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CDA Journal
Volume 38, Number 7
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published by the California Dental Association
1201 K St., 14th Floor
Sacramento, CA 95814
800.232.7645
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Foreign: $80
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Journal of the California Dental Association (ISSN 1043-2256) is published monthly by the California Dental Association, 1201 K St., 16th Floor, Sacramento, CA 95814, 916-554-5330. Periodicals postage paid at Sacramento, Calif. Postmaster: Send address changes to *Journal of the California Dental Association*, P.O. Box 13749, Sacramento, CA 95853.

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The Shadow of Your Smile

KERRY K. CARNEY, DDS

I was thinking of *Alice's Adventures in Wonderland* the other day. Often that is the result of spending too much time reading about national and state politics. Lewis Carroll's beautifully crafted exercise in logic and wordplay makes the perfect backdrop for so many of the curious things people in politics utter. However, on this day I found myself remembering the Cheshire Cat and his amazing grin. More than any of his philosophical repartee, it is his disembodied smile that we all remember.

The smiles we aim for are those of health, self-confidence, high self-esteem, pleasure, and joy.

The smile is an interesting mannerism. There is some evidence that the smile can be recognized across cultures as a facial expression associated with a happy emotion. If smiles are defined by the flexing of specific facial muscles or the baring of teeth, then there are many kinds of smiles. There is the threat gesture associated with the predators' display. There is the fear grimace associated with subordinate conciliatory behavior. There is the rictus of horror or death, and there is the enigmatic smile of the Mona Lisa.

Our profession is all about smiles. We take the grimace of pain and through our ministering, we produce the smile of relief. The smiles we aim for are those of health, self-confidence, high self-esteem, pleasure, and joy. Our patients desire smiles so radiant they would be accompanied by a "bling" notation in graphic novels. Hollywood makeovers depend heavily on reconstructed smiles to convey the transformation of a "new" person, more perfect than the "old" person. The desire for smile enhancement has spawned a whole industry devoted to snap-on and no prep veneers.

A smile can win the confidence of the gullible and wile the guileless. These sinister powers are only possible because they are a corruption of the commonly accepted expectations of a smile. A smile can disarm the hostile. It can welcome the stranger. It can cheer the sad. It can encourage the lover or faint of heart. It can reinforce the bonds of friendship.

When the smile is considered too intimate, some cultures require smiles be obscured by a demure hand, fan, or a veil. The smile is so powerful it can even be transmitted by another part of the body. Smiling eyes are not confused with the mouth. Instead, they act as a surrogate and communicate the emotion associated with a smile.

The smile is a physical expression of an emotional state.

Research has shown that the memory of an emotional state can last long after the emotion itself has passed. An interesting investigation examined the long-term effect of emotional states on individuals with memory loss.[1] In the experiment, individuals with damage to the hippocampus, which is essential to the processing of long-term memory, were shown films clips. The first set of clips included maudlin moments in cinema, e.g., a man crying at his wife's grave. The subjects were moved and some sobbed in empathy for the man's loss. After some time, they were questioned about the film and could recall nothing about it, but the subjects reported that their emotional state was one of sadness without cause.

The same experiment was conducted with film clips of happy or humorous moments. These elicited the desired laughter and indications of joy among the subjects. Later testing showed that the subjects reported themselves in a happy emotional state long after they could no longer recall having seen the films. The memory of the emotion was not dependent on a functioning hippocampus.

The researcher drew the conclusion that bringing moments of happiness to victims of memory dysfunction had beneficial effects even if the victim could not remember the event or the person involved. Specifically, the researcher was concerned that family members used the patient's memory loss as a rationale for not visiting or communicating with a patient with Alzheimer's. (He does not recognize me and will not remember that I have been to see him.) The researcher maintains it is worth the effort to bring moments of happiness to the patient because the memory of the emotion has beneficial effects that outlast the memory of the event.

It is a bit like the Cheshire Cat. After the image of the cat's tail, and body, and head slowly dissolves, there remains the smile. The smile, the essence of the emotion, is the last to fade. ■■■■

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1. Feinstein JS, Duff MC, Tranel D, Sustained experience of emotion after loss of memory in patients with amnesia. *Proc Natl Acad Sci USA* April 12, 2010 (e-pub ahead of print).

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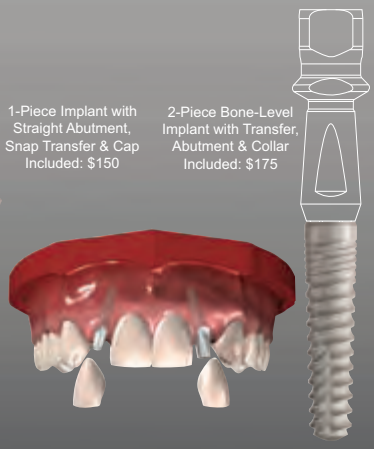

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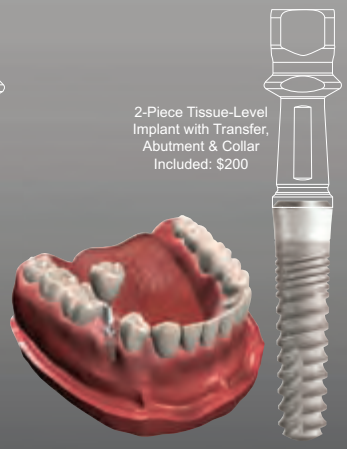

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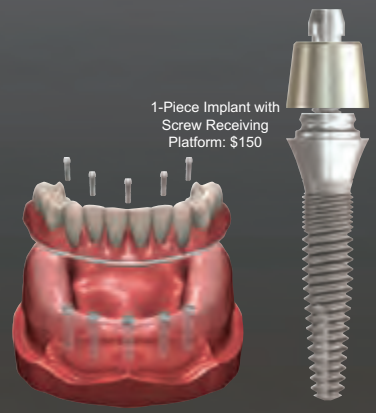

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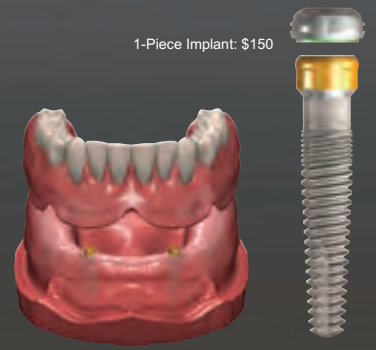

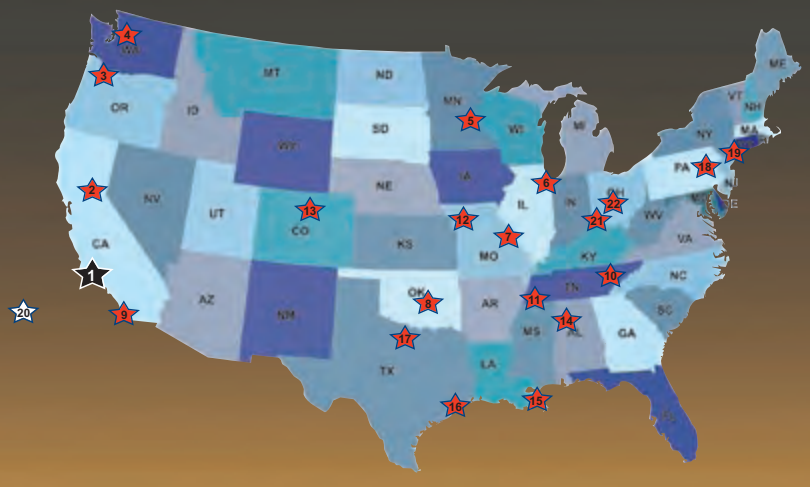

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Dan Hubig

More Strides Made in Detecting Oral Cancer Using Nano Biochips

A new diagnostic instrument that can aid in the early detection of oral cancer has been developed, and now creators want to deploy nano biochips, which are showing great promise in identifying lesions.

Trials carried out on the nano biochip sensor showed it was 97 percent "sensitive" and 93 percent "specific" in identifying which patients had premalignant or malignant lesions, findings that measured well with traditional tests.

John McDevitt, PhD, and his team at Rice University in Houston developed the new nano biochip; their study appears online in the journal *Cancer Prevention Research*. "One of the key discoveries in this paper is to show that the miniaturized, noninvasive approach produces about the same result as the pathologists do. This area of diagnostics and testing has been

CONTINUES ON 479

Supreme Court Overturns Ban on PAC Soft-Dollar Spending

The Supreme Court's decision earlier this year overturning the ban on independent corporate expenditures provides ADPAC more leeway in supporting pro-dentistry candidates. However, it remains to be seen how much the new leeway will improve the organization's effectiveness.

"Hard dollars" and "soft dollars" are the two forms that come into ADPAC. Contributions earmarked for specific campaigns are considered hard dollars while soft dollars are monies that go into a general fund that ADPAC can use in different ways except for those ways that don't ask people to vote for specific candidates . Now, with the Supreme Court's ruling, PACs are free to use their soft dollars in ways that support specific candidates, for advertisements, for example.

Additionally, the court ruled that corporations are allowed to spend their own money on behalf of candidates. The ban on direct corporate contributions to campaigns remains intact.

ADPAC emphasized the importance of dentists meeting with their lawmakers face to face, getting to know them and discussing the issues with them. So while direct or in-kind contributions to campaigns are important, they are important only insofar as they help get dentistry's message to lawmakers, messages delivered by dentists.

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Genetic Testing Registry in Development

The National Institutes of Health is creating the Genetic Testing Registry, a public database, which can be accessed by consumers, researchers, and health care providers.

"The need for this database reflects how far we have come in the last 10 years," said Francis S. Collins, MD, PhD, NIH director. "The registry will help consumers and health care providers determine the best options for genetic testing, which are becoming more and more common and accessible. Our combined expertise in biomedical research and managing such large databases makes NIH the ideal home for the registry."

While there are more than 1,600 genetic tests available to consumers and patients, there is not one public resource providing detailed data about them. The goal of the registry, which should be available next year, is to improve research into the genetic basis of disease and health. Among the registry's key functions:

- Encourage providers of genetic tests to publicly share data about the availability and utility of their tests;
- Provide a resource to the public, including researchers, health care providers and patients, to locate laboratories that offer particular tests; and
- Facilitate genomic data sharing for research and new scientific discoveries.

The NIH Office of the Director will oversee the registry project. Responsibility for developing registry is with the National Center for Biotechnology Information, part of the National Library of Medicine at NIH. Registry genetic test information will be integrated with information in other NIH/NCBI genetic, scientific, and medical databases to facilitate the research process. This arrangement simplifies the scientists' ability to make the connections that can lead to scientific advances and discoveries.

