposure to dentistry for their resume. Several Deans of dental schools have expressed how impressed they are with the UCF students' knowledge and understanding of the dental profession on their applications, at interviews, and upon entering as first year students.

To give you an idea of the extent of seminar and workshop opportunities, and clinical exposure handled through PDSA, here is a partial list: introduction to the dental office, dental anatomy and carving, dental instruments and tray set ups for procedures, OSHA, sterilization, radiograph interpretation, composites, suturing, medical and dental history taking, chart notes, implants, patient management, dexterity, design and equipment of dental office, Spanish for dental terms and exams, chairside assisting, shadowing at private office and clinic, Florida Mission of Mercy, Dental Care Access Foundation clinics, and local dental events like Give Kids a Smile.

There is no doubt that we all want our profession to continue to be well respected and to have newly trained dentists who know they have chosen the right profession, are well trained, and love what they do. The UCF Pre-Dental Student Association, along with its sponsors and officers, are doing a great job of giving students the opportunity to understand dentistry, know what a dentist does, and know whether they feel comfortable in that environment before they ever apply to dental school. You may eventually have a former UCF PDSA member as an associate one day and be proud of their Central Florida roots.

HAVE YOU HAD AN INCREASE OF "CRACKED TOOTH SYNDROME"?

By Dr. Ericka Ferguson
Apopka Endontics

There has been a significant increase in the incidence of cracked teeth due to high levels of stress and anxiety due to the COVID-19 pandemic. Cracks allow bacterial invasion which can lead to inflammation and infection. Diagnosis and treatment of cracked teeth is one of the most fascinating and challenging aspects of Endodontics. Fascinating because it, at times, requires the collaboration of the general dentist with multiple specialists. Challenging because there are various views on the detection and treatment of it. In fact, there are different opinions on the management and preservation of cracked teeth when the crack extends onto the root surface. Some dentists extract cracked teeth because they think the prognosis is hopeless. However, according to Kang et al., the preservation of cracked teeth with subgingival extensions can have a success rate ranging from 66.7% to 88.3% at 21 years. In this article, I will be focusing on the diagnostic and treatment challenges related to cracked teeth.

Definition of a Cracked Tooth

It is important to distinguish between a "cracked tooth" and "vertical root fracture". These terms are often used interchangeably in dental literature. According to Rivera et al., a cracked tooth is defined as a longitudinal incomplete fracture, which starts from the coronal tooth structure and extends apically. There can also be mesiodistal extensions that involve the marginal ridges and proximal surfaces. Cracks may extend onto the root surface, but not always. In contrast, vertical root fractures are usually found in endodontically treated teeth, occur in the buccolingual direction, and are considered hopeless requiring an extraction. Cracks usually start coronally and extend apically, whereas vertical root fractures are opposite, originating apically.

Cracking can affect any tooth in the dental arch, however, they are primarily seen in the posterior dentition with more cracks occurring in the mandible. Factors which negatively affect the success and survival rate of endodontically treated cracked teeth are multiple cracks in multiple directions, deep probing depths of more than 6mm, terminal location of tooth in the dental arch, pre-operative pain, presence of class II cavities and pulp necrosis at the initial examination. Mandibular molars are more prone to cracks due to the protruding palatal cusp of the maxillary molars, especially if it is the only remaining tooth in the quadrant. Maxillary premolars are also more prone to cracks due to the steep inclines on the non-functional cusp which leads to high torque forces during mastication.

Cracking the Code on Cracked Teeth - Diagnostic Steps

The term "longitudinal" fracture is used because the crack typically changes over time and distance. The dynamic nature of the cracks cause challenges with diagnosis and treatment of these teeth. **Visual examination is considered the main technique for crack examination and is ideally done with an electronic microscope.**

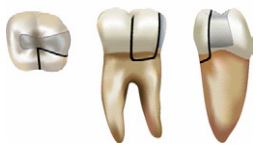
Here are diagnostic steps that should be taken when evaluating cracks:

- ***What are the patient's symptoms?*** Cracked teeth are often characterized by acute pain on mastication and brief pain with cold. Grainy, tough foods can be particularly challenging.
- ***Dental history?*** Did the patient bite on something hard, have a history of clenching and grinding, chew ice, or cracked other teeth?
- ***Can we see the crack on detailed examination?*** Magnification, special dyes, restoration removal and transillumination should be used.
- ***What is the status of the pulp and periapical tissues?*** Vitality testing, periodontal probing, and the tooth sloth are invaluable. Is there irreversible pulpitis or pulp necrosis?
- ***What do the radiographs show?*** Typically, a cracked tooth shows no signs on an x-ray however a vertical root fracture can show a j-shaped radiolucent lesion.
- ***Is surgical assessment needed?*** This is used as a last resort only in the most challenging cases.

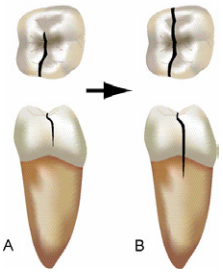
Different Cracks= Different Treatment Options

There are 5 different types of fractures that each require different treatment.

