THE DENTAL SOCIETY OF GREATER ORLANDO

Journal

WINTER 2022

A TIPPING POINT?

What Have We Chosen to Deny, Forget, Overlook and Ignore?

Sink Your Teeth Into This
HELP WANTED

Recognize & Reflect
THE PRICE TAG OF INEFFICIENCIES

Specialist Corner
- "HOT TOOTH" DIAGNOSIS & TREATMENT
- CHOOSING THE RIGHT PONTIC DESIGN

President's Message
LOOKING FORWARD TO 2022

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

WELCOME NEW MEMBERS

Dr. Craig Aebli
2421 Maple Ave.
Sanford, FL 32771
(407) 323-5340

Dr. Daniela Alvarez
865 Balch Ave
Winter Park, FL 32789
(407) 629-2161

Dr. Mark Angeloni
400 West Morse Blvd.
Winter Park, FL 32789
(407) 794-0739

Dr. Keren Castellucci
5745 Canton Cove Ste 101
Winter Springs, FL 32708
(407) 755-4119

Dr. Fabiola Douglas
430 N. Mills Ave #2
Orlando, FL 32803
(407) 843-8180

Dr. Kamyar Raiss Giglou
2045 Lee Rd
Winter Park, FL 32789
(407) 629-4444

Dr. David Hall
610 North Mills Ave.
Orlando, FL 32803
(407) 843-2261

Dr. Allison Harris
1097 Douglas Ave.
Altamonte Springs, FL 32714
(407) 834-4500

Dr. Brenna Kever
2990 Bliss Cove
Oviedo, FL 32765
(407) 366-3799

Dr. Utumporn (Penny) Laowansiri
3311 Daniels Rd. Ste 104
Winter Garden, FL 34787
(407) 656-0990

Dr. Ana O'Farrill
1031 Plaza Dr.
Kissimmee, FL 34743
(407) 344-1550

Dr. Jennifer Somoray
2180 N. Courtenay Pkwy.
Merritt Island, FL 32953
(321) 452-3388

Dr. Ruby Wagimin
5946 Curry ford Rd Ste 101
Orlando, FL 32822
(407) 377-7560

Dr. Nicholas White
974 International Pkwy
Lake Mary, FL 32746
(407) 942-0225

From left: Angel Hance, Sharon Hamilton and Kelly Millett attend the course *Florida Prescribed Controlled Substance* at the October Membership Meeting, held at the Country Club of Orlando.

DSGO Dues are Due!

At the beginning of November, the Florida Dental Association mailed the annual dues statement for the American Dental Association, Florida Dental Association, and the Central Florida District Dental Association (tripartite) to members. The Dental Society of Greater Orlando (DSGO) has its own dues statement, which was first mailed out on May 1 for the July 1, 2021-June 30, 2022, dues year. Please note, when you pay the ADA, FDA, and CFDDA dues, you are not remitting for Greater Orlando. If you have not paid your DSGO dues, you have until December 31, or your name will be dropped from our membership roster.

Remember, you must be a member of the ADA/FDA/CFDDA to be a DSGO member …

Looking Forward *to 2022*

Dear Colleagues,

I want to start off by saying how grateful I am for this society and the camaraderie that it encourages. It has been great to see many of you at our recent events. I'm proud to report that in 2021 we have welcomed a number of new members and reconnected with many existing members, while continuing to develop an engaging curriculum that strives to advance our profession.

As the calendar page turns to a new year, let me say thank you. Thank you for your continued dedication, loyalty and support. It is a great honor for me to be leading the Dental Society of Greater Orlando and I look forward to a very successful year ahead. Let us all march into 2022 with pride of what we have accomplished and the drive to make the next year even more amazing as we advance dental health in our region.

We are going to start 2022 with some fun! Join us in welcoming new members and connecting with old friends on Thursday, January 27th, 2022. We will gather to kick start our year with wine, appetizers and great conversation at Grape & the Grain Wine Bar (located near DSGO headquarters, nestled between the Mills 50 & Ivanhoe Village neighborhoods). Bring your colleagues and let's have a blast!

I want to once again thank you all for your continued commitment and contributions to our society over this past year.

Happy Holidays and blessings to you and yours!

Sincerely,

Caroline Gordy-McHugh

Dr. Caroline Gordy-McHugh
DSGO PRESIDENT
2021-2022
407-422-1130
Carolinegordymchugh@gmail.com

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

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.

THURSDAY, FRIDAY & SATURDAY
JUNE 23-25, 2022
FDA Florida Dental Convention
Gaylord Palms

Invitation Extended

CAN'T WAIT TO SEE YOUR SUBMISSIONS

Happy Holidays DSGO! We are close to wrapping up another year of official business and fun times spent amongst one another. The leadership of our organization has done and continues to do a phenomenal job at hosting valuable CE courses and meetings that keep us informed and professionally advanced. In this edition of our journal, you will find articles submitted from colleagues of various specialties, while also enjoying photos that highlight time we've spent both together and apart. Time continues to fly but my hope is that our fondest memories will linger this season. To ensure that they do, let us hear from you!

We would like for our membership to share more photos of you engaged with your dental teams or your favorite hobbies. We'd also like to extend the invitation for you to submit articles so that we can highlight your expertise but learn from it as well. Although we're concluding this calendar year officially, remember that 2022 is quickly approaching. Your DSGO leadership has planned another year of growth, success, and fun with you in mind.

ArNelle Wright, DMD, MS
EDITOR

Happy Holidays!!

Clockwise from left: Dr. ArNelle Wright pictured with Dr. Witt Wilkerson; Dr. Caroline Gordy-McHugh; Dr. Lidddell; Dr. Lisa Yurkiewicz

WHO IS THAT SITTING *in the Patient Chair?*

By Denise Murphy, BA, CDA, CDPMA, EFDA

Dental assistants are well aware of what a rewarding career dental assisting can be, and that knowledge is spreading — people outside dentistry have started to notice the advantages of working in this growing profession. In fact, this year U.S. News & World Report rated dental assisting as the #17 best healthcare support job in the country, and the #72 overall best job.