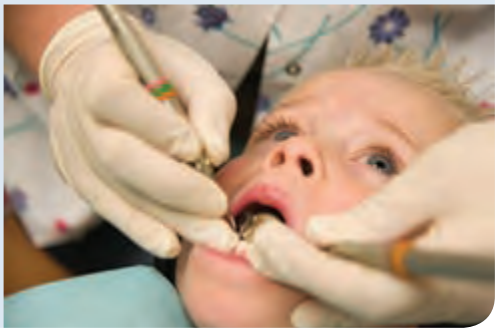
The Food and Drug Administration, Centers for Medicare and Medicaid Services, among other federal agencies, will be consulted. NIH will work with test kit manufacturers, health care providers, researchers and patients, and genetic test developers during the registry's development process in an effort to determine the best way to gather and present test data. For more information about the Genetic Testing Registry and NCBI, go to ncbi.nlm.nih.gov/gtr/.

ADHP Pilot Program Moves Forward in Connecticut

The Joint Human Services Committee of the Connecticut General Assembly approved a bill creating a "pilot" advanced dental hygiene practitioner program for the Constitution state. Should the Public Health Committee, which has shared jurisdiction, pass the bill, it then goes to the House.

A number of members of the Joint Human Services Committee, in supporting the bill, said they were casting their "yes" vote to "help children" or "keep the bill moving," even though they had some reservations and preserving the ability to oppose the bill later.

In the meantime, the Connecticut State Dental Association is fully dedicated to educating Joint Public Health Committee members on the numerous limitations of the concept and the bill. The American Dental Association is helping the CSDA through the state public affairs program.



ORAL CANCER, CONTINUED FROM 477

terribly challenging for the scientific and clinical community. Part of the problem is that there are no good tools currently available that work in a reliable way."

McDevitt said the deployment of nano biochips will cut the cost of medical diagnostics and contribute significantly to the task of bringing quality health care to the world. It may be possible that dentists could be the first line of defense against oral cancers, with the ability to catch early signs of the disease in the chair.

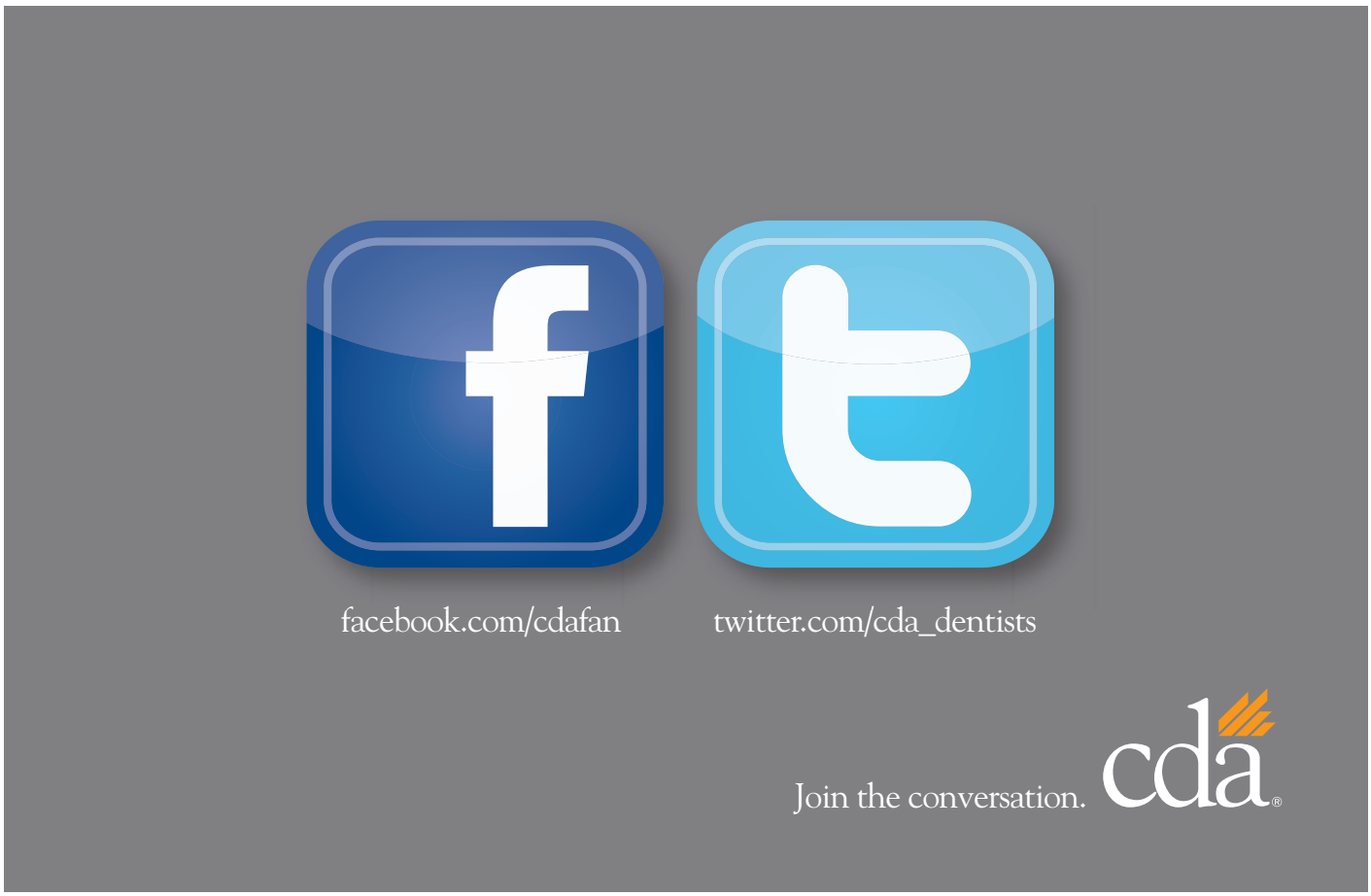
The diagnostic tool, which resembles a toothbrush, is able to detect accurately a lesion by gently touching the cheek or tongue. Used chairside, results can come in as little as 15 minutes, and could be an alternative to painful, invasive biopsies.

McDevitt said patients with suspicious lesions, usually discovered by dentists or oral surgeons, end up getting scalpel or punch biopsies as often as every six months. "People trained in this area don't have any trouble finding lesions. The issue is the next step: Taking a chunk of someone's cheek. The heart of this paper is developing a more humane and less painful way to do that diagnosis, and our technique has shown remarkable success in early trials."

Professor McDevitt and his researchers hope the eventual deployment of nano biochips will dramatically cut the cost of medical diagnostics and contribute significantly to the task of bringing quality health care to the world. A larger trial involving 500 patients has been planned.

"The chips should also be able to see when an abnormality turns precancerous, McDevitt said. "You want to catch it early on, as it's transforming from precancer to the earliest stages of cancer, and get it in stage 1. Then the five-year survival rate is very high. Currently, most of the time, it's captured in stage 3, when the survivability is very low."

Nigel Carter, DDS, chief executive of the British Dental Health Foundation, applauded the arrival of the technological advancements. "Mouth cancer is a deadly and debilitating disease that would greatly benefit from such early diagnostic technology as the nano biochip. Currently, the best chance of beating the cancer comes from early detection, which improves survival rates to 90 percent. Mouth cancer is a potentially fatal condition that is taking more lives each year. Without early diagnosis chances of survival plummet down to 50 percent."



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Number of Natural Teeth Linked to Heart Disease Deaths

Numbers do count, according to a Swedish study that found the risk of coronary heart disease was higher in those with fewer natural teeth.

"Cardiovascular disease and, in particular, coronary heart disease are closely related to the number of teeth" an individual has remaining, said Anders Holmlund. "A person with fewer than 10 of their own teeth has a seven times higher risk for death by coronary heart disease than a person of the same age and of the same gender with more than 25 teeth left," said Holmlund.

Holmlund, along with colleagues Gunnar Holm and Lars Lind, studied more than 7,600 men and women who had been suffering long term (12 years on average) from periodontal disease. They also investigated the causes of deaths of more than 600 people who died during the study period and found that 299 of them passed away due to cardiovascular disease.

While other research published in the past 15 years indicated a link between cardiovascular disease and oral health, Holmlund's investigation demonstrated a direct association between the number of teeth in a person's mouth and cardiovascular disease.

In explaining his theory, Holmlund said "infections in the mouth and around the teeth can spill over to the systemic circulation system and cause a low-graded chronic inflammation," a known risk factor for cardiovascular issues and heart attacks.

ADA Applauds New Anti-tobacco Law

The American Dental Association said it scored a legislative victory when President Barack Obama recently signed the Prevent All Cigarette Trafficking Act into law. This federal edict now requires Internet and mail-order retailers to check the age and identification of customers at the time of purchase and at the time of delivery in an effort to curb online sales of smokeless tobacco and cigarettes to those underage.

Additionally, stronger controls have been put in place to ensure the proper collection of all tobacco taxes from Internet and mail-order tobacco sales and retailer compliance with other state tobacco control laws.

UPCOMING MEETINGS

2010	
Aug. 20-21	World Congress of Minimally Invasive Dentistry 11th annual conference, San Diego, wcmidentistry.com.
Sept. 2-5	FDI Annual Dental World Congress, Salvador, Brazil, congress@fdiworldental.org.
Sept. 9–11	*CDA Presents The Art and Science of Dentistry*, San Francisco, 800-CDA-SMILE (232-7645), cdapresents.com.
Oct. 9-12	ADA 151st Annual Session and World Marketplace Exhibition, Orlando, ada.org/goto/session.
Oct. 24–27	National Primary Oral Health Conference, Kissimmee/Orlando, nnoha.org/conference/npohc.html.
Nov. 7–13	United States Dental Tennis Association, Grand Wailea, Hawaii, dentaltennis.org.
2011	
May 12-14	*CDA Presents* the Art and Science of Dentistry, Anaheim, 800-CDA-SMILE (232-7645), cdapresents.com.
Sept. 22-24	*CDA Presents* the Art and Science of Dentistry, San Francisco, 800-CDA-SMILE (232-7645), cdapresents.com.