1. Craze Lines - These are cracks that only affect the enamel. There is typically no pain. No treatment is needed.
2. Fractured Cusp - This is a complete or incomplete fracture usually directed both mesiodistally and buccolingually. Typically, it crosses the marginal ridge and also the buccal or lingual groove. A restoration is typically present. This fracture generally extends to the cervical third of the crown or root and ends at or just below the gum line. Symptoms include mild pain on biting with a normal pulp and normal periapex. Treatment is removal of the fractured cusp and restoration of the tooth with a full crown. Prognosis is usually good. Root canal is only needed if the pulp chamber is affected or there is irreversible pulpitis.



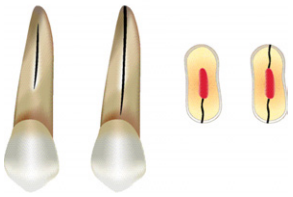
3. Greenstick Fracture/Cracked Tooth - This an incomplete fracture that is located in the crown portion of the tooth only or may extend from the crown to the proximal root. Growth/propagation of the crack includes both mesial and distal marginal ridges and is seen extending onto the distal root surface. A restoration is usually not present and the crack is more centered when viewed from the proximal. This type of crack is more likely to cause pulpal and periapical pathosis as it extends apically. The patient may feel acute pain when chewing or a sharp, brief pain when exposed to cold. Transillumination works great to detect a cracked tooth as the



light will not shine through the crack. Cracked Teeth usually need endodontic treatment and full crown. The patient should be informed that there is a guarded prognosis because the crack could continue to progress even after crown placement. Unfortunately, there is no guarantee of success.

4. Split tooth - This is a complete fracture initiated from the crown and extending subgingivally, usually in a mesiodistal direction through both marginal ridges and the proximal surfaces. This is the end result of a cracked tooth. Tooth segments are entirely separate. A split tooth can be confirmed by using wedging forces. The patient will have pain when chewing and soreness in the periodontium surrounding the tooth. The treatment of a split tooth depends on the extent of the split. Most of the severely fractured teeth need to be extracted. If a small segment of the tooth can be removed, the remainder of the tooth can usually be salvaged. Treatment of split teeth always includes root canal treatment.

5. True Vertical Root Fracture – This is a complete or incomplete fracture initiated from the root and usually directed buccolingually. This patient usually has minimal signs and symptoms. Typically, these teeth have a sinus tract, narrow isolated probing defect, and j-shaped radiolucency. The recommended treatment is extraction or removal of the cracked root.



Conclusion

In summary, cracked teeth present many challenges in dentistry and often the guidelines are not clear. Most researchers agree that cracks that are supragingival have a better prognosis than those which extend subgingivally. When the pulp or periapical tissues are affected, endodontic treatment is necessary. To preserve the tooth and prevent further propagation of the crack, the occlusal surface of the teeth should be reduced to decrease the force stresses, the patient should avoid chewing on that side, and a full coverage restoration is preferred (especially after endodontic treatment). Cracked teeth have increased in incidence recently due to the COVID-19 pandemic, however, with correct diagnosis and treatment many of these teeth can be saved.

SINGLE-IMPLANT-RETAINED MANDIBULAR OVERDENTURE

By Dr. Mailis Soler

Both the McGill (2002) and the York (2009) consensus statement strongly favor the two-implant-retained overdenture as the standard of care for treatment of the edentulous mandible. This consensus is based on substantial published evidence of very high implant survival rates in the anterior mandible accompanied with greatly reduced bone loss, as well as on numerous studies that show superior patient satisfaction when wearing a two-implant mandibular overdenture compared to a conventional denture. However, the cost difference between these treatments can be significant for many patients. Takanashi and coworkers showed the direct cost of the two-implant overdenture to be 2.4 times the cost of the conventional complete denture (Int J Prosthodont. 2004; 17:181-6). For this reason, the treatment modality of using a single symphyseal implant for anchorage of a mandibular complete denture is gaining popularity as an alternative.

The concept of the single-implant-retained overdenture has been shown to be successful and there is a growing body of evidence to support it. However, there is a lack of long-term follow-up studies in the literature of more than 5 years. Based on comparative studies of single-implant-retained and two-implant-retained mandibular overdentures, here is a list of advantages of treating patients with single-implant-retained mandibular overdentures:

- Cost is 1.31 times that of conventional dentures.
- Surgical procedure is less challenging and takes less time.
- Potentially less risk of mental nerve damage and postsurgical paresthesia.
- Relatively less maintenance cost and fewer adjustment recalls.
- Retention is optimum.

(Sudhindra Mahoorkar et al. Single Implant supported mandibular overdenture: A literature review. J Indian Prosthodont Soc. 2016; 16(1):75-82)

Studies evaluating patient satisfaction report improved quality of life and chewing ability with single-implant-retained overdentures compared to conventional dentures. Although single-implant-retained overdentures are less retentive than two-implant overdentures, patients report equally acceptable satisfaction with the retention perceived from both types of prostheses.