This isn't the first time dental assisting has been called out as one of the best jobs in the U.S. — it's been topping lists for the last five years. Think about the patient in your dental chair … do they have the potential to become an outstanding dental assistant?

Does the patient enjoy a nice smile and pretty teeth? Do they keep their appointments and follow home care instructions? Then maybe, you or your staff might ask if they have ever thought of a career in dental assisting.

Below are some of the reasons why dental assisting is one of the best careers:

DENTAL ASSISTING IS:

1. Flexible

We have an ADA Accredited dental assisting program right here in Central Florida at Orange Technical College ~ Orlando Campus. There are many options once you become a dental assistant. General practice, specialty practice, front desk, practice coordinator or instructor! Once you get into the field, you may be able to take advantage of the flexible hours many dental assistants enjoy.

2. Fascinating

Dental assistants interact with nearly every patient who walks through the dental practice's door. As a result, your job is fast-paced and interesting — there's always someone new to meet, a new problem to solve, or a new technique to try. No two days are ever the same!

3. Fast-Growing

According to the U.S. Bureau of Labor Statistics, dental assisting is supposed to grow 18% over the next 10 years — which is much faster than the national average. This puts dental assisting among the top 25 fastest-growing occupations in the country.

4. Full of Opportunity

More and more, states are expanding the functions that dental assistants are allowed to perform. In most states, passing DANB exams or holding Certified Dental Assistant (CDA) certification is recognized or required to take on more duties. Look up your state requirements or find out more about DANB exams and certification.

It's an exciting time to be a dental assistant, and word is getting out about the advantages of this growing career path. Help fill the need in your practice and the profession by encouraging one or more of your patients to consider a career in the dental profession!

Excerpts from *Dental Assistant Life*, April 15, 2016

THE PRICE TAG OF *Inefficiencies*

By Janet Valazquez

Eliminating inefficiencies in your practice is crucial to unlocking your maximum financial potential. The truth is that inefficiencies in your practice are costing you tens of thousands of dollars each year. I get it, you're busy! You're diagnosing, treating patients, trying to remain on time, in your already overbooked schedule, while one of your assistants called out, and you're already understaffed!

Evaluating, and refining operational systems often is a fundamental and required process if you want growth at any level for your practice. Let's examine just a few key facts.

1. **Time:** Just 23 minutes of wasted time each day is equivalent to two weeks of paid vacation per year.
2. **Work Quality:** Things that take longer have more errors. Increased patient expectations and worker shortages nationwide have meant heavier workloads for everyone. This has increased turnover rates and led to compromised quality to "get it all done" within a day's work.
3. **Workflow:** No or slow workflows will cost your practice the value of consistent patient care.
4. **Risks:** Inefficiencies in both clinical and administrative processes result in costly liabilities.

The bottom line is that inefficiency is very expensive! An inefficient approach to your operational struction will often result in frustrations, devalue your efforts, make your team members appear incompetent, and reflect in your reports as decreases in the bottom line.

Improve inefficiencies in your practice by starting with these two steps:

Step One: Recognize and Reflect. Inefficiencies not only cost money, however, it also negatively impacts the patient experience, affects treatment acceptance rates, and adds unnecessary stress to team members.

Step Two: Ask yourself the following questions:

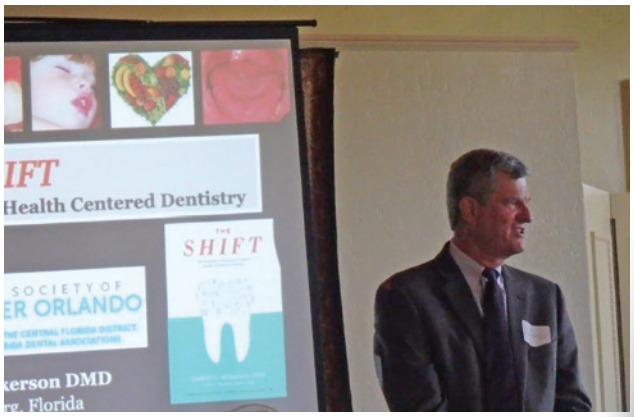
1. Do your employees embrace the value and importance of time management? If so, do they manage and prioritize their daily activities to align with your practice performance expectations?
2. Can you and your patients count on getting the same level of quality performance and care from each employee?
3. Are all of your team members able to efficiently and effectively answer the phone, help the patient, and secure an appointment?
4. Does everyone in your practice live out the core values as they work in alignment with the company vision and goals each day?

If you answered, "No" to any of these questions, you are not alone. Remember, the devil is always in the details.

Failure to make necessary changes that ensure your team is patient-focused, and readily available directly impacts your financial bottom line. Addressing and resolving these inefficiencies will impact patient satisfaction rates, restore interrupted comprehensive patient care, limit risks, and increase profits.

Janet is a Systems and Operations Efficiency Specialist, a Business Management Consultant, and the CEO of JV Practice Solutions, LLC. She partners with private practices to identify and close operational gaps that are financially impacting the bottom line. With over two decades of experience, she has a proven track record of implementing a company culture that is based on an elevated level of organization and attention to detail, that has directly resulted in increased profitability for practices. Janet has helped many practices fine-tune the many operational systems that are required in developing high-performing organizations. She creates solid consistency and sustainable long-term financial growth in an ever-changing market. She strongly values education and holds countless certifications and accomplishments including fellowship status with the American Association of Dental Office Management, and a Bachelor's in Organizational Behavior and Business Communications from Rollins College in Winter Park.