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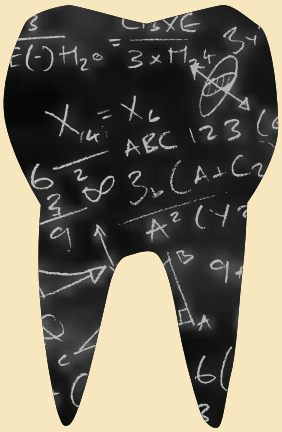
Scientists Getting Closer to Determining Formula to Develop Teeth

Institute of Biotechnology of the University of Helsinki scientists are getting closer to the cusp of growing perfect teeth and perhaps other organs. Researchers were able to create a computer model that can produce "population-level variation in complex structures like teeth and organs," according a *ScienceDaily* news release.



Jukka Jernvall, academy professor, and his team studied the progressive growth of mammal teeth. The findings were published in a recent article in *Nature*. After more than 15 years of research, so much data has been gathered that a formula for tooth development is emerging as well as the growth of other organs.

To test their theoretical model, which is based on tooth development in mice, researchers looked at Ladoga ringed seals for its highly variant dentitions. The team's proposed mathematical model could shed light on understanding the formation of an organisms' 3-D shapes. Results could advance medical research, such as growing new organs.

Congressional Members Urged to Support School-Based Dental Sealant Programs

The Pew Center on the States pressed congressional leaders to support and finance dental care measures in the new Patient Protection and Affordable Care Act. The House Appropriations Committee, in May, held its first hearings on the Department of Health and Human Services budget. This budget would fund the grants to states for school-based dental sealant programs, demonstration projects with new dental providers, and to guarantee all states have help with prevention programs.

"With federal funding to back these measures and smart state efforts to implement them, millions of children would gain better access to proper dental care," said Shelly Gehshan, director of the Pew Children's Dental Campaign. "These proven policies can help eliminate the pain, missed school hours and long-term health and economic consequences of untreated dental disease."

Dental sealants have been shown to prevent 60 percent of decay in molars and cost one-third as much as filling a cavity. A recent Pew analysis, however, found that only 17 states reach 25 percent or more of targeted high-risk schools even though school-based programs are a good way to offer sealants to disadvantaged children, according to a news release.

An estimated 17 million low-income, Medicaid-eligible children do not visit a dentist largely due to a lack of dentists who will treat them.

"The new health care reform law expands insurance coverage and that's what makes these grants to states so critical," Gehshan said. "More dental coverage will encourage more demand, so federal support for innovative workforce models will help spur states to improve access and efficiency."

Pew recommended considerable investments for fiscal year 2011, including transfer of a portion of the newly created Prevention and Public Health Fund to expand these oral health programs to all 50 states.

"These proven policies can help eliminate the pain, missed school hours and long-term health and economic consequences of untreated dental disease."

SHELLY GEHSHAN, DIRECTOR OF THE PEW CHILDREN'S DENTAL CAMPAIGN

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Jon Draper

From left: Nima Aflatooni, Bill Jeffrey, University President Pamela Eibeck, Dean Patrick J. Ferrillo Jr., and Lauren Young.

Kids in the Klinic Endowment Program Receives a Financial Boost

Following a highly successful fund-raising event held recently in San Francisco, the Kids in the Klinic Endowment at University of the Pacific, Arthur A. Dugoni School of Dentistry will receive more than $125,000. This puts the program closer to its goal of achieving a $2 million endowment to support dental care for children at the school's pediatric dentistry and orthodontics clinics.

"The Kids in the Klinic endowment helps us provide the best possible treatment regardless of a family's ability to pay," said Patrick J. Ferrillo Jr., dean of the Dugoni School of Dentistry. "Without the generous support from the attendees, donors and sponsors, much of what we do to help these underserved children would not be possible. Thank you to everyone who participated in this remarkable event."

An estimated 200 wine and food enthusiasts gathered at the May 8 event to support much-needed dental care, education, and oral health prevention to socioeconomically disadvantaged children throughout Northern California. The clinics provide access to dental care for approximately 1,500 children each year, according to a news release. Each year, the clinics at the Dugoni School of Dentistry provide $500,000 of free care and $10,000,000 of below market-rate care for 14,000 patients of record.

A silent auction of fine wines, dining and destinations experiences kicked off the evening followed by a live auction with prizes such as a seven-day Caribbean cruise; a wine and dine trip to New Orleans; exclusive and private access to a number of restaurants and vineyards, as well as a farm dinner at the French Laundry orchard in Yountville, Calif.

Venerated Icons of ACD on Display at National Museum of Dentistry

The American College of Dentists has loaned its gold-plated mace and torch to the National Museum of Dentistry, along with other items of interest including the ACD's fellowship key, pin, and rosette.

The mace and torch, used for membership ceremonies for approximately 70 years, are a few symbols of the ACD, which is the oldest honorary organization for dentists in the country. The exhibit also includes the William J. Gies Award, which acknowledges college fellows who have contributed greatly to the advancement of the profession.

"We are honored to have the mace and torch on view at the National Museum of Dentistry," said Stephen Ralls, DDS, EdD, MSD, American College of Dentists' executive director. "They represent an important historical link to key leaders of dentistry from the early 20th century onward."

The torch was chosen when the ACD was founded 90 years ago. The torch symbolizes the college as a source of enlightenment and guidance. Membership to the ACD is only by invitation. Currently, there are 7,400 fellows, selected for membership based on their contributions to organized dentistry, oral health care, dental research, dental education, the profession, and society. The ACD's mission includes its commitment to advance professionalism, leadership, ethics, and excellence.

"The National Museum of Dentistry preserves and celebrates the history of the dental profession," said Jonathan Landers director at the museum. "This is the perfect place to showcase these fragile and magnificent historic symbols of such a respected organization in dentistry."

cda® PRESENTS

THE ART AND SCIENCE OF DENTISTRY

San Francisco | Moscone South

Please note **new** days: Thursday – Saturday, September 9–11, 2010

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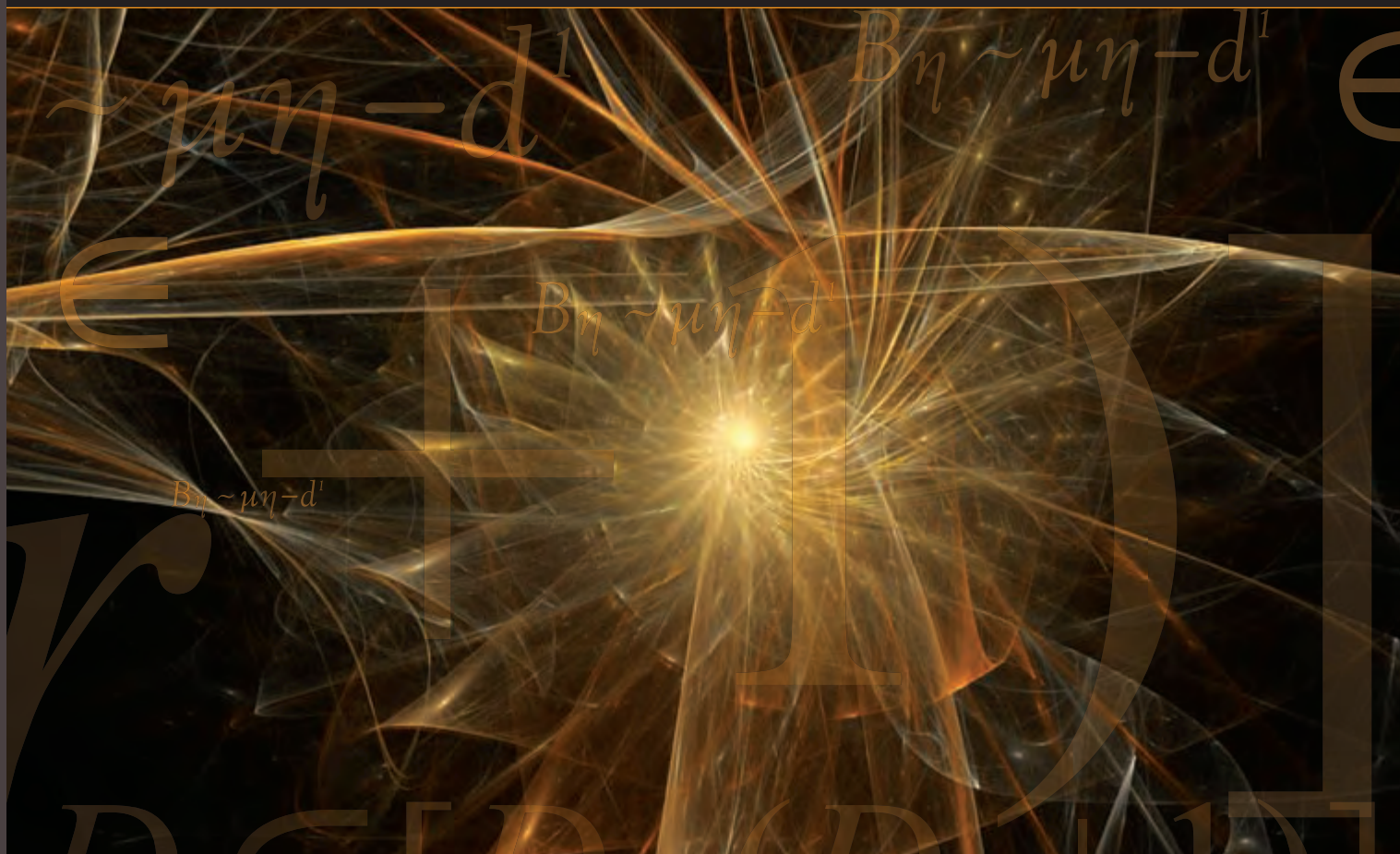

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Please note **new** days: Thursday – Saturday, September 9 – 11, 2010

HIGHLIGHTS

HAPPY HOUR

The show has new days (Thursday - Saturday) and we're hosting a party to celebrate.

SPEAKERS

Drs. Henry Gremillion, DeWitt Wilkerson, Sascha Jovanovic, and Bill Blatchford will spark your curiosity and expand your mind.

MOMA PARTY

Designed by famed architect Mario Botta, SFMOMA provides the ideal backdrop to enjoy a delectable buffet before you peruse the museum's current exhibits.

SF ATTRACTIONS

If the food, art, music, and culture aren't enough to lure you to San Francisco, remember, there's always the fabulous shopping.

To register, or for more information: cdapresents.com

CDA Membership Party at the San Francisco Museum of Modern Art!

CDA members and their guests will enjoy exclusive entrance into MOMA from 7 to 10 p.m. The evening will consist of a buffet that will serve as either a perfect prelude for a dinner in San Francisco or a light dinner for those who wish to stay and enjoy the entire evening visiting some of the fascinating exhibits.