A study by Jingyin Liu and coworkers examined the influence of implant number on the biomechanical behavior of mandibular implant-retained overdentures using three-dimensional finite element analysis (J Dent. 2013; 41:241-9). They found that, under vertical load, the single-implant overdenture rotated over the implant from side to side with no obvious increase of strain in the peri-implant bone. In the two-implant overdenture model, there was more apparent rotation around the fulcrum line passing through the two implants, producing higher stresses in the abutments than in the other models. In the three-implant overdenture model, there was no strain concentration in the peri-implant bone of the middle implant. The authors concluded that the single-implant-retained overdenture is a feasible treatment option because of the absence of damaging strain concentration in the peri-implant bone. They also suggested adding a third implant between the original two when patients report constant denture rotation around the fulcrum line in a two-implant overdenture.

There is no consensus in the literature on the most appropriate protocol for loading single-implant-retained overdentures. Although several studies report success with immediate and early loading protocols, these are limited to a 1-year follow-up period, which is insufficient to determine the long-term success of the implants and prostheses. Several authors caution that there is higher expectation of failure with an immediate loading protocol. Conventional and delayed loading protocols (after 3months or more of healing) are encouraged.

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When it comes to attachments, most of the literature available on performance in single-implant overdentures is based on in-vitro studies and in-vivo randomized controlled trials with short follow-up periods. A group of researchers led by Dr. Alsabeeha reported on the retention forces of different attachment systems based on an in-vitro study. They found that the standard 2.25mm ball attachment (17.32 ± 3.68 N) had significantly higher retentive forces than the Locator attachments: Locator white (12.39 ± 0.55 N), Locator pink (9.40 N ± 0.74 N), and Locator blue (3.83 ± 0.64 N) (Int J Prosthodont. 2010; 23:160-6). The same group conducted a randomized controlled clinical trial with a 1-year follow-up period evaluating ball and locator attachment systems in single implant overdentures and concluded that the prosthodontic success was comparable (Alsabeeha et al. Clin. Oral Impl. Res. 2010; 22: 330-7). Maintenance visits were required with the use of both systems, and both doctors and patients should be aware of potential maintenance costs associated with this treatment.

Most of the information on single implant retained mandibular overdentures currently available in the literature is based on short-term follow-up studies. Although the results look promising, they should be interpreted with caution, especially those related to immediate loading protocols. Still, this is an exciting alternative treatment modality that can benefit many of our patients with limited financial resources. — mailis@schmittprosthodontics.com

Orange County Dental Clinic
Volunteers

With the recent closure of the Orange County Dental Clinic at Orange Technical College, we are transitioning our services to Grace Medical Home in order to continue providing comprehensive dental care to the underserved in our Orlando community.

In an effort to create an excellent volunteer experience, Michelle Lawton, Director of Dental Operations at Grace Medical, is available by phone or email to answer questions, provide a formal tour of Grace Medical Home, and review additional information regarding CE credits and sovereign immunity.

We're excited about this transition and the opportunity it creates to continue providing excellent dental services to those in our community who need it most. Please contact Pilar Guiu or Michelle Lawton with your interest or inquiries and they will be happy to assist you with the volunteer process.

We look forward to your continued commitment to our patients!

HOW IMPORTANT IS RIDGE PRESERVATION?

By Dr. Sara Shah

One of dentistry's greatest challenges is the loss of the labial crestal bone following dental extraction. The need to maintain and even expand bone volume, as well as soft tissue contours, prior to tooth replacement cannot be overstated. Traditionally, healing following the extraction of a tooth is by secondary intention; collapse of the socket walls leads to loss in alveolar volume and height. A systematic review by Hammerle & Araujo demonstrated that the alveolar ridge undergoes a mean horizontal reduction in width of 3.8mm and a mean vertical reduction in height of 1.24mm within 6 months after tooth extraction (Hammerle et al 2012). While there is, on average, a limited reduction in the vertical dimension the horizontal reduction is quite significant. Araujo sets the following expectations: (i) up to 50% reduction of the original ridge width will occur; (ii) the amount of bone resorption will be greater at the buccal aspect than at its lingual/palatal aspect; and (iii) a larger amount of alveolar bone reduction will take place in the molar regions (Araujo et al 2015). These alveolar ridge deformities compromise esthetics of fixed partial dentures and future implant placement.

In an effort to maintain bone volume after extraction, ridge preservation is advised. The goal of this procedure is to maximize bone formation while minimizing ridge contraction. While patient anatomy varies widely, consistency in the prognosis of bone grafting is key. Factors that affect the prognosis of ridge preservation include: defect size and topography (e.g. bony walls), absence of infection, soft tissue closure (e.g. primary closure), space maintenance, graft immobilization, regional acceleratory phenomenon, host bone vascularity, growth factors, healing regeneration time, graft materials (e.g. FDBA allograft), and the transitional prosthesis (Misch et al 2016). Adjuncts such as platelet rich fibrin (PRF) may be used to promote graft stability and post-operative healing outcomes. Caution and careful consideration is always advised for any patient with a history of bisphosphonate use, history of radiation treatment, uncontrolled diabetes, immune deficiency and severe infection.