Thank you to Dr. Tony Wong for the pictures



Dr. Witt Wilkerson, speaker, at the Country Club of Orlando

Dr. Eric Wu at the Wilkerson meeting

Dr. Witt Wilkerson

"The Shift: The Dramatic Movement Toward Health Centered Dentistry"

Doctors Witt Wilkerson, Nathan Mayo and Cathy King

Past President of DSGO Dr .Tom Hand, Dr. Witt Wilkerson and President Caroline Gordy

Attendees at the Goodwin presentation

Dr. Aaron Goodwin

"All about Dentistry, Osteopathy and TMD"

Dr. Aaron Goodwin, speaker

Doctors Tom Holehouse, David Blue, Bernie Kahn and Dr. Tony Wong at the 2021 House of Delegates at the Florida Dental Convention

Dr. Hector Vila, speaker, at the Winter Park Community Center October Membership Meeting

Thank you to Dr. Keren Castellucci for the picture

Dr. Hector Vila

"What Can *and Has* Gone Wrong in Dental Sedation"

Doctors Clay Miller, Past President, and Treasurer Scott McCauley

Doctors Mike Abufaris and Don Thomas at the Controlled Substance Course

Dr. Marc Kaprow, speaker, at the Country Club of Orlando

Dr. Marc Kaprow

"Florida Prescribing Controlled Substances Course"

William "Bill" Benjamin Kent III, DDS

Bill was born on May 5, 1935, to Madelyn Claire Edam and William Benjamin Kent, Jr., at St. Johns Hospital in Cleveland, Ohio. A Catholic, he grew up in Columbus, Ohio where his father was a newspaperman for The Columbus Dispatch.

He received his education at Immaculate Conception grade school St. Thomas Aquinas, taught by the Dominican Fathers and the Ohio State University where he earned a Bachelor of Science degree. He then served for two years in the United States Army Armored Corps where he rose to the rank of Captain. His tours of duty included the 9th Cavalry, 1st Cavalry Division in Korea and Ft. Knox, Kentucky where he met his bride of 50 years, the former Margaret "Peggy" Hart Rapier of Louisville, Kentucky.

Bill and Peggy had four children, Deborah Hart Kent Thomas (Gordon) of Cincinnati, Ohio, William Benjamin "Ben" Kent IV (Kristi), of the Orange County Sheriff's Office of Orlando, Florida, Lisa Hayden Kent Meyer (Mark), Orange County Public Schools Exceptional Education Placement Specialist of Orlando, Florida and Diane Forbes Kent, loving caregiver of William of Orlando, Florida. They were blessed with nine grandchildren, Megan Meyer, Adam Thomas, Zachary Kent, Grant Meyer, Tanner Kent, Eric Thomas, Luke Thomas, Kent Meyer, and Ryan Thomas.

Dr. Kent graduated from Case Western Reserve University School of Dentistry in 1966. After a year of internship at Chattahoochee State Hospital, he practiced general dentistry in Orlando for 46 years (1969-2015). A member of the senior staff at Orlando Regional Medical Center, he also belonged to the Dental Society of Greater Orlando, Florida State Dental Society, the American Academy of General Dentistry, and served in many positions and committees over the years. He was active in the Orange County Republican Party and Orange County community affairs.

He was a 3rd degree and charter member of the Knights of Columbus, Chapter #5958 and a parishioner of St. Patrick's Catholic Church, Mr. Dora, Florida.

Preceded in death by his loving wife Margaret "Peggy" Hart Rapier and survived by his siblings George "Buzz" Kent, Madelyn "Sis" Smith, Marcie Grealis and Constance "Connie" Riebling.

We will cherish all the writings left behind, including one letter recently found where he said "I feel the love of all those I've left behind me, and the joy of seeing those who have gone before me. I will wait, for in time, you too will come. This is not goodbye – just see you later. Love, Dad." Dad, you were loved by many and will be deeply missed … until we meet again!

A viewing was held on Saturday, September 25 at Woodlawn Funeral Home and Memorial Park.

Dr. Charles McNamara

Dr. Charles Richard Patrick Gerard McNamara, of Winter Park, Florida, entered into the presence of the Lord on September 27, 2021, surrounded by his family.

Born August 6, 1954, in Melrose, Massachusetts, Charlie was the fifth child of Christine & Dr. Francis McNamara.

A 1979 graduate from Tufts University School of Dental Medicine in Boston, MA, Charlie's compassionate practice as an Oral and Maxillofacial Surgeon was unmatched. He completed two residencies in Anesthesiology and Oral and Maxillofacial Surgery at Duke University Medical Center in Durham, NC. He completed a third residency in Dental Implantology at Jackson Memorial Hospital in Miami, FL. He taught Clinical Oral Surgery at Tufts University and was a Clinical Instructor for the University of Miami Department of Oral and Maxillofacial Surgery. Charlie eventually settled in Winter Park, FL where he became a partner with the Oral & Facial Surgeons of Mid-Florida. He was a Diplomate of the American Board of Oral and Maxillofacial Surgery, and served as the Chairman of the Department of Dentistry for Florida Hospital and Orlando Regional Medical Center. He was also a member of the Board of Directors for the Dental Society of Greater Orlando.

More important than being a surgeon, Charlie was a family man. Nothing took priority over being a father, husband and friend. He had that well known sense of humor and brilliantly quick wit. He had a listening ear and he always knew how to get the monsters out from under the bed. Charlie loved fly fishing and grilling. His day started before sunrise with coffee and games of solitaire before work and often ended watching WW II documentaries and eating cereal before bed. He would argue with "Alexa" and challenge contestants on Jeopardy. Charlie was proof that having an extortionary impact and living an ordinary life are not mutually exclusive. He truly possessed a servant's heart. Charlie leaves his family with a legacy to be kind, to give of ourselves, to laugh, and when able, to ease the suffering of another.

Charlie's death came suddenly just at the time he was looking forward to retiring, being with his family and watching his precious grandson grow up with "Papa's" counsel. May our broken hearts be a testament of the love we feel for you.