One of the more popular performers throughout the California music scene, Lavay Smith is internationally recognized for her jazz talents. She and her Red Hot Skillet Lickers will perform throughout the evening for your dancing and listening enjoyment.

Two complimentary beverages from the bar will be provided to all CDA ticket holders. A cash bar will be available throughout the evening. MOMA is just a short walk from the Moscone South Convention Center!

Friday, September 10

7–8 p.m. – Admittance into the MOMA*

7–10 p.m. – Enjoy the museum food and entertainment!

Price $65

Event # 049

**Entry will not be allowed after 8:30 p.m.*

EXHIBIT HALL INFORMATION

Visit cdapresents.com to maximize your tradeshow experience.

CDA Presents will feature more than 400 exhibiting companies showcasing the latest in dental technology, products and services. Stay ahead of the curve by checking out the innovative new products being launched in the exhibit hall.

Please note new days: Thursday – Saturday, September 9–11, 2010

To celebrate our new convention days, we are hosting a happy hour in the exhibit hall on Thursday, 4:30–6 p.m. Complimentary refreshments will be served.

Grand Opening
Thursday, 10 a.m.

New Exhibit Hall Days and Hours
Thursday, Sept. 9, 10 a.m.–6 p.m.
Friday, Sept. 10, 9:30 a.m.–5:30 p.m.
Saturday, Sept. 11, 9:30 a.m.–4 p.m.

Exhibit Hall Happy Hour
Thursday, 4:30–6 p.m.

Family Hours
Daily, opening of exhibit hall until noon.

THE SPOT

the spot

A lounge for learning, networking and fun!

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- An educational theater providing C.E. credits
- Cool and new products
- Internet Café with Wi-Fi access
- C.E. stations

Experience it.

Moscone South.

WINE RECEPTION

WineFUNdamentals Seminar and Reception

Join us for interactive wine activities and trivia! Learn to distinguish the various scents and flavors in wine by tasting both white and red varietals. Learn about pairings with both cheese and chocolate, and put your knowledge to the test and win prizes!

Friday, Sept.10
4–5:30 p.m.
Price $25
Event # 050
The Spot, Exhibit Hall, 1900 Aisle

HEADLINING SPEAKERS

Victoria L. Wallace, CDA, LDA (Roundtable)

Assistant Programs	Team FABULOUS!	Thursday workshop
	Totally Bonding! Simple and Easy Tips for a Great Adhesive Restoration	Friday morning lecture
	Tooth Whitening at Its Best? Absolutely!	Friday afternoon lecture
	White Done Right With Custom Fit Trays ... Let's Make Some Whitening Trays Workshop	Saturday workshop


Brian P. LeSage, DDS, FAACD; Edward A. McLaren, DDS

Esthetic Dentistry	Esthetic Continuum Workshop	Friday and Saturday two-day workshop

Sascha Jovanovic, DDS, MS

Implants	Hands-on Porcine Workshop: Optimal Implant Placement and Bone and Soft Tissue Grafting	Saturday workshop


Henry A. Gremillion, DDS; DeWitt C. Wilkerson, DMD

Occlusion	Two-Day Continuum Lecture: The Dynamics and Function of the Masticatory System: The Multiple (Inter)Faces of Occlusion	Thursday and Friday two-day lecture

John A. Svirsky, DDS, MEd

Oral Pathology	Cases Only a Mother Could Love	Thursday and Saturday morning lecture
	Drugs I Have Known and Loved for Diseases That We Catch	Thursday afternoon lecture
	Great Cases With New Faces	Saturday afternoon lecture

Jane A. Soxman, DDS

Pediatric Dentistry	Managing the Developing Dentition	Friday morning lecture
	Clinical Techniques in Pediatrics	Friday and Saturday afternoon lecture
	Becoming the Pediatric Alpha Pup	Saturday morning lecture

Robert C. Fazio, DMD

Periodontics	Antibiotics in Dentistry	Thursday morning lecture
	Medicine and Dentistry	Thursday afternoon lecture
	Periodontitis and Peri-implantitis: The Good, the Bad and the Ugly	Friday lecture

Harold L. Crossley, DDS, PhD

Pharmacology	Street Drugs Exposed: What Your Patients and Your Kids Are Not Telling You!	Friday lecture
	Avoid Liability: Know Your Patients' Medications and Their Impact on Dental Treatment	Saturday lecture

William Blatchford, DDS

Practice Management	Leadership Challenge: Playing Your "A" Game	Friday lecture
	Conversations With Patents That Work	Saturday morning lecture
	Growth Strategies — Marketing, Acquisitions and Transitions	Saturday afternoon lecture

Mark A. Latta, DMD, MS

Restorative Dentistry	Essentials for Creating Stratified Anterior and Posterior Direct Composites	Friday lecture
	Direct Anterior Composite Veneers/ Posterior Resin Restoratives	Saturday workshop

California Dental Practice Act and Infection Control — Ticketed admission only

The Dental Board of California mandates continuing education in infection control and the California Dental Practice Act for license and permit renewal. CDA is proud to present the following courses that will fulfill these required units for license renewal.

Please note:

- Admission to these C.E. courses will be by ticket only.
- You may purchase your ticket in advance by completing the registration form in the Preliminary Program. Tickets are $20 and will guarantee your seat in the course.
- If available, tickets will also be sold on-site at the Ticket Booth located in the registration area of the Moscone South Convention Center.
- There will be no late entries allowed. The California mandatory education requires 2 full hours for credit. It is strongly recommended that you arrive a minimum of 15 minutes in advance of the starting time.
- Seating is limited. Tickets will be sold on a first-come, first-served basis.

Infection Control for California

Dental Board requirement for 2 units: This program provides you with the latest educational requirements specific to CCR section 1005, the Dental Board of California Infection Control Regulations.

Note: This 2-hour course does not meet the new infection control education requirement that unlicensed dental assistants take an 8-hour infection control course.

California Dental Practice Act (CDPA)

Dental Board requirement for 2 units: This course meets the new C.E. requirement for California Dental Practice Act education, including the new one-time course requirement for unlicensed dental assistants.

New Educational Requirements for Unlicensed Dental Assistants

Unlicensed dental assistants, who include any unlicensed individuals in the dental office who perform the duties of a dental assistant, hired on or after Jan. 1, 2010, and employed beyond 120 days must complete the following ONE-TIME within 12 months of hire:

- California Dental Practice Act
- A specific 8-hour course in infection control (to include clinical evaluation)

Additionally, they will be required to maintain a current basic life-support certificate.

Dentist employers will be responsible for ensuring that any individual performing dental assisting duties complies with these requirements. Dental assistants who have completed these courses should keep evidence of completion in their files for all future employers' records.

Note: Due to specific number limitations placed on the clinical portion of the 8-hour infection control course, CDA is currently unable to provide this course. For a list of courses approved by the Dental Board of California, go to cda.org/education.

Note new days! Thursday through Saturday, Sept. 9–11

Registration/Ticket Sales/Tote Bag and Lanyard Pickup

Moscone South Convention Center	Thursday, 7 a.m.–6 p.m. Friday, 6:30 a.m.–5:30 p.m. Saturday, 6:30 a.m.–4 p.m.

Programs

Moscone South Convention Center, the InterContinental San Francisco and the Marriott Marquis	Express Lecture Series, Thursday, various times Lectures/Workshops, Thursday–Saturday, various times

Exhibit Information — Moscone South Convention Center

Exhibit Hall Hours	Thursday, 10 a.m.–6 p.m. Friday, 9:30 a.m.–5:30 p.m. Saturday, 9:30 a.m.–4 p.m.
Grand Opening of the Exhibit Hall	Thursday, 10 a.m.
Family Hours	Daily – opening of exhibit hall until noon

Special Events

Child Care	Marriott Marquis Thursday, Friday and Saturday, 7 a.m.–6 p.m.
Exhibit Hall Happy Hour	Thursday, 4:30–6 p.m.
Membership Party at SFMOMA	Friday, 7–10 p.m.
The Spot	Thursday, Friday and Saturday, during exhibit hall hours

Register online at cdapresents.com

Join the conversation:

#cda10sf

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TERRACE

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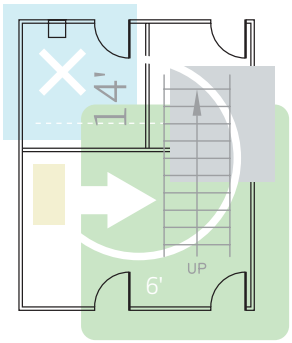


Improving From Within

RUCHI K. SAHOTA, DDS, CDE

GUEST EDITOR

Ruchi K. Sahota, DDS, CDE, is an instructor, Restorative Dentistry Department, Arthur A. Dugoni School of Dentistry, and an associate editor for the *Journal of the California Dental Association.*

The financial crisis of our lifetime has created a dent in dental practices. While many practices are surviving amidst the storm, the American Dental Association reports a decline in dentists' incomes and gross billings. Appointment books are more open and treatment plans are less accepted.[1] Thriving in today's economy has been challenging.

John F. Kennedy illustrated the Chinese definition of the word crisis. "The Chinese use two brush strokes to write the word. One brush stroke stands for danger; the other for opportunity. In a crisis, be aware of the danger, but recognize the opportunity."

So as we hope to see the economic pendulum to swing once again, we acknowledge the financial vulnerabilities of our practices. Dental offices take advantage of the opportunity to pause and look inward, examine new marketing strategies, consider rearrangements of our scheduling, and optimize office and staff strengths and skills.

This issue focuses on one other opportunity to improve from within. Tough but improving economic times may be an optimal period to renovate, redesign, and rejuvenate your dental practice.

One of the articles outlines the financial, accounting, and tax implications of an office remodel. Haden Werhan, a certified public accountant, presents the practical points that should be considered during the planning stages of an office reface, remodel, or rebuild.

Another article highlights steps a practice can take fully optimize the benefits of an office redesign. Virginia Moore and Debbie Castagna describe the possible strategies for maximizing the true investment of a newly remodeled practice.

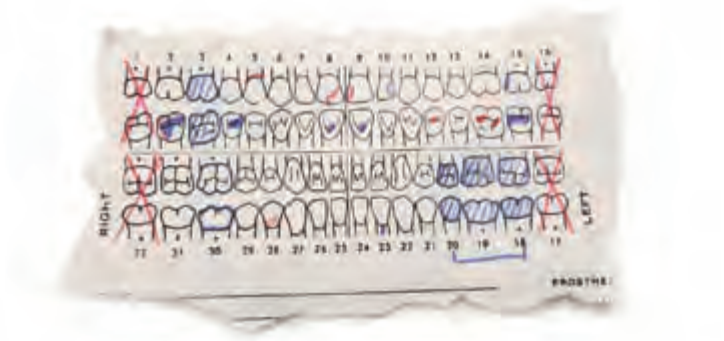
"First comes thought; then organization of that thought, into ideas and plans; then transformation of those plans into reality. The beginning, as you will observe, is in your imagination," said Napoleon Hill, an American motivational author.