Araujo MC, Silva CO, Misawa M, Sukekava F. Alveolar socket healing: what can we learn? Periodontology 2000. 2015 68:122-134.

Hammerle CHF, Arajuo MG, Simion M. Evidence-based knowledge on the biology and treatment of extraction sockets. Clin Oral Implants Res. 2012 May;23(5):641

Misch CE, Roknian VA. Keys to Predictable Socket Grafting – Part 1. Oral Health Group 2016.

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A Brush Up on Delegated Duties
For Your Dental Team Members

By ArNelle Wright, DMD, MS – *Contributor*

Every person on the dental team plays a vital role in the daily operations of our dental practices. Without the administrative staff, our phones would go unanswered, thus no patients to care for. Similarly, without chairside assistants, dentists would have limited ability to even perform much patient care, not to mention quality. Despite their official title, all dental team members have the responsibility of knowing and adhering to a special set of rules set by the Florida Board of Dentistry

Chapter 466, Florida Statues and Rule 64B5, Board of Dentistry, Florida Administrative Code, regulate the practice of dentistry. The legislature makes changes to statutes and the Board of Dentistry makes changes to Rule 64B5. Any time there are substantive changes to either statues or rules, the Florida Dental Association will update its members. Although the laws and rules are studied for licensure, their practice is sometimes forgotten, or simply overlooked. In order for our dental practices to meet and surpass the set standards, we must know them, review them, and practice them. For the purpose of this article, we will focus our attention on rules 64B5-16.005, 64B5-16.006, which are Florida Administrative Code and Chapter 466.024: Delegation duties; expanded functions.

Rules 64B5-16.005 & 64B5-16.006, Florida Administrative Code

The Florida Administrative Code, rules 64B5-16.005 and 64B5-16.006 defines and informs the remediable tasks delegable to dental assistants and hygienists. Simply put, it tells the tasks that can be delegated to our chairside assistants and dental hygienists. Before delegation begins, it's important to review a few key components of the discussion:

- General vs Direct vs. Indirect Supervision Levels
- Expanded Function Dental Assistant & Required Training
- Remediable vs. Irremediable Tasks

All Supervision Levels begin with and require the licensed dentist to examine the patient, diagnose the condition to be treated, and authorize the procedure to be performed. The differentiation is that they build on one another. General Supervision stops at the original definition, while Indirect builds upon General: requiring the presence of the licensed dentist while patient undergoes the procedure. Direct Supervision builds upon Indirect, requiring the dentist to review and approve the outcome prior to patient being dismissed from the practice.

In order to become a Florida Board of Dentistry approved Dental Assistant (DA) it is important to know these things: the Dental Assistant must obtain BOTH the EFDA Certification, as well as the Dental X-Ray Certification. DAs demonstrating competent clinical skill as well as passing a written exam of 75% or higher will be issued a Florida EFDA Certification. DAs can take advantage of 1-day EFDA Certification courses under special circumstances, hybrid type courses, or Dental Assisting courses that span a 12-week time period. Finally, should your DA elect to obtain the Dental X-ray Certification, be reminded that legally their only contribution to your practice would be taking X-rays. In order to work chairside, the EFDA is needed in Florida. Whatever the certification your DAs have, be sure to display their credentials conspicuously. Florida does not accept any other states' certifications.

Chapter 466.024: Delegation duties; expanded functions

Remediable tasks have been defined in this section as reversible intra-oral tasks, and those that do not alter the oral cavity and protect the patient from risk. Irremediable tasks in dentistry as just the opposite and are only to be performed by the licensed dentist. The remediable tasks delegable to dental assistants may also be delegated to hygienists, considering the patient is protected from increased risk, as well as proper training and supervision requirements have been met.

- While all tasks, definitions, and identities enumerated in Chapter 466, Florida Statues are of equal significance, for the purpose of your piqued interest commonly forgotten standards are listed below. "Any authorization for remediable tasks to be performed under general supervision is valid for a maximum of 24 months; after which, no further treatment under general supervision can be performed without another clinical exam by a Florida licensed Dentist." – *64B5-16.001*
- "Polishing clinical crowns when not for the purpose of changing the existing contour of the tooth and only with the following instruments and appropriate polishing materials – slow speed hand pieces, rubber cups, bristle brushes and Porte polishers" [Direct Supervision] – *64B5-16.005*
- *"Under Direct Supervision, a Certified Registered Dental Hygienist may administer local anesthesia … "* – Upon issuance of the Anesthesia Certification, the RDH will be referred to as a Certified Registered Dental Hygienist (CRDH) and must comply with administration of anesthetic parameters enumerated in Section 466.017(5). – *65b5-16.006*

We all know the difficulty associated with hiring and retaining team members that are a culture fit, as well as those team members interested in learning more about the field than what's introduced during their formal training. Knowing this, the goal of this article is to serve as a reminder of the guiding resources available and provided by the Florida Board of Dentistry, the Florida Dental Association, and The Dental Society of Greater Orlando. Additionally, we as a collective body value the associated respect and progression of our field. The last thing of interest to any of us having involuntary communication with the Florida Board of Dentistry as a result of avoidable mishaps.