Charlie is survived by his wife and best friend, Joan McNamara. He leaves behind four children and their spouses: Charles McNamara, Jr. and Sarah Minnis; Muriel Collins and Ryan Collins; Rory McNamara; and Anna Christine Faircloth. He is also survived by his grandson, Charles Collins; his siblings and sisters-in-law, Dr. Francis McNamara and Genevieve McNamara; Paul McNamara and Sam Johnson; Christine "Honey" Haigis; and John McNamara and Linda McNamara; and numerous beloved nieces and nephews. Reunited with the family and friends he has not seen in a long time, Charlie is preceded in death by his father and mother, Dr. Francis McNamara and Christine McNamara; his mother-in-law and father-in-law, Dr. Grover Smith and Christine Smith; and his brother-in-law, Dr. Michael Smith.

A funeral mass was held on Saturday, October 16th, at St. Margaret Mary Catholic Church in Winter Park, Florida. Following the mass, a reception was held at the University Club of Winter Park.

GET INVOLVED – BECOME A DENTAL SOCIETY OF GREATER ORLANDO BOARD MEMBER

- Must be an Active Member in good standing of the Society
- Attend nine dinner board meetings at the Dental Society of Greater Orlando office or via Zoom-takes about an hour of your time on Monday evenings at 6:00 p.m.
- Attend 4 quarterly membership meetings
- Attend Dentist Day on the Hill in Tallahassee usually in February or March
- The Board of Directors shall transact all business of the Dental Society of Greater Orlando, Inc. It shall determine the policies, fiscal matters, and in general assume responsibility for the guidance of the affairs of the Society.
- It is important to have a quorum at each board meeting to be able to vote on any business. A quorum is a minimum of 10 people.

If interested contact Sharon Hamilton at 407-894-9798 or sharonhamilton@dsgo.org

TAKING THE PAIN AWAY
"HOT TOOTH" DIAGNOSIS & TREATMENT

By Dr. Ericka Ferguson
Apopka Endontics

Every dentist, whether you are a newbie or a seasoned veteran, has encountered the "hot tooth". You know, the tooth that does not get numb no matter how hard you try. It comes along with a terrified patient that has not slept and they are holding their face in agony. Traditional anesthetic techniques do not work. Your patient has not eaten in several days and is quickly losing faith in your skills. You feel defeated as a dentist. All you want to do is help. The tooth remains sensitive to pressure, temperature, and touch. It's the infamous "hot tooth", highly inflamed and unresponsive to traditional methods of anesthesia. We have all been there. This article is here to help! Diagnosis, Dental Treatment, Drugs and techniques to successfully anesthetizing the "hot" dental pulp.

Dental Diagnosis – Thinking beyond the tooth:
Our ability to accurately diagnose acute inflammatory dental pain is paramount to our professional survival. There are many different causes of dental pain and sometimes it can be non-odontogenic in origin. The "hot tooth" is typically Symptomatic Irreversible Pulpitis, an inflammatory condition of the pulp. It is characterized by spontaneous pain, decreased pain threshold, and increased response to a painful stimulus. There caries, history of trauma, or a leaky restoration. When the etiology of tooth pain is unclear, please consider all non-odontogenic sources of pain before proceeding with treatment. Here is a chart to help!

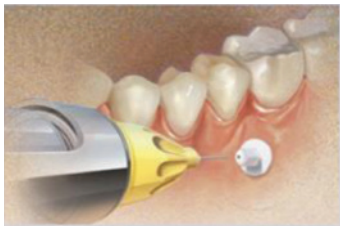
Table 1. Differential Diagnosis of Dental Pain

ODONTOGENIC PAIN
Odontalgia – e.g., symptomatic reversible pulpitis, symptomatic irreversible pulpitis, symptomatic apical periodontitis, pulp necrosis
VS. NON-ODONTOGENIC PAIN
Musculoskeletal – e.g., TMD
Neurovascular – e.g., migraine, cluster headache
Inflammatory Conditions – e.g., sinusitis
Systemic Disorders – e.g., cardiac pain
Psychogenic – e.g., persistent somatoform pain disorder
Neuropathic – e.g., trigeminal neuralgia, herpes infection

Dental Treatment and obtaining successful local anesthesia:
Next, we need to reduce pain in a terrified patient. "Hot teeth" are difficult to anesthetize. Sometimes the Inferior Alveolar Nerve Block does not achieve pulpal anesthesia. Adding additional carpules of anesthetic does not work and unfortunately, lip numbness alone is not enough. Surprisingly, failure of pulpal anesthesia is higher in the incisor teeth than the molars and premolars. Research shows, pulpal anesthesia failure occurs in approximately 17% of first molars, 11% of first premolars and 32% of lateral incisors. After using your traditional methods of anesthesia via infiltration or IAN block try using the following:

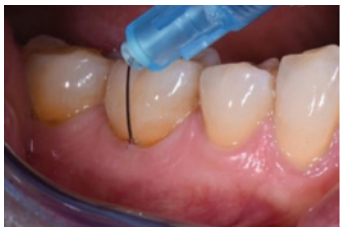
■ **Intraosseous injections (IO):** Clinically, the intraosseous injection works very well providing approximately 60 minutes of pulpal anesthesia approximately 86% - 90% of the time when used after the Inferior Alveolar Nerve Block. The IO injection technique can provide anesthesia to a single tooth or multiple teeth in a quadrant, depending on the site of injection and the volume of anesthetic administered. The system typically consists of a perforator, a guide sleeve, and a 27-gauge ultra-short needle.

Method: After confirming by radiograph that there is adequate interproximal bone between the teeth, the perforator and guide sleeve are attached to a slow-speed handpiece and a perforation is made approximately 2 mm coronal to the mucogingival line, distal to the tooth to be anesthetized. The handpiece and perforator are removed, leaving the guide sleeve in the attached gingiva. A 27-gauge ultra-short needle is introduced through the guide sleeve and approximately one-third of the carpule of local anesthetic is injected.