Ultimately, a successful practice remodel requires a thoughtful vision, collaborative team of experts, and a thorough plan whether it is as simple as new paint and flooring, or as elaborate as rearranging walls and layout. Talk to colleagues who have recently renovated. Arrange a complete team — a financial adviser, architectural expert, dental equipment specialist, and practice management consultant — to help ensure this investment during tough economic times brings the best bang for the buck. ■■■■

REFERENCE

1. Furlong A, Financial climate: ADA takes close look at how dentists are faring. ada.org, Feb. 3, 2009.

Sure, you could do dental charting blindfolded.



It's the business of dentistry that's the real eye opener.

You're more than a dentist. You're also a business owner, a distinction that requires you to navigate everything from maternity leave to office leases. Thankfully, CDA has published a new Legal Reference Guide for California Dentists with answers to over 200 legal questions pertaining to the business of dentistry. Available only on the Compass, it'll give you the foresight you need to practice like a pro.

cdacompass.com | where smart dentists get smarter.™

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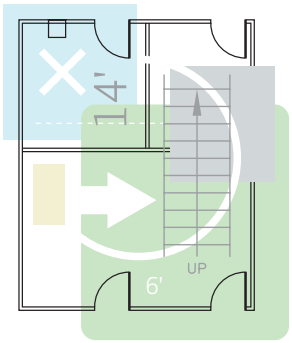

Reface, Remodel, or Rebuild Your Dental Office

J. HADEN WERHAN, CPA/PFS

ABSTRACT Upgrades to a dental practice can range from a minor facelift to all new construction. Consulting a certified public accountant is important to properly account for all the various assets that go into a new office so the tax benefits from each can be optimized. After all the dust has settled, practitioners will be able to take pride in their new dental facility and enjoy their surroundings for many years to come.

AUTHORS

J. Haden Werhan, CPA/PFS, is with Capital Performance Advisors, Thomas, Wirig, Doll & Co., CPAs, in Walnut Creek, Calif.

Chances are the practice purchased or started a decade or more ago is not housed in the office one would create if building it today. X-ray viewers have been replaced by HD monitors. Patient education includes multimedia videos and computer imaging versus a picture drawn on a sheet of paper. Then there's the improved materials and devices, a host of other technological advances, and increasingly savvy patients with increasingly higher service expectations.

To compete in the world of dentistry today, one must take advantage of the tools available and think toward the future. Dentists need a state-of-the-art dental practice to deliver the modern care their patients are, or soon will be, demanding. What are the options and best-practice strategies for funding, constructing, and tax managing the accounts of today's ideal dental offices?

Upgrading the Existing Office

When planning to modernize an existing space, among the first decisions is whether the upgrade should be gradual or comprehensive.

The author, who is from San Francisco, learned that by the time the painters finish painting the Golden Gate Bridge, they have to go back to the other side and start all over again. On the other hand, one can only imagine what people might say if the planners simply closed the bridge for several weeks annually to paint it all at once. Similarly, dentists may decide to bridge the distance between reality and their ultimate goal by remodeling incrementally.

A CASE IN POINT: *Dr. Brown bought an older practice a few years ago. Knowing he was not going to move anytime soon, he decided to modernize his office over time. After familiarizing himself with his patients and practice, he began the upgrades. A new networked computer system was first, followed*

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by a makeover in the reception area including new flooring, wall covering, artwork, lighting, and furniture. It made a huge difference. Later, he updated the operatories with new cabinetry and new equipment. Then came the lab, sterilization area, and restroom. Finally, he renovated his private office. By spreading his upgrades across two years, they were completed with almost no downtime.

Over time, like painting the Golden Gate Bridge, incremental upgrades can keep one's practice modern, optimally functional, and an enjoyable environment for the dentist, their staff, and their patients. In doing it in this manner, one is also protecting their investment, helping them realize full value of the practice when it is sold.

In other situations, incremental upgrades may not be ideal. For example, modifications that go beyond a cosmetic makeover require building permits and building permits begat building inspectors. One may need to do something as simple as removing a doorway to expand into adjacent space or as complex as an expansion with costly modifications like retrofitting. Either way, it might be easier to rip the proverbial Band-Aid off more quickly by planning an all-out upgrade, with no corners cut, and the building inspector prohibiting shortcuts anyway.

A CASE IN POINT: *Dr. Green wanted to add an operatory for hygiene. There was no adjacent space to expand into so she worked with a planner to reconfigure her existing office. Picture a "wave" making its way around a ballpark, that is how Dr. Green remodeled for her new operatory. They started with the private office behind the front desk and circled their way through the rest room, operatories, sterilization and lab, and a large room that doubled as a staff lounge and storage room. By reducing the size of each room and incorporating more modern and efficient cabinetry, Dr. Green was able to add the new operatory. While this seemed like a fairly small project, it required all the same aspects of building a brand-new office, including blueprints and building permits. With careful planning and preparation, the work was completed over the course of an extended holiday break, about four weeks in all.*

Taking the New Office Approach

But what if remodeling the existing space doesn't make sense or isn't an option? What about a brand-new office? One advantage with this option is less worry about downtime. One may face a few days of lost production during the move or one may miss a desired target date for the grand opening, but with good planning and an excellent team, the transition or start-up can be achieved with minimum stress and disruption.

Whether relocating a practice or opening a new one, it's a major project. Over the years, the author has seen dozens of dental offices built in various settings including converted and rezoned homes, older buildings in need of retrofitting, new buildings, and shopping centers. Whatever the space, building a brand-new dental office is a serious undertaking.

That's one reason it's not a good time to pinch pennies when selecting a project team. Dentists can reduce their stress and enhance their results by hiring competent, dental-specific space planners, architects, and contractors. They'll probably cost more upfront, but professional, specialized expertise will save money in the long run by reducing costly changes, surprises, and mistakes. After all, the dentist is going to be in the office, day in and day out, for many years to come. Why not strive for perfection?

The Costs of Construction

Costs for building a brand-new office can vary depending on location, market conditions, local economy, and personal preferences. A four-operatory practice in approximately 1,500 square feet will probably look something like this (**TABLE 1**).

TABLE 1

Estimated Cost of Construction for Four-Operatory Practice

Leasehold improvements*	$225,000
Cabinetry*	$60,000
Equipment	$200,000
Technology	$100,000
Furnishings/décor	$40,000
Contingencies & misc.	$55,000
Total	**$680,000**

*Leasehold improvements are estimated at $150 per square foot and cabinets at $40 per square foot.

The author surveyed colleagues in the Academy of Dental CPAs (adcpa.org), which consists of 25 dental-specific CPA firms across the country, and found these numbers were fairly consistent. One should be careful about using per-square-foot costs as a frame of reference for leasehold improvements, however. Each contractor will have a unique interpretation of what to include. Focus on total project costs and have the dental architect give the contractors and vendors guidelines for their project quotes so they are all inclusive and comparable.

Financing the Project

One should be able to finance a project using one of the major dental lenders, or, if a dentist is well-established, a local bank. Lenders will hold the purse strings during construction to ensure the project is completed. A variety of loan programs, including options to defer the first three payments or to pay only accrued interest on the outstanding balance for the first six months — similar to a line of credit — are available. More complicated financing is available too, but here are some examples of typical loans and the corresponding monthly payments (**TABLE 2**).

If one pays "interest only" during the construction period, the loan payment will

TABLE 2

Examples of Typical Loans and Corresponding Monthly Payments

Loan Term (Years)	Fully Amortized Loan Payment	Payments Deferred for the First 3 Months
7	$10,263	$10,744
10	$7,895	$8,177
15	$6,112	$6,279

TABLE 3

Sample of Dental Office Depreciation Schedule, Sorted by Useful Life

Asset	Cost	Useful Life (Years)	Annual Depreciation
Leasehold improvements	$225,000	39	$5,769
Contingencies & misc.	$55,000	15	$3,667
Cabinetry	$60,000	7	$8,571
Furnishings/décor	$40,000	7	$5,714
Equipment	$200,000	5	$40,000
Technology	$100,000	5	$20,000

be calculated on the balance outstanding after all the funds have been disbursed and then amortized over the remaining term.

When starting a practice from scratch, one shouldn't forget to arrange for sufficient working capital. There are hybrid loan programs with deferred or stepped-up payments that can help with cash flow when starting from scratch. But be careful. Payments are calculated by adding any unpaid (accrued) interest to the amount borrowed, making the loan more costly in the long run.

A Taxing Challenge

Whether remodeling or building, it pays to first take a good look at one's taxes. Maybe it's tempting to postpone that step, but if one is wincing from project costs, it should actually feel good to know any tax-related benefits available from the improvements being planned have been considered and maximized. This is where a dental-specific CPA can really shine. He or she should have in-depth expertise in the many important tax considerations associated with building a dental office, and should communicate them to the dentist, their architect, and contractor. Tax planning should happen before one begins the projects so it can be smoothly integrated with the efforts.

Many available opportunities are related to the appropriate use of depreciation.

Depreciation Overview

Depreciation is a "noncash" expense, designed to provide for the replacement of assets over time through reduced taxes. When acquiring new assets for one's practice the cost of those assets is deducted (depreciated) over an assigned number of years (useful life). The author's sample dental office depreciation schedule is as follows, sorted by useful life (TABLE 3).

Converting 39 Years Into Five

Notice the difference between the depreciation values on the 39-year leasehold improvements versus the five-year equipment. What a difference 34 years makes. What if some of the 39-year property could be moved into the five-year category for a write-off that one could actually use before retirement? Thanks to the Hospital Corporation of America (HCA), it's possible.

In 1997, the tax court sided with HCA against the Internal Revenue Service, providing legal support to use cost segregation studies for computing depreciation. Basically, HCA won their argument that certain expenses, such as plumbing and electrical, were necessary for the operation of hospital equipment and therefore, should be considered part of that equipment and depreciated with it over five years instead of 39.

In a new dental office, one needs water and electricity in the operatories, lab, and sterilization area along with air, suction, and maybe nitrous oxide. A cost segregation study will assign the cost of improvements necessary to make the equipment operational to the same depreciation category as that equipment.