For more information on the scope and area of practice for Dental Hygienists, and Dental Assistants refer to Ch. 466.023 F.S. on the Florida Board of Dentistry's website www.floridasdentistry.gov

To print the Delegation of Duties Chart, go to the Florida Dental Association's website Delegation of Duties (floridadental.org)

The Dental Society of Greater Orlando is also a resource for accredited schools should any of your Dental Assistants need to obtain the EFDA Certification. For future Dental Assistants, The Florida Dental Association offers an online radiography course as well.

DELEGATED DUTIES CHART FOR DENTAL ASSISTANTS AND DENTAL HYGIENISTS IN FLORIDA

Dental Assistant (Formal Training)

Level	Procedure
D	Placing or removing temporary restorations with non-mechanical hand instruments only
D	Polishing dental restorations of the teeth when not for the purpose of changing the existing contour of the tooth and only with the following instruments used with appropriate polishing materials – burnishers, slow-speed hand pieces, rubber cups, and bristle brushes
D	Polishing clinical crowns when not for the purpose of changing the existing contour of the tooth and only with the following instruments used with appropriate polishing materials – slow-speed hand pieces, rubber cups, bristle brushes and porte polishers
D	Removing excess cement from dental restorations and appliances with non-mechanical hand instruments only
D	Cementing temporary crowns and bridges with temporary cement
D	Monitor the administration of the nitrous-oxide oxygen making adjustments only during this administration and turning it off at the completion of the dental procedure
D	Selecting and pre-sizing orthodontic bands, including the selection of the proper size band for a tooth to be banded which does not include or involve any adapting, contouring, trimming or otherwise modifying the band material such that it would constitute fitting the band
D	Selecting and pre-sizing archwires prescribed by the patient's dentist so long as the dentist makes all final adjustments to bend, arch form determination, and symmetry prior to final placement
D	Selecting prescribed extra-oral appliances by pre-selection or pre-measurement which does not include final fit adjustment
D	Preparing a tooth surface by applying conditioning agents for orthodontic appliances by conditioning or placing of sealant materials which does not include placing brackets
D	Using appropriate implements for preliminary charting of existing restorations and missing teeth and a visual assessment of existing oral conditions
D	Fabricating temporary crowns or bridges intra-orally which shall not include any adjustment of occlusion to the appliance or existing dentition
D	Packing and removing retraction cord, so long as it does not contain vasoactive chemicals and is used solely for restorative dental procedures
D	Removing and recementing properly contoured and fitting loose bands that are not permanently attached to any appliance
D	Inserting or removing dressings from alveolar sockets in post-operative osteitis when the patient is uncomfortable due to the loss of a dressing from an alveolar socket in a diagnosed case of post-operative osteitis
D	Making impressions for study casts which are being made for the purpose of fabricating orthodontic retainers
D	Taking of impressions for and delivery of at-home bleaching trays
D	Taking impressions for passive appliance, occlusal guards, space maintainers and protective mouth guards
I	Making impressions for study casts which are not being made for the purpose of fabricating any intra-oral appliances, restorations or orthodontic appliances
I	Making impressions to be used for creating opposing models or the fabrication of bleaching stents and surgical stents to be used for the purpose of providing palatal coverage as well as impressions used for fabrication of topical fluoride trays for home application;
I	Placing periodontal dressings
I	Removing periodontal or surgical dressings
I	Placing or removing rubber dams
I	Placing or removing matrices
I	Applying cavity liners, varnishes or bases
I	Applying topical fluorides which are approved by the American Dental Association or the Food and Drug Administration, including the use of fluoride varnishes
I	Positioning and exposing dental and carpal radiographic film and sensors
I	Applying sealants
I	Placing or removing prescribed pre-treatment separators
I	Securing or unsecuring an archwire by attaching or removing the fastening device
I	Removing sutures

Dental Assistant (On the Job Training)

Level	Procedure
D	Applying topical anesthetics and anti-inflammatory agents which are not applied by aerosol or jet spray and
D	Changing of bleach pellets in the internal bleaching process of non-vital, endodontically treated teeth after the placement of a rubber dam. A dental assistant may not make initial access preparation
I	Retraction of lips, cheeks and tongue
I	Irrigation and evacuation of debris not to include endodontic irrigation
I	Placement and removal of cotton rolls
I	Taking and recording a patient's blood pressure, pulse rate, respiration rate, case history and oral temperature
I	Removing excess cement from orthodontic appliances with non-mechanical hand instruments only
G	Instructing patients in oral hygiene care and supervising oral hygiene care
G	Provide educational programs, faculty or staff programs, and other educational services which do not involve diagnosis or treatment of dental conditions
G	Fabricating temporary crowns or bridges in a laboratory

Hygienist (pre-licensure education or who has received formal training as defined by Rule 64B5-16.002, F.A.C)