■ **Periodontal Ligament (PDL) Injections:** This injection technique is frequently used when an isolated area has inadequate anesthesia in a mandibular molar. It is often accomplished using a PDL injector but can also be accomplished with your traditional syringe and needle. This technique successful about 75% of the time.

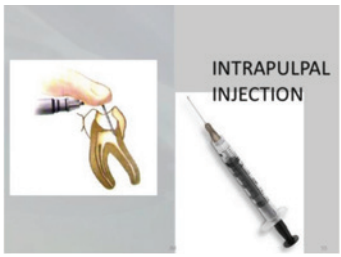
Method: Use a 30-gauge ultrashort needle with the bevel oriented towards the root surface. Administer a small amount (0.2ml) of anesthetic solution slowly to the distal of each root. The needle is firmly placed into the periodontal space between the root of the tooth and the interseptal bone. Excessive amounts of anesthetic should not be administered into this confined space. Also, you must feel a resistance. Ischemia (blanching) will often be seen which will indicate you have been successful. Advantages of this technique are profound pulpal anesthesia with a minimal volume of anesthetic and the absence of lingual and lower lip anesthesia when used without the IAN block.



■ **Intrapulpal Injection:** You will find that 5-10% of mandibular molars do not obtain pulpal anesthesia with the supplemen-

tal injection techniques above. In this situation, an intrapulpal injection is indicated. It is considered a technique of last resort because it is very painful to the patient and profound anesthesia only lasts 15 – 20 minutes. However, the pain to the patient is only momentary lasting 1-2 seconds.

Method: Quickly access the dental pulp at the highest pulp horn using a #2 round bur in your high-speed handpiece. Place a 30-gauge short needle bent to almost 90 degrees into the access opening and administer anesthetic under pressure.



■ **Drugs:**

The final step in treating the "hot tooth" is discussing appropriate pre-treatment and post-treatment analgesics. Research has shown that non-steroidal anti-inflammatory drugs (NSAIDs) such as Ibuprofen 400mg – 600mg can produce profound pulpal analgesia. Therefore, preoperative administration of NSAIDs may increase the effectiveness of the local anesthetic IAN block. However, beware, NSAIDs can "mask" symptoms making diagnosis of an inflamed tooth difficult. Ibuprofen 800mg taken within 4-6 hours prior to a dental appointment can reduce palpation pain by 40%, percussion pain by 25%, and cold pain by 25% in teeth with symptomatic irreversible pulpitis and symptomatic apical periodontitis.

Post-treatment analgesics are equally important in managing emergency pain patients. Together with antibiotics, we can provide valuable relief to patients. Here is a chart of commonly prescribed analgesics.

Table 2. Commonly Prescribed Analgesics for Treating Dental Pain

Drug	Brand Name	Dosage	Maximum Dosage	Rx or OTC
Ibuprofen	Advil, Motrin, Nuprin	400-600 mg every 4-6 hours	3200 mg/day	Rx > 200 mg OTC 200 mg
Naproxen	Aleve, Naprosyn	440-500 mg every 12 hours	1000-1100 mg/day	Rx > 220 mg OTC 220 mg
Acetaminophen with Codeine #3	Tylenol with Codeine #3 (30 mg codeine/ 300 mg acetaminophen)	1-2 tablets every 4-6 hours	3000 mg acetaminophen/day and 360 mg codeine/day	Rx
Acetaminophen with Hydrocodone	Vicodin-5 (5 mg hydrocodone/ 300 mg acetaminophen)	1-2 tablets every 4-6 hours	3000 mg acetaminophen/day and 60 mg hydrocodone/day	Rx
Acetaminophen with Oxycodone	Percocet-5 (5 mg oxycodone/325 mg acetaminophen)	1-2 tablets every 4-6 hours	3000 mg acetaminophen/day and 60 mg oxycodone/day	Rx
Tramadol	Ultram (50 mg tramadol)	1-2 tablets every 4-6 hours	400 mg/day	Rx
Acetaminophen with Tramadol	Ultracet (37.5 mg tramadol/ 325 mg acetaminophen)	1-2 tablets every 4-6 hours	3000 mg acetaminophen/day and 400 mg tramadol/day	Rx

3 D's to treating the hot tooth:

In summary, successful implementation of the above strategies along with endodontic therapy can save teeth and provide patients with 90% pain reduction within one week of treatment. Treating emergency dental pain can be the most rewarding and challenging aspect of our career. Using the 3-Ds: diagnosis, dental treatment, and drugs will provide a systematic approach to successfully providing care in a challenging terrified patient. When the etiology of dental pain is unclear or you need pulpal anesthesia, please do not hesitate to contact your endodontist. We offer same day appointments to patients with severe pain and this service has proven to be valuable and appreciated by both the referring dentist and patient.

My Mission: *Save Teeth with the Least Patient Trauma*

CHOOSING THE RIGHT PONTIC DESIGN FOR YOUR FPD RESTORATION

By Dr. Mailis Soler

Fixed Partial Dentures (FPD) are very common procedures in our restorative dental practices that we employ to replace missing teeth. Whether an FPD is fabricated over natural abutment teeth or dental implants, the considerations are the same for the selection of the design of the basal surface of the pontic. I will review here some of the considerations for selection of pontic designs that can help us in challenging situations. I will reference the article "A review of esthetic pontic design options" by Daniel Edelhoff and coworkers (Quintessence Int 2002;33:736-746) where you can find a broader discussion on this topic.

From our study of Fixed Prosthodontics, we know about different pontic designs that have been developed in the past to satisfy esthetic, functional, and hygienic requirements in FPD restorations. Unfortunately, there is no one simple answer to all scenarios. Thus, understanding the advantages of each design allows us to choose the best match for any situation. It is also important to first identify the location of the pontic (anterior vs. posterior), the type of ridge defect present in the edentulous area (horizontal vs. vertical vs. combination), and the height of the smile in anterior cases to guide our decisions.