Furthermore, one can associate to those reassigned improvements a proportionate share of the project's soft costs, such as design and architectural fees, building and utility permits, and contractor supervision. They too are reassigned and depreciated over five years. So, if improvements specifically related to equipment operation equal 15 percent of the total improvements, one would include 15 percent of the soft costs in the calculation of the total costs included in the five-year equipment depreciation category.

Cost segregation is a specialized and valuable service provided by very few firms. It requires specialized knowledge of dental office construction.

A CASE IN POINT: *Dr. Black hired a dental-specific CPA who helped him determine that he could reallocate $75,000 of the leasehold improvements and associated soft costs to the five-year depreciation category. By taking this action, he increased the annual depreciation he is allowed by $13,077 and lowered his annual taxes by $5,231 for the next five years (in the 40 percent bracket).*

Dr. Black's CPA also advised him he should depreciate the entire project cost over

TABLE 4

Statement of Cash Flows — Five-Year Depreciation

	Year 1	Year 6
Net income	$200,000	$300,000
Add depreciation	$96,799	$21,799
Subtract loan principal	$78,028	$110,615
Cash flow	$218,771	$211,184
Difference	$18,771	$(88,816)
Tax (at 40%)	$(7,508)	$35,527

the appropriate scheduled useful life and that he should not take additional first-year depreciation as allowed under Section 179.

Why not?" asked Dr. Black. His CPA replied, "The Section 179 deduction has been all over the map for the past decade and its future remains unknown. But in 2010 you are allowed to expense up to $134,000. If you were to take the full $134,000 deduction on your $200,000 of equipment, this would leave you with only $66,000 to depreciate over five years, or $13,200 per year.

In other words, Section 179 is a double-edged sword. Dr. Black could get a big write off in his first year, but the trade-off is minimized deductions during the next four years, when he could probably use them to greater advantage when tax rates will be higher.

Fifteen Years and Counting

The 15-year depreciation category for contingencies and miscellaneous is sometimes used to depreciate start-up costs that don't fit into the other categories mentioned previously but pertain to the project.

Start-up costs are those incurred to investigate a business opportunity prior to that business opening. For example:

- Feasibility or demographic study costs, to identify potential new office locations;
- Real estate attorney fees in conjunction with one's new premise lease;
- Legal and filing fees related to incorporating; and
- Accounting fees for one's business plan and cash flow projections.

The author is often asked whether such costs can be deducted in the year they are paid, especially if it is the year prior to the new office opening. The answer is, it depends. The main determination is whether one is opening their first practice or moving an existing one. Start-up expenses incurred by dentists opening their first practice are not deductible when paid. Rather, they are deducted (amortized) over 15 years as in TABLE 3. However, for dentists already in practice and simply relocating, those same start-up costs are deducted as regular business expenses when paid.

Seven-Year Itches

Continuing with the sample dental office depreciation schedule, the cabinetry and furnishings and décor items in the seven-year category could have instead been depreciated over five years. The author prefers the seven-year depreciation for the following reason. A difficult, but important concept to grasp in accounting is the difference between the practice's taxable income and its actual cash flow. The "Statement of Cash Flows" is a report that reconciles taxable income with all the inflows and outflows of money. For example, with a seven-year loan at 7 percent interest, the Statement of Cash Flows would look like the one in TABLE 4 for the first and sixth years after opening the new office.

This sample Statement of Cash Flows is overly simplified. But basically, one starts with net income, add any depreciation (and amortization) and subtract the loan principal to arrive at available cash flow from the practice. Here are some additional insights regarding depreciation and loan principal:

- The big difference between depreciation in Year 1 and Year 6 is because all the five-year assets have been fully depreciated by Year 6. For the loan principal, the difference occurs gradually with the normal amortization of the loan.
- One does not write a check for depreciation. It is a systematic, non-cash deduction to help save for future expenditures, which is why it is added back in the Statement of Cash Flows.
- On the other hand, a monthly check is written for the loan payment, some of which is deductible interest and some of which is nondeductible return of principal. Since it lowers both the net income and cash, nothing is done about the interest. But the principal paid is subtracted since it comes out of the cash but has no impact on the net income.

The Statement of Cash Flows in TABLE 4 assumes that the Year 1 net income is $200,000, and that it has grown to $300,000 by Year 6. In Year 1, when the depreciation is added and the principal is subtracted, there is $18,771 more cash than taxable net income. By Year 6, the five-year depreciation is gone and the loan payment consists of more nondeductible principal than deductible interest, leaving the cash flow at only $211,184. One has to pay tax on $300,000 from cash flow of $211,184. If the tax on that $300,000 is $120,000, the dentist only has $91,184 to live on. Imagine how much worse it would look if one took the lion's share of depreciation in the first year, as allowed by Section 179.

Suddenly, seven-year depreciation and passing on a Section 179 Year 1 deduction

TABLE 5

Statement of Cash Flows — Seven-Year Depreciation

	Year 1	Years 6 and 7
Net income	$200,000	$300,000
Add depreciation	$75,370	$75,370
Subtract loan principal	$78,028	$110,615
Cash flow	$197,342	$264,755
Difference	$(2,658)	$(35,245)
Tax (at 40%)	$1,063	$14,098

are looking like good ideas. If all of the five-year assets were moved to a seven-year schedule and straight-line depreciation was elected instead of other accelerated methods (TABLE 5), the difference between net income and cash flow would be less dramatic in the last two years of the loan ($35,245 instead of $88,816).

Once the loan is paid off, the pain that results from this mismatch between taxable income and cash flow is alleviated.

One could also take out a 10- or 15-year loan to alleviate the pain with lower principal payments, but longer-term loans carry more interest expense. As an automotive advertisement says, "You can pay me (a little) now or you can pay me (a lot more) later." Or, as one of the author's clients described following his move into a brand-new facility, "Let's do a slow burn this time around; it's less painful."

Other Tax Tips

Tax management isn't all about depreciation. Here are a few other tax-related tips:

Section 44 Tax Credit

For eligible expenditures under the Americans with Disabilities Act, one may take a credit against tax equal to 50 percent of those expenditures, up to $5,000 provided the dentist spent $10,250. But the credit is suspended if the dentist is in Alternative Minimum Tax (AMT), which most readers of this journal are likely. As long as one is in AMT, the credit is suspended for a maximum of 20 years, after which it becomes a deduction. The author believes it is wiser to take the depreciation deduction now rather than wait for the credit. Even if one finds themselves no longer subject to AMT, one only gets to take small bits of the credit at a time against future taxes.

The author cautions what should be considered eligible expenditures. These do not include new construction or most dental equipment. The purpose of the ADA is to remove barriers or obstacles to access, so one must think in terms of modifications to existing facilities.

Section 190

Also related to the ADA, the Section 190 provision of the tax code allows one to deduct up to $15,000 spent on qualified expenditures for the removal of access barriers and for "minor improvements." This means one can deduct such expenses in the year they are incurred rather than having to depreciate them over 39 years. "Minor improvements" means they are not part of new construction. So in the case of a brand-new office, think in terms of demolition. Examples might include tearing out noncompliant workspaces, front desks, restrooms, overly narrow hallways and doorways, and floor treatments (tile, carpet, linoleum) and replacing them with ADA-compliant improvements such as a lowered front desk workstation, non-slip flooring, handrails, bathroom fixtures, and other similar updates.

Business Energy Investment Tax Credits

Tax credits are available for eligible systems placed in service on or before Dec. 31, 2016. The credit is equal to 30 percent of expenditures, with no dollar maximum. Eligible solar energy property includes equipment that uses solar energy to generate electricity, to heat or cool (or provide hot water for use in) a structure, or to provide solar process heat. This law also allows taxpayers eligible for the business tax credit to receive a grant from the U.S. Treasury instead of taking the business tax credit for new installations. This credit is not affected by AMT.

Some Parting Gifts

The following are a few ideas that can apply to just about any dental office project undertaken.

Don't Overlook Oversight

Don't think for a minute this project will happen by itself. The dentist will be on a treadmill during the entire process with all sorts of distractions. Do whatever is necessary to maintain sanity, focus, and good nature, so that the patients, staff, and family are able to get through it too.

Go Green

The Leadership in Energy and Environmental Design Green Building Rating System, developed by the U.S. Green Building Council, provides guidelines and oversight to help one become a LEED-certified "green" facility. In addition to being good for the environment, it's probably good marketing.

State Business Property Tax

Each California county assesses a tax on business assets very similar to the property tax for a home. One must file Form 571-L with the appropriate county by April 1 and pay the tax by Aug. 31. The

tax is assessed on assets owned on Dec. 31 of the prior year. In the new dental office example, the property tax would be in the neighborhood of $6,000. Do not forget to include this amount in one's budget.

Office Makeover=Image Makeover

A brand-new office is like making a fresh start — for the dentist and their practice. Take full advantage of this by promoting one's new image among existing and potential new patients, particularly if new to the neighborhood. A qualified marketing consultant can help with this. A practice management consultant can work with the dentist and their staff to develop fresh approaches to patient communications.

One will have worked very hard and endured a great deal of stress during the remodel or construction of a dental office. But brush off all that stress before seeing patients and convey enthusiasm for the new, state-of-the-art dental facility. ■■■■

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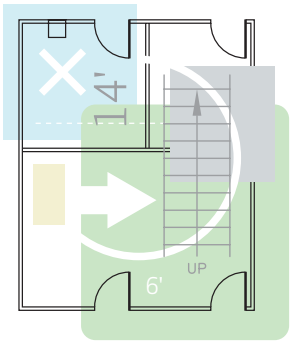

Maximizing Practice Management in the Newly Remodeled Practice

VIRGINIA MOORE AND DEBBIE CASTAGNA

ABSTRACT Embarking on the building of a new facility, or remodeling an existing space, can be an exciting time. In the midst of planning and decision-making, do not overlook two groups of people who represent driving forces behind the overall success of this investment — patients and staff. In rejuvenating a facility, it is important to remember that at every level, patients' needs must be taken into consideration, including a fundamental review — and potential "overhaul" — of internal systems.

AUTHORS

Virginia Moore and **Debbie Castagna** are co-founders of The Practice Source. Their consulting focus is on measurable, sustainable, bottom line results. Moore and Castagna speak on a regular basis at dental meetings across the United States and internationally, and are authors of the training resources, *The Doctor as CEO* and *The Ultimate Staff*.

After adequate planning, a practice remodel can allow for more space to allow for increases in production; a better "form follows function" space to enhance ergonomics and reduce stress; and enough room to accommodate a new associate or partner.