Level	Procedure
D	Fabricating temporary crowns or bridges intra-orally which shall not include any adjustment of occlusion to the appliance or existing dentition
D	Selecting and pre-sizing orthodontic bands, including the selection of the proper size band for a tooth to be banded which does not include or involve any adapting, contouring, trimming or cementing or otherwise modifying the band material such that it would constitute fitting the band
D	Selecting and pre-sizing archwires prescribed by the patient's dentist so long as the dentist makes all final adjustments to bend, arch form determination, and symmetry prior to final placement
D	Selecting prescribed extra-oral appliances by pre-selection or pre-measurement which does not include final fit adjustment
D	Preparing a tooth surface by applying conditioning agents for orthodontic appliances by conditioning or placing of sealant materials which does not include placing brackets
D	Packing and removing retraction cord, so long as it does not contain vasoactive chemicals and is used solely for restorative dental procedures
D	Packing and removing retraction cord, so long as it does not contain vasoactive chemicals and is used solely for restorative dental procedures
D	Removing and re-cementing properly contoured and fitting loose bands that are not permanently attached to any appliance
D	Inserting or removing dressings from alveolar sockets in post-operative osteitis when the patient is uncomfortable due to the loss of a dressing from an alveolar socket in diagnosed cases of post-operative osteitis

Hygienist (pre-licensure education or who has received formal training as defined by Rule 64B5-16.002, F.A.C)

Level	Procedure
I	Placing or removing rubber dams
I	Placing or removing matrices
I	Applying cavity liners, varnishes or bases
I	Securing or unsecuring an archwire by attaching or removing the fastening device
I	Taking impressions for passive appliances, occlusal guards, space maintainers and protective mouth guards
I	Marginating restorations with finishing burs, green stones, and/or burlew wheels with slow-speed rotary instruments which are not for the purpose of changing existing contours or occlusion
I	Cementing temporary crowns and bridges with temporary cement
I	Monitor the administration of the nitrous-oxide oxygen making adjustments only during this administration and turning it off at the completion of the dental procedure
I	Using adjunctive oral cancer screening medical devices approved by the U.S. Food and Drug Administration

Hygienist (pre-licensure education or who has received formal training as defined by Rule 64B5-16.002, F.A.C)	
Level	**Procedure**
G	Polishing restorations which is not for the purpose of changing the existing contour of the tooth and only with the following instruments used with appropriate polishing materials – burnishers, slow-speed hand pieces, rubber cups, and bristle brushes
G	Polishing clinical crowns of the teeth which is not for the purpose of changing the existing contour of the teeth and only with the following instruments used with appropriate polishing materials – slow-speed hand pieces, bristle brushes, rubber cups, porte polishers and air-abrasive polishers
G	Applying of topical fluorides which are approved by the American Dental Association or the Food and Drug Administration, including the use of fluoride varnishes and silver diamine fluoride
G	Removing excess cement from dental restorations and appliances with non-mechanical hand instruments or ultrasonic scalers only
G	Placing periodontal or surgical dressings
G	Removing periodontal or surgical dressings
G	Removing sutures
G	Using appropriate implements to preassess and chart suspected findings of the oral cavity
G	Applying sealants
G	Placing or removing prescribed pre-treatment separators
G	Insert and/or perform minor adjustments to sports mouth guards and custom fluoride trays
G	Apply bleaching solution, activate light source, monitor and remove in-office bleaching materials
G	Taking impressions for study casts which are not being made for the purpose of fabricating any intra-oral appliances, restorations or orthodontic appliances
G	Taking impressions to be used for creating opposing models or the fabrication of bleaching stents and surgical stents to be used for the purpose of providing palatal coverage as well as impressions used for fabrication of topical fluoride trays for home application
G	Placing subgingival resorbable chlorhexidine, doxycycline hyclate, or minocycline hydrochloride
G	Taking of impressions for and delivery of at-home bleaching trays
G	Taking impressions for passive appliances, occlusal guards, space maintainers and protective mouth guards

Hygienist (Pre-licensure education or on the Job Training)	
Level	**Procedure**
G	Fabricating temporary crowns and bridges in a laboratory
G	Applying topical anesthetics and anti-inflammatory agents which are not applied by aerosol or jet spray
G	Taking or recording patients' blood pressure rate, pulse rate, respiration rate, case history and oral temperature
G	Retracting lips, cheeks and tongue
G	Irrigating and evacuating debris not to include endodontic irrigation
G	Placing and removing cotton rolls
G	Placing or removing temporary restorations with non-mechanical hand instruments only
G	Obtaining bacteriological cytological (plaque) specimens, which do not involve cutting of the tissue and which do not include taking endodontic cultures, to be examined under a microscope for educational purposes

Hygienist (On the Job Training)	
Level	**Procedure**
D	Changing of bleach pellets in the internal bleaching process of non-vital, endodontically treated teeth after the placement of a rubber dam. A dental hygienist may not make initial access preparations

Certified Registered Dental Hygienist (CRDH)	
Level	**Procedure**
D	Under direct supervision, a CRDH may administer local anesthesia in accordance with the following: 1. The patient must be eighteen years of age or older; 2. The patient must not be sedated; and 3. The CRDH may administer intraoral block and soft tissue infiltration anesthesia.