We have learned to steer away from concave pontic designs such as saddle and ridge lap because their shape and large contact area with the alveolar ridge makes it difficult for patients to remove plaque underneath, leading to inflammation and ulceration of the soft tissues. Instead, hygienic, modified ridge lap and ovate designs are more favorable because of their convex basal surfaces and small or no contact area. However, these more hygienic designs do present with

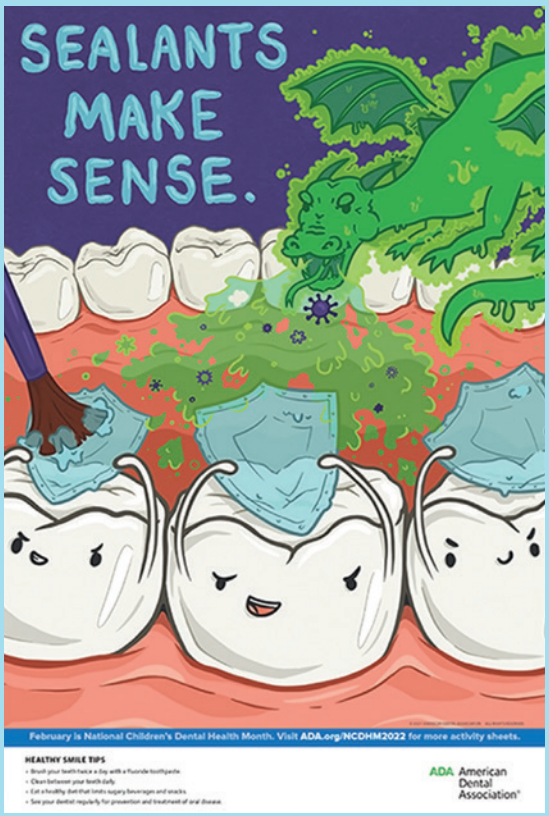
esthetic and functional challenges that may require additional interventions. Here are some considerations for each of these three convex designs.

Hygienic pontic: This pontic design has no contact with the periodontium and provides easy access for cleaning with different oral hygiene aids like floss and interdental brushes, so it is suitable for patients with poor motor skills. It is only recommended to be used in the posterior area because of its esthetic and phonetic restrictions. An additional disadvantage is that the gap between the pontic and the alveolar ridge may be large enough to allow food to get trapped and the tongue to enter the space.

Modified ridge lap pontic: Both the convex basal surface and small contact area with the alveolar ridge that provides an adequate contact for the dental floss contribute to the prevention of irritation of the periodontium and makes this design the most popular for both anterior and posterior areas. In situations when the anterior edentulous area has vertical ridge resorption and the patient has a high smile line, using this pontic design alone may result in unnaturally long pontics with open interdental spaces with increased flow of saliva and air. This can lead to unesthetic restorations and phonetic impairment. Hard and soft tissue ridge augmentation procedures are desired in these situations to improve the ridge contours and the relation of the pontic to the ridge. However, when surgical procedures are contraindicated, gingiva-colored ceramics can be used to reconstruct the missing papilla and alveolar defect, and additional pontic modifications may be necessary to improve esthetics and phonetics.

Ovate pontic: The basal convex surface of the ovate pontic comes in contact with a larger area of the underlying soft tissue, so it requires more attentiveness from the patient to oral hygiene procedures. This design is ideal for anterior cases with a high smile line because it produces an emergence profile that looks similar to that of a natural tooth and fulfills both esthetic and phonetic functions. Producing this type of pontic requires having an adequate amount of soft tissue present and manipulation of the tissues by relining a long-term provisional prosthesis to develop the right contours over time (a minimum of 6 months). A conical pontic can be used at the time of tooth extraction to guide the regeneration of the tissues around the pontic (immediate pontic technique). However, when the tooth is already missing, soft tissue grafting and conditioning of the tissues with a provisional restoration is an alternative treatment. It is important to note that a graft may experience volumetric shrinkage ranging from 25% to 45% within the first 6 weeks after the surgery, as has been reported in the literature.

I hope this overview about pontic designs serves as a refresher on the topic. This is certainly very useful knowledge in our profession to provide our patients with natural-looking restorations.



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A Tipping Point in a *New Paradigm?*

By Lisa A. Yurkiewicz, DMD, MS – *Contributor*

Lisa A. Yurkiewicz, DMD, MS
Specialist in Orthodontics & Dentofacial Orthopedics-
Orlando-Clermont-
Lake Mary-Winter Springs

What's new in dentistry? No, I'm not referring to the usual dental buzz of 3D-imaging, insurance woes, the future of solo private practices vs. corporate dentistry, sleep and snoring appliances, or government bureaucracy and over-regulation. These concerns are each important and timely, but I'd like to bring up another issue that can fundamentally change how we do our job and how we view our role as dentists relative to the overall health and wellness of our patients.

The question I'm concerned with is this: What, as dentists, have we chosen to deny, forget, overlook and ignore?

We dentists are skilled diagnosticians and mechanics of the mouth, but I raise the bar and challenge the status quo. Is this the best we can do? Are we offering the most appropriate treatment, or are we collectively guilty of over-treatment, undertreatment or a lack of sufficient preventative efforts (i.e. patient education)? Are we acting in the best interest of the patient in terms of the cost-benefit-risk relative to the time, money, burden of care, and value? What is our treatment goal, outside of the goals of our practice? This is not an editorial about ethics but rather one that is much more fundamental.

When I was asked to put my thoughts together for this op-ed I hesitated at first, but after further consideration, I thought it may be of some worth to share my perspective and experience in the event it may help others or encourage us to help each other.