Whatever the reasons, embarking on the building of a brand-new facility or remodeling existing space can be an exciting time. Working with professionals who understand and can execute the dentist's vision make the project not only more enjoyable, but much more financially sound knowing the eventual outcome will meet — or even exceed — objectives.

Two All-important Factors That Must Not Be Overlooked

In the midst of planning, meetings, and decisions, two groups of people that should not be overlooked as they both represent driving forces behind the long-term success of the investment the dentist is making in the rejuvenation of their facility: patients and staff.

The obvious reason to have a facility in which to practice dentistry is because dentists have patients, not vice versa. Experience has shown that while many patients will tolerate inconveniences associated with physical office space, they will not, for long anyway, tolerate being cared for in a manner that is unprofessional or uncaring.

For example, one of the authors' clients conducted a patient survey (administered by a professional third-party) that showed the No. 1 concern for patients was parking. Accessing the parking area and walking to the front door took skills akin to those of a mountain goat. But while a large number of patients cited the irksome parking as a concern, their other remarks were glowing. Why? Because once they made it past the front door, they were warmly greeted by a staff

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member who made eye contact and addressed them by name; they were personally escorted to the treatment room; and there was a solid hand-off from one staff member to the next, and eventually to the doctor. Team work every step of the way.

Patients also indicated satisfaction in the respect for their privacy shown by having a private consultation room available to discuss their treatment needs and financial arrangements.

The results of a patient survey revealed the opposite in another case. Bountiful and easy-access parking, however, upon entering the facility, patients felt an overall lack of caring and respect. They felt unacknowledged and unheard.

People won't tolerate that. In rejuvenating your facility, it's important to remember that from the functionality of the design to the consideration of the spaces and décor, patients' needs must be taken into consideration.

Fundamental to meeting patients' needs are consideration of the internal systems that impact them on a daily basis. A professional dental office design architect will take your systems into consideration in the design process. In how patients move, for example, through the new patient experience, treatment, financial arrangements, scheduling, and recare. The dentist must also look at how their systems affect their patients.

The New Patient Experience

Let's start where every new patient starts — the new patient experience, which usually begins with a telephone call, or can be the result of drive-by or walk-by traffic. Even if one is not involved in a completely new building project, this assessment is important to see the facility as the patients see it.

What do people see as they approach the office? Is the signage easy to read? Does it provide good direction? Or do administrative staff members find themselves constantly "talking people into the office" on their cell phones due to confusing signage?

Walking up to the door through which the patients enter, what is seen? Remember, most patients don't measure the quality of care by the margins on crowns, they measure it by the things they can measure, i.e., cleanliness, neatness, a well-maintained facility, care, and compassion from the doctor and the staff. A worn doormat speaks volumes about one's attention to detail, which is the last thing a dentist wants a patient or potential patient worrying about when they've made an appointment for esthetic treatment.

FROM THE
functionality of the design to the consideration of the spaces and décor, patients' needs must be taken into consideration.

Once past the doorway, what do the senses take in? What are the scents? The sights? The sounds? How is the front desk area arranged? Can the staff member responsible for greeting patients see people as they arrive? Can a patient walk in to the welcome of a warm smile and the sound of their name being used? The most beautifully designed facility cannot overcome the absence of a warm greeting.

The Staff Experience

The other very important party one must consider in planning is staff. Their health and enjoyment at work is an important part of the dentist's responsibility as an employer, as well as an important element in assuring the dentist offers a competitive work environment that helps limit turnover and encourages the best and brightest to become, and stay, part of the staff. When the staff member responsible for greeting patients is in an ergonomically sound position to greet patients, answer phones, and conduct their other responsibilities, the employer is fulfilling an important consideration in the health and enjoyment of their staff.

How the Right Physical Environment Can Lead Patients to Say 'Yes'

Now that the new patient has experienced a nicely presented facility, coupled with a warm, personal greeting, give them every opportunity to share what's important to them. What typically is seen is an enthusiastic rush to let the patient know what can be done for them. While the authors applaud that positive approach, Stephen Covey said it best in the book, *Seven Habits of Highly Effective People*, "Seek first to understand before being understood."

It is remarkable what often occurs when a new patient knows they have been heard, a huge sense of confidence comes from knowing their dentist is interested in what is important to them. The authors also know that the most conducive atmosphere in which to have that "getting to know you" time is in a space in a facility that lessens intimidation, offers privacy, and speaks to the dentist's professionalism. The authors' recommendation, whenever possible, is the addition of a consultation room. This space, wisely utilized, can considerably enhance treatment acceptance as a direct result of the patient feeling respected at receiving the doctor's undivided attention in a friendly and nonintimidating space.

Accompany the new patient to the consultation room and devote 10 or 15

minutes at the beginning of the new patient experience in getting to know the patient. Ask questions and listen to their replies. Employ the "80/20" rule where the dentist is doing 80 percent of the listening and 20 percent of the talking. It is amazing what is learned that can help frame the treatment recommendations in such a way that the patient sees a direct correlation between what they want and how the dentist's recommendations will help them to achieve their objectives.

Lou Holtz, famous Norte Dame football coach, once said that every person you meet is asking themselves three questions about you. One, can I trust you? Two, do you care about me? And three, are you committed to excellence? It's true. When one can answer those three questions before beginning the physical exam, dentists will find patients saying "yes" much more frequently to treatment recommendations.

The Space for Financial Agreements

Now that the patient has said "yes" to treatment, it's time to nail down payment agreements. Financial discussions can be intensely personal and wrought with anxiety. Offer a private space for these conversations to take place, ideally a consultation room similar (or the same) to the one in which the new patient experience took place. Using this private space is highly advantageous to discussing in detail the financial aspect of the care the patient wants and needs, and arriving at a financial agreement that will be honored.

Successful financial coordinators say that having a private consultation room helps patients relax, as well as offering them the privacy they need to feel comfortable asking questions and sharing concerns. Most adults, forced to discuss a payment arrangement within sight and sound of others, will opt for the quickest way to "yes" and then call back and cancel. Put in context of servicing the debt on a dentist's new or newly remodeled facility, the more one can do to ensure patients walk out with a win-win payment arrangement in place, the better off everyone will be.

Scheduling for the Ideal Day

Regardless of how many of the staff are involved in scheduling, the important question is this: Now that additional treatment rooms have been added, is the scheduling system and staff ready to maximize the new additional space?

HAVING A PRIVATE consultation room helps patients relax, as well as offering them the privacy they need to feel comfortable asking questions and sharing concerns.

Over the years, the authors have watched many practices operate their new "Ferrari" in the same way they drove their "Ford." But reaching the ultimate goal of greater productivity with additional space means taking a new approach to scheduling.

Begin with discussing the purpose/usage of the new operatories.

- Is the plan for the addition of hygiene days?
- Will it be the operatory designated for the use of the new associate?
- If staffing levels remain the same, how will the staff utilize the additional number of operatories that the project has provided?

These are all serious questions that must be discussed. Avoid the mistake of "introducing" a new facility by being late and running behind schedule. Now that one has the space, utilize it wisely. Dentists can invest time in discussing their "Ideal Day," and how that template meshes with and utilizes the space. By taking this necessary step, the doctor is poised to take advantage of the opportunity they have created for themselves — additional space to increase productivity and reduce stress.

Recare — a Cornerstone of a Successful Practice

Retaining patients and helping them maintain good oral health is a cornerstone of a successful practice. Unfortunately, this is often seen as one of the most underutilized systems in a practice. When it comes to questions about recare, dentists should ask themselves:

- What message is sent to the patients via this system?
- How does the staff view its importance?
- Is there someone who is designated in their job description to take responsibility for operating this system?
- Does the remodel provide more space allowing for additional hygiene days?
- Will the facility enhancements have the potential to encourage referrals?

The recare system should be robust, allowing for maximum patient retention with the goal of helping achieve and maintain good oral health.

Rejuvenate the recare system by first determining how the system will be operated:

- Does current software allow for timely tracking of patients and when they are next due to be seen?
- Who will follow-up with patients and invite them back onto the schedule? Does a written message effectively convey the dentist's philosophy? For instance, is a "Garfield" postcard with the words, "If you need to cancel your appointment, call

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us!" in harmony with the image you want to project? Will the enhanced image of the office demand a more sophisticated look?

As a group, discuss what the verbal message will be when patients are called for follow-up. Make sure the message that is sent, whether via mail, text, e-mail, or voice mail, is one that encourages patients to be involved in achieving and maintaining their good health, and also reflects the dentist's care and concern for them. People want to know they matter; dentists need to make sure the recare system makes that abundantly clear.

Making Meetings Work, Each and Every Time

Following the need to plan, prepare, and work through systems with the staff, next up is the most valuable staff system: meetings. Through the years, countless numbers of the authors' offices have come to appreciate the importance of having meetings that solve problems. Too often the authors hear that meetings are a waste of time, the same things are discussed with no resolution, or it's a "gripe" session.

Based on the dentist's new financial commitment, this is not the time to "play" at solving problems. Open up the lines of communication, utilize the abilities, ideas, and solutions that exist amongst the staff. To achieve that:

- Assign a facilitator and a recorder (neither of whom are the doctor);
- Post an agenda form that everyone can and should add to; and
- Limit meetings to no more than one hour.

The facilitator's job is to keep the staff focus on the agenda items. Come up with solutions and make an action plan for how those solutions will take place, who will be responsible, and by when they will be done. If possible, make sure the project planning includes a designated staff lounge, complete with room for a table and chairs. This space allows for privacy to post agendas and action plans in an area every staff member uses and add significant importance and impact to meetings.

Remember, it's not just about working in one's practice. One must also work on their practice to maximize the return on investment involved in its rejuvenation.

The Rejuvenation Is Complete

The paint is dry, the last piece of artwork is in place, and that wonderful scent of "brand new" wafts through the air. It's complete. All one's time, energy, planning, and investment have culminated in a fresh new environment for the dentist to provide care.