Hygienist (Without additional training as defined in Chapter 64B5-16, F.A.C)	
Level	**Procedure**
D	Gingival curettage.
G	Root planing
I	Removal of excess remaining bonding adhesive or cement following orthodontic appliance removal with slow-speed rotary instrument, hand instrument or ultrasonic scalers
G	Removing calculus deposits, accretions and stains from exposed surfaces of the teeth and from the tooth surfaces within the gingival sulcus (prophylaxis)
G	Placing and exposing dental and carpal radiographic film and sensors
N	Perform dental charting as defined in s. 466.0235
N	Provide educational programs, faculty or staff training programs, authorized fluoride rinse programs, apply fluoride varnishes, instruct patients in oral hygiene care and supervising patient oral hygiene care and other services which do not involve diagnosis or treatment of dental conditions
N	Apply fluoride varnishes, and silver diamine fluoride, instruct patients in oral hygiene care and supervising patient oral hygiene care and other services which do not involve diagnosis or treatment of dental conditions.
N	Perform the remediable tasks specified in Sections 466.023(3), 466.0235, and 466.024(2), F.S., as long as all provisions of the respective statute are met

Hygienist in a Health Access Setting (Section 466.03, Florida Statutes)	
Level	**Procedure**
N	Perform dental charting as defined in s. 466.0235
N	Measure and record a patient's blood pressure rate, pulse rate, respiration rate, and oral temperature
N	Record a patient's case history
N	Apply topical fluorides, including fluoride varnishes
N	Apply dental sealants
N	Remove calculus deposits, accretions, and stains from exposed surfaces of the teeth and from tooth surfaces within the gingival sulcus

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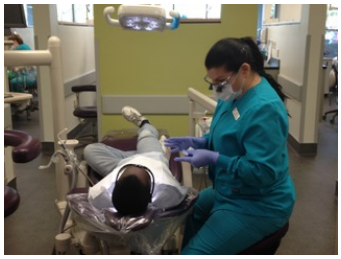
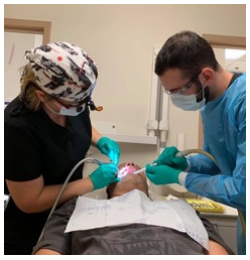


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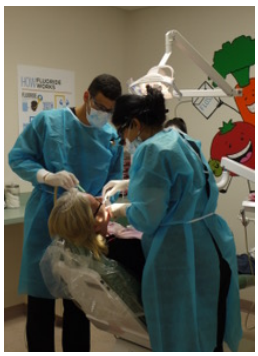

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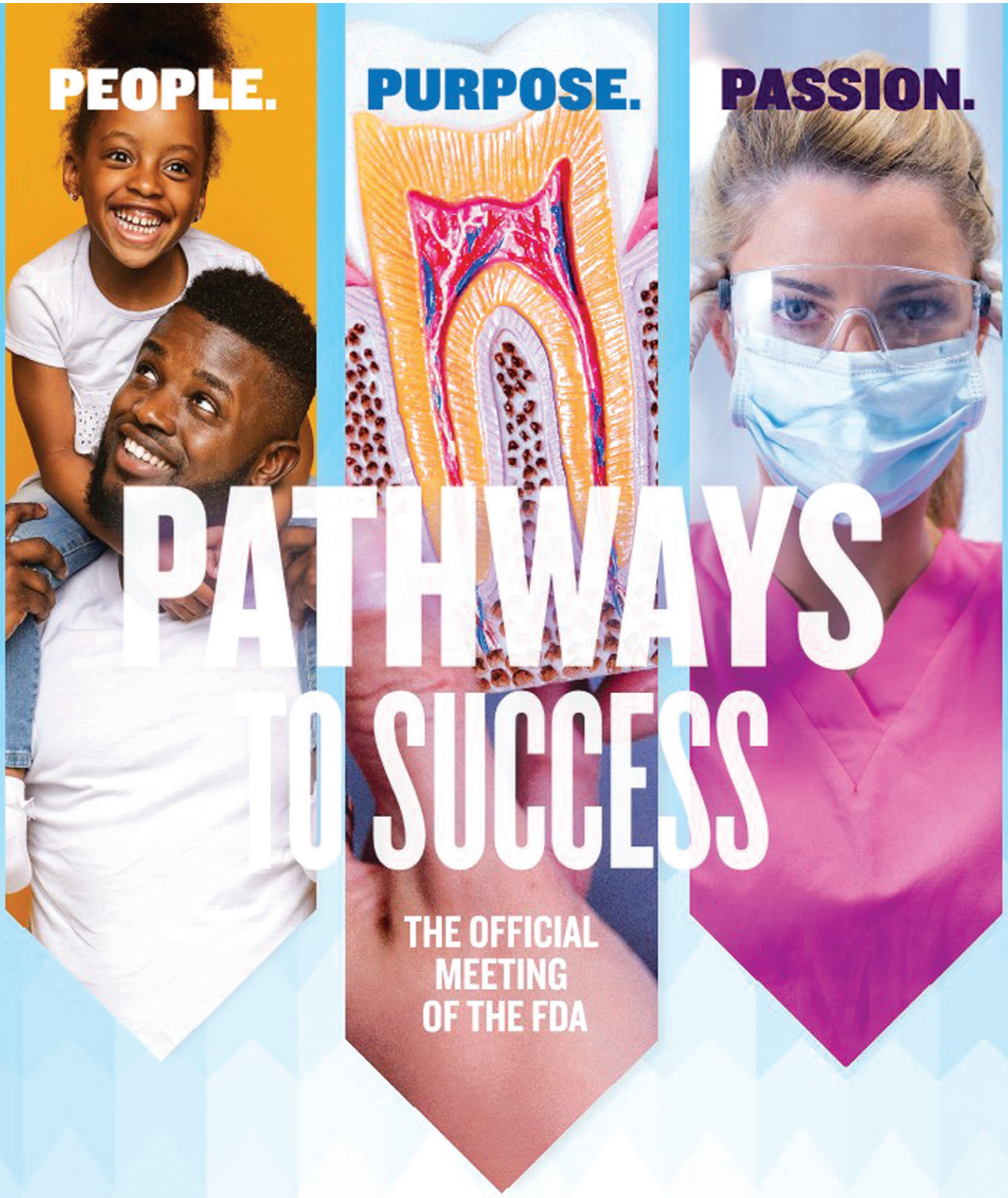