As an orthodontist for the past 25 years, I've often questioned why we routinely advocate long-term or permanent retention. You already know the obvious answer: to prevent orthodontic relapse. But the real crux of the question is: Why do some of our orthodontic results not tend to hold over time despite extraction or even prolonged treatment time (as in my own case; I spent six-and-a-half years in braces with the simultaneous extraction of four bicuspids and third molars at age twelve)? When you've been performing your trade for some time, one starts to see "patterns, tendencies, predictabilities, possibilities and probabilities" with more acumen—that which only comes with time and practice (translation: mistakes, trials, and triumphs). For me, the stark realization of these patterns was cause to pause.

Before initiating my orthodontic residency, I briefly but seriously contemplated a purely academic career track, on the suggestion of a professor. Even now, I still have an overwhelming tendency for academic analysis, conjecture, and more heavily intellectual problem-solving. My academic background enables me to better assess the effectiveness and quality of specific treatments to help individual patients. Clinical decision-making is a balancing act of need and demand, ethics and pragmatism, and is not always easy or straight-forward.

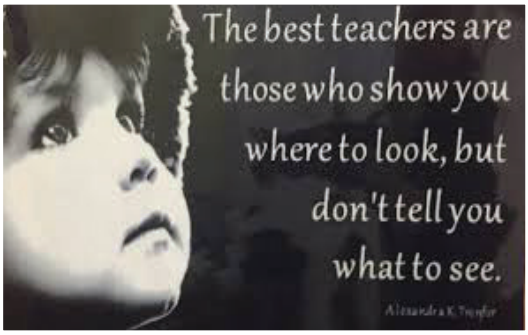
I have also learned that in the academic world, it is most difficult to make big changes. Instead, advances in science are typically made in small increments, and the operating framework may often pose barriers to real and quick developments. We must change as the science progresses and changes. Good science always challenges assumptions. As clinicians, we have a little more freedom to take a leap of faith and make progressive adjustments more readily for an idea or a developing concept that may eventually become a new paradigm.

The Truth can't be denied, and like parenting, it takes a village. We need all of us to troubleshoot, to solve and resolve issues—even to question the seemingly obvious. Hence my open-mindedness and willingness to venture out of my "comfort zone" to talk to non-dentist practitioners who work with not only the head and neck, but the whole body. It has been an intriguing, uncomfortable, humbling and enlightening experience full of childish wonder and pensive reflection. Whether we are scientific clinicians or clinician scientists, we must work in tandem with academicians to help pose questions and direct research to truly validate, refute, explain and optimize clinical outcomes.

In my personal and professional quest over the past few years, I have been keeping significant time and company with health practitioners outside of dentistry who weigh in on the same or similar afflictions and conditions that we treat in dentistry and who share mutually common "territories" such as muscle, fascia, bones, joints.

In my journey thus far and in conversations with mentors and colleagues alike, I have stumbled upon some key concepts which have prompted reflection and created resonance in my mind:

- Healthy, balanced systems maintain. Unhealthy, unbalanced systems decline.
- The body whole and the whole body. As with any living unit, the body is designed to function and survive at the lowest energy level to maintain homeostasis. The body is self-correcting. It adjusts, accommodates, adapts and ultimately heals, at times with the assistance of but not directly due to pharmaceuticals (pills) and mechanistic procedures (surgeries).
- Nature and the natural order of things. If we truly understand how the body works, then we're working with the body, or nature, not against it. Traditional osteopathy and complementary integrative medicine operate under this important guiding principle.
- French anthropologists and orthodo tists hold that the crux of orthodontics lies in the basi-cranium.
- The postural basis of malocclusion, which highlights once again the importance of proper nutrition, whole foods, and fibrous diet for masticatory function as well as for GI health and balance, breast-feeding, tongue position, swallow pattern, and not only a patent airway but obligate nasal breathing. These are highly impactful determinants in the course of a child's midfacial growth and development before age eight.



- As dentists and physicians, even though we may be forced to learn our trade via fragmented "-ologies" (e.g. histology, physiology, pathology, pulmonology, otolaryngology, gastroenterology, pharmacology, cardiology, and so on), remember that these "parts" do not operate singly but rather simultaneously, synergistically, synchronously and systematically. Teeth, occlusion, TMJ and jaws are not just isolated, procedural parts to be repaired, but vital components of a complex neural network of proprioceptive systems involving the brain which communicate and rhythmically coordinate with muscles, bones, tendons, ligaments, vessels, nerves, and fascia to serve and respond in daily life functions. Our dental training and our literature are full of detailed nuances but the gestalt is more elusive.
- TMJ, occlusion and gnathology are worth a deeper and broader look.
- General Systems Theory (GST) is now being applied to biology to more effectively explain the complexities of the whole rather than the long-standing practice of breaking down the organism into its parts to study them. For closed (e.g. non-living) systems, Newtonian laws of physics and chemistry apply. However, open (e.g. biological living) systems cannot be understood by analysis based in Cartesian science or Newtonian mechanics, but can only be understood within the context of the larger whole, such as in quantum mechanics. Open systems are non-linear, complex, dynamic, self-regulating far from equilibrium. To adopt this paradigm shift, we must adjust our way of thinking and our investigative methods and framework appropriate for open systems.
- As dentists, we try to work with the body in a reliable, predictable, efficacious way to protect, promote, and produce not just an aesthetic but functional, stable, harmonious and balanced system. As such, shouldn't we triage the patient with all necessary and relevant diagnostic tools and metrics which go beyond tooth diseaseand the oral cavity?
- And above all, do no harm.

I feel there are some significant missing links in what we're doing. Think of Gaudi's mosaic or the construction of a home: What makes the structure so aesthetic, functional, proportionate and balanced is the grout or cement that connects the pieces. What is the grout, the "connectors" which bring it all together in dentistry? How do we implement them? Again, what is our goal or purpose? For ourselves? For our patients?