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Plandemic

Well, 2020 and the Covid-19 pandemic certainly shook up the world to say the least. Maybe now we can begin to see the light at the end of the tunnel with vaccines being widely distributed and fairly well accepted. In this country alone we are closing in on 600,000 deaths attributed to this nasty virus. As we seem to be emerging from this global nightmare (maybe), I am left with a lot of questions and very few answers. Okay so what now?

First is how did we even get here? The international cooperation when this first emerged was sketchy at best. Denial and obfuscation was in play for the entire world to see. As of April 2021, we still do not have a consensus explanation of the true origins. As this pandemic swept across the globe, both the medical and scientific community struggled with how to best combat the virus and protect the populace.

In the United States somehow this virus and its treatment protocols became politicized along the way. Does everyone remember February 2020 when Dr. Anthony Fauci declared that there was no need for mask wearing? Information has been both confusing and conflicting. Social distancing and mask wearing became mandatory or not depending on where you lived. In my opinion the WHO and the CDC have made a hash out of this. Mask mandates were issued in 38 states and the efficacy of mask wearing was and is hotly debated. Some scholars contend that mask wearing is not supported by clinical evidence to support the spread of disease. This is of course despite the common sense practicality of reducing droplet spread.

The lockdown policies implemented globally have had questionable value as to virus spread. What is not in question are the other deleterious effects of lockdowns. Significant harm to children has occurred due to the suspension of in-person schooling including drop outs, poor learning and suicides. The CDC reports an overall four-fold increase in depression, a three- fold increase in anxiety, and a doubling of suicide ideation. Reports of drug overdoses have also skyrocketed. Unemployment as a result of these policies has played a factor as well.

Overall health has suffered in our country with treatments delayed and diagnosis unavailable. A recent study estimates that 78% of cancers were never detected due to missed screening during a 3-month time period.

Let's talk about the dental world, shall we? My first concern is the world wide shut down of all but emergent dental care. This was hypothesized to be necessary due to dental aerosols. However, since the HIV crisis in the mid 1980's no one does PPE better than us. While I realize the virus was an unknown, in the past the dental setting has not been identified as a point of disease transmission. So what was the basis for our shut down? Subsequently at least 37 scholarly articles have indicated that Covid transmission in the dental office is just not a thing. Also troubling was here in Florida there was no organized effort to provide vaccinations for dentists and staff. Our patients are also suffering the effects of delayed diagnosis and treatment stemming from a variety of reasons associated with this pandemic.

As we move forward, what are the lessons to be learned? Do we as practitioners need to have some type of plan in place for the next pandemic? We are an interconnected world and this could certainly happen again. What would a pandemic plan for an individual practice even look like or what form would it take? I am afraid we at least need to consider the possibility of a future recurrence of some form.

As far as dental training is concerned, there are senior dental students that are still waiting to complete their first full coverage crown due to the constraints placed on school clinics. How do these students make up for are lost training time? This is likely to have ripple effects in the profession for years to come.

Another concern will be the hidden effects of Covid infection in those that are recovered. There are now documented oral manifestations to consider. One thing that worries me are any unknown sequela that could manifest itself while sedating a patient. The range of post infection issues affecting some individuals is in a word bizarre.

In the future let's hope we never see anything like this again, but if we do, let's hope everyone from ourselves to world leaders are better prepared to handle it. It will be interesting.

Jeff Sevor

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FRAUD ALERT

Finally, an important reminder that dentists should be aware of potential fraud schemes. The Florida DOH is warning health care practitioners about fraudulent calls from scammers who are threatening action against health care licenses, demanding money and requesting personal identifying information. The DOH has posted information and guidance about licensure and fees. **Licensees will never receive unsolicited calls from the department where personal information is requested, payments are demanded or threats are made against licenses.**

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