I have changed from this exposure to professionals outside dentistry and integrated this knowledge into my practice by always asking about the patient's birth history (even older adult patients), breathing habits, sleep behaviors, and accidenttrauma events (not just of the head but of the body). I observe more, looking at the tongue, face, head, neck, and entire body from different positions and angles. You too may be surprised at what you see, if you try it. Also, I have noted that by making certain changes in the mouth, there are subtle but highly significant changes in the posture of the head and overall body. There is basic scientific logic and rationale to confirm and support this phenomenon. Just keep asking how and why.

We are at a crossroads. I fear there is a cascade of events and influences that is prioritizing financial gain. The commercialization of DIY orthodontics is not a futuristic folly but a current reality.

Our patients are on a continuum, but so are we as practitioners and as a society. If we are truly health professionals and not just aestheticians (a wonderful career in its own right), should we not embrace the continuum of change? On a final and positive note, I also sense there is a growing movement of clinicians and scientists alike who, if we successfully bridge the divide, can achieve convergence in the study and explanation of the body's capacity for self-regulation, self-healing, and ultimate balance, function, and health. I hope this piece will promote conversation, clarity and collaboration between our various backgrounds, experience, philosophies and specialties, and perhaps even serve as a tipping point in a new paradigm.

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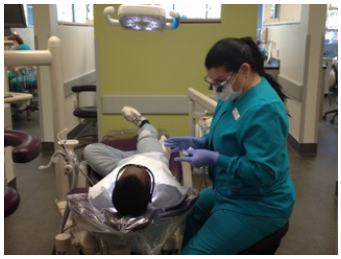
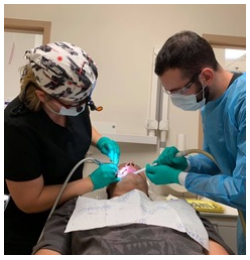


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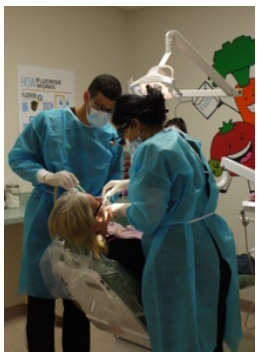

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Renewal Reminders

DENTAL LICENSE - All Florida-licensed dentists must renew their licenses by midnight on **Monday, Feb. 28, 2022**. As a reminder, all verified continuing education (CE) courses taken at the 2021 Florida Dental Convention (FDC) have been reported to CE Broker on your behalf. Don't wait until Feb. 28 to report or review your CE! Log in to your CE Broker account to review your current CE credits or self-report other courses you may have attended.

IMPORTANT:
Medical Errors and Domestic Violence Courses Available Online Now for CFDDA Members!

DOMESTIC VIOLENCE: A domestic violence course is due every third biennium for license renewal. The CFDDA now has this available online at www.cfdda.org. This is a CFDDA membership benefit and is **only available to current CFDDA members and their registered dental hygienists at no cost**.

Please follow the instructions and complete each section of the test form before submitting to the CFDDA. After submission, you will be mailed a certificate of completion and the CE will be entered into CE Broker.

Please note:
This biennium ends February 28, 2022. The course will be pulled from the website on February 22, 2022, to allow time for all CE to be entered into CE Broker.

MEDICAL ERRORS:
Medical Errors is due every biennium. Currently, this website has two options available. Each course is two hours long and each has a test that you must complete to earn the 2 CEUs.

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Option #2
Go to the link listed below on CE Broker. This is not a free, the costs vary. CE broker will automatically put your CE into your account. To view available online medical errors courses, visit: https://courses.cebroker.com/search/fl/dentist

Also, there may be local dental meetings having medical errors lectures that you can attend in person.

Help Wanted

Current statistics project a shortage of dental auxiliaries extending into the foreseeable future. A recent survey by the Academy of General Dentistry determined that 34% of existing general dental practices are currently seeking help. A multitude of factors have created this situation. First and foremost, the profession of dentistry has been slip shod in the recruitment and training of auxiliaries. This coupled with low pay, and a lack of benefits creates little desire for younger people to pursue dental careers.

Dentists have collectively been slow to increase wages and provide benefits. Once COVID became our reality, 99% of dentists temporarily laid-off their staff, and upon reopening, many of their staff members simply chose not to return to work. Whether the issue was fear of contracting COVID in the workplace or feeling unappreciated, again many chose not to return. In addition to said hiring woes, especially for the solo practitioner is the advent of signing bonuses offered by various dental corporations. These bonuses can be as high as $5000, which can make it tough for smaller offices to compete.

I have been blessed by a stable staffing situation for my entire career. I have made it my custom to compensate well. However, in July of this year it became apparent that I was losing the critical core of my staff. My office manager of 30 years will be leaving soon due to recent health reasons. We've had the pleasure of working together for 30 years, and I am even the God-Father to her children. There is simply no way to replace her. Additionally, two of my long-term assistants are leaving. One is leaving to have a child, the second is retiring. Collectively, amongst these three employees, I am losing a combined 60 years of experience working for me. So, I've now entered the circus of trying to hire, not to mention that there seems to be a "new" work ethic taking place these days.

I can unequivocally say that this has been a nightmare that I wouldn't wish on anyone. For the last 6 months I have desperately tried to hire and train for an experienced staff. Interviewees oftentimes fail to show up for their appointments. It has been a circus of working interviews, hiring, and then turning around to fire for cause. Finally, at the end of the year, I have managed to assemble a crew that I can work with. A lot of patience and training will have to take place, but I am on stable footing again. I just never could have dreamed that I would have gone through something like this at this stage of my career. It's like starting over again; I guess I have been spoiled.

In short, take care of your staff. You can't do this alone.

Enjoy the Holidays,

Jeff Sevor

COLUMNIST
Jeff Sevor
DMD, MS

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