Coupling an investment in one's facility with a commitment to rejuvenating the systems is almost certain to result not only in the growth and return on investment one desires, but in a patient-focused practice that truly sets dentists and their staff apart. What could be more rejuvenating than that? ■■■■

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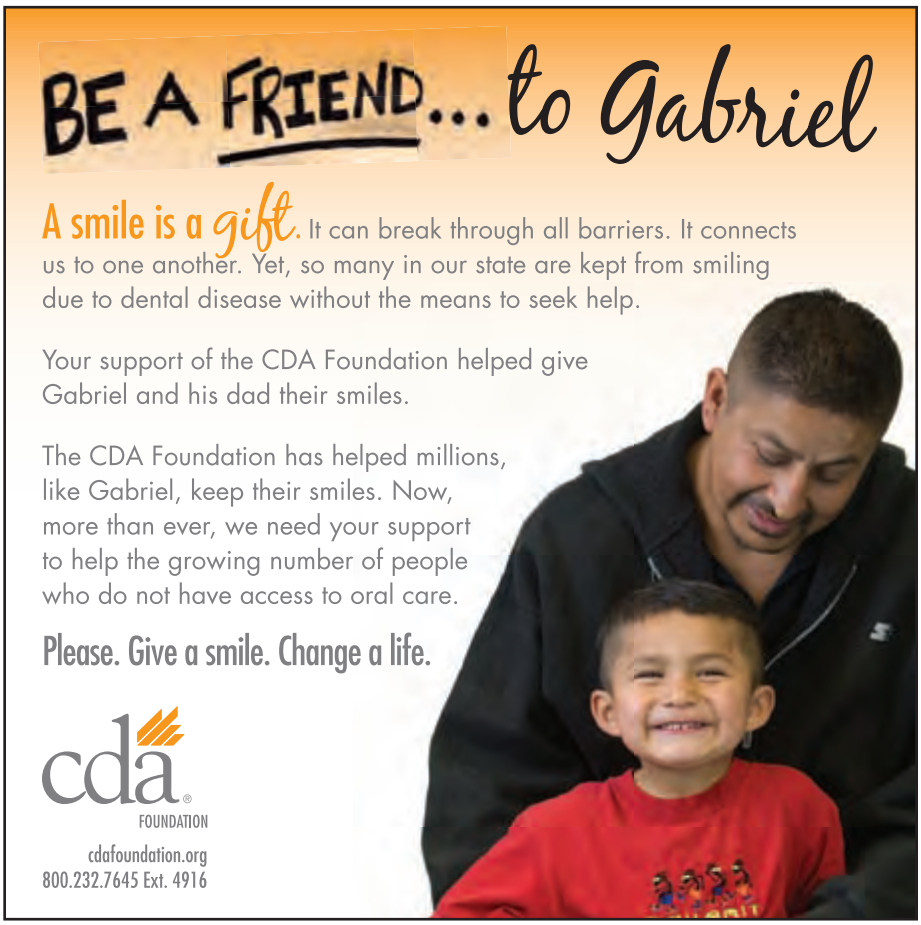

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Effect of Axial Height and Palatal Wall on the Resistance Form of a Maxillary Anterior Metal-Ceramic Crown Preparation

AMIR H. KHATAMI, DDS, AND WAYNE V. CAMPAGNI, DMD

ABSTRACT The effect of palatal wall modifications and height of a maxillary central incisor on the resistance form of metal-ceramic crowns are compared. Dies with adequate preparation height show no crown dislodgement in groups with a palatal wall, palatal wall/groove, and no palatal wall. This study suggests the use of a palatal groove improves the resistance to dislodgement in short maxillary anterior tooth preparations.

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Resistance form is defined as "the features of a tooth preparation that enhance the stability of a restoration and resist the dislodgement along an axis other than the path of placement."[1]

Traditionally, resistance was accomplished by evaluating forces applied obliquely to the long axis of the tooth.[2] Resistance of a tooth to forces applied to an axis, other than the path of placement, can be divided into those related to crown fabrication and those related to the tooth preparation design.[3] Tooth preparation modifications that offer improved resistance form have been studied extensively.[2-17] Preparation modifications enhancing the resistance form of anterior teeth include the use of auxiliary grooves, decreasing the convergence angle or total occlusal convergence, TOC, and increasing the occlusocervical dimension in association with the faciolingual dimensions.[2-17]

The features of a crown preparation affecting resistance form were initially investigated by Reisbick and Shillingburg.[3] The authors concluded that the placement of interproximal grooves and boxes increased the retention of the posterior tooth preparation without commenting on the resistance.[3] The importance of the location of grooves and boxes has also been emphasized by Woolsey and Matich.[4] Higher resistance values were obtained with grooves placed in interproximal locations compared to grooves placed in buccolingual locations, provided the forces were applied in a buccolingual direction.[4] A clinical study has shown that auxiliary preparation elements such as grooves are rarely used in

spite of having clinical tooth preparations with excessive total occlusal convergence.[5]

TOC is another preparation modification that affects the resistance form.[2,6,7, 11-16] Dodge et al. evaluated the tipping resistance of crowns on teeth with 10-, 16-, and 22-degrees TOC with a 3.5 mm occlusocervical dimension and a 10 mm diameter.[2] The authors reported that 22 degrees of TOC produced inadequate resistance and there was no significant difference between resistance of the 10- and 16-degree specimens. The resistance form has been shown to have an "on-off effect" through geometric analysis.[9,10,17] In vitro studies, however, have produced results that conflict with the geometric analysis. These studies indicate that decreasing the TOC and increasing the height of the preparation reduce crown dislodgement under function.[2,4-8]

In addition to the TOC, the height and diameter of the prepared tooth affect resistance. Woosley and Matich proposed that 4 mm is the minimal height for anterior teeth that are prepared within the recommended TOC range of 10 to 20 degrees.[4] Resistance can be increased, even at a increased TOC by modifying the gingival portion of the axial walls.[10,11,17] Gingival extensions may create uneven vertical margins, which have been shown to decrease resistance.[17] Hegdahl and Silness have recommended preserving the facioproximal and linguoproximal "corners" of a tooth preparation to provide adequate resistance form; the authors suggest that a round preparation outline offers little resistance to rotational forces.[12]

In vitro and in vivo studies have evaluated anterior tooth preparation modifications, including the preparation height and diameter, TOC, and the use of auxiliary grooves on resistance form.[2-17] A component of the maxillary anterior crown preparation, the palatal wall may have an effect on resistance form. The palatal wall is considered to be any point on the palatal portion of the tooth preparation from the margin to the incisal edge. The effect of the palatal wall and its modifications on the resistance form of the maxillary anterior metal-ceramic crown preparation is unknown. The purpose of this study was to evaluate the effect of the palatal wall, an auxiliary palatal groove, and a vertical height reduction of the preparation on resistance form of the maxillary anterior metal-ceramic crown preparation.

TABLE 1

Ideal Crown Preparation in MM

Dimensions	Group PW	Group PWG (Groove)	Group NPW (No Palatal Wall)
Cervicoincisal	8.42	8.42	8.42
External-labiopalatal	7.33	7.33	7.33
Internal-labiopalatal	5.80	5.80	5.80
External-mesiodistal	6.87	6.87	6.87
Internal-mesiodistal	5.32	5.32	5.32
Palatal wall height	1.53	1.53	0.00
Palatal groove mesiodistal		1.20	
Palatal groove labiopalatal		1.00	

Materials and Methods

An Ivorine maxillary right central incisor (Columbia, Long Island, N.Y.) was centered with wax (Red Casting Wax, Jelenko, Armonk, N.Y.) in a prefabricated plastic block (22 x 20 x 20 mm) and was rigidly stabilized by pouring acrylic resin (Ortho-jet, Lang Dental Mfg Co, Wheeling, Ill.) into the block. The tooth was prepared with 285.5 M, 256.8 M, 747.6 M (Two Striper, Abrasive Technology, Lewis Center, Ohio), following the suggested guidelines for ideal anterior metal-ceramic restorations.[14,18-20] A 10-degree TOC, 1.0 shoulder finish line, uniform 1.0 mm labial reduction, 2.0 mm incisal reduction, and 1.0 mm palatal reduction with 0.5 mm chamfer finish line was incorporated in the tooth preparation. The completed tooth preparation possessed a cervicoincisal dimension of 8.42 mm, external labiopalatal dimension of 7.33 mm, internal labiopalatal dimension of 5.80 mm, external mesiodisal dimension of 6.87, and an internal mesiodistal dimension of 5.32 mm. The palatal wall height was 1.53 mm (TABLE 1). All of the measurements were recorded and verified three times with a caliper (Darby Dental Supply Inc, Pompano Beach, Fla.). The labial and palatal proximal line angles were preserved in the tooth preparation. The junction of the labial and palatal preparation surfaces with the proximal prepared surface forms these line angles.

A split aluminum tray (19.14 × 19.14 × 32.63 mm) (FIGURE 1) was fabricated and an impression of the tooth preparation was made using a low-viscosity vinyl polysiloxane impression material (Affinis; Coltene/Whaledent, Cuyahoga Falls, Ohio). A wax (Red Casting Wax, Jelenko) was melted into the polysiloxane impression and 10 wax replicas of the tooth preparation were fabricated. The wax replicas were sprued and attached to a crucible former (Whip Mix Corp, Louisville, Ky). One hundred mg of investing powder (Formula 1; Whip Mix Corp) with 4 mL of distilled water and 18 mL of special liquid (Formula 1; Whip Mix Corp) was vacuum-mixed under 735 mm of Hg pressure for 30 seconds using a vacuum mixing unit (Combination Unit, Whip Mix Corp).

The investment material mix was mixed and poured into the casting rings (Whip Mix Corp) allowed to bench set

FIGURE 1. Split aluminum tray.

FIGURE 2. Proximal view of Group PW (preparation with a palatal wall).

FIGURE 3. Proximal view of Group PWG (preparation with a palatal wall and an auxiliary groove).

for 15 minutes. The crucibles were placed into the induction-casting machine (ECM 1-D, Dentsply Intl, York, Penn.) and were heated at 455-degrees Celsius for the first hour. Heating was continued at 1,010-degrees Celsius for the second hour and the patterns were cast (group PW) in a base metal alloy (Wironit, composition: Co 64 percent, Cr 28.5 percent, Mo 5 percent, Mn 1 percent, CO 5 percent; BEGO, Bremen, Germany) at 1,500-degrees Celsius (**FIGURE 2**).

For the second group (PWG) of 10 specimens, the originally prepared Ivorine tooth of the maxillary right central was modified by preparing a groove with a carbide bur (No. H23.31.016; Brasseler, Savannah, Ga.) on the center of the palatal surface of the Ivorine tooth and parallel to the long axis of the tooth. The groove was extended to the level of the finishing line at the gingival portion; on the gingival portion, the groove was 1.2 mm in mesiodistal and 1.0 mm in faciolingual dimension. Ten metal dies were fabricated for this group using the previously mentioned materials and methods (**FIGURE 3**). For the third group (NPW)

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FIGURE 4. Proximal view of Group NPW (preparation without a palatal wall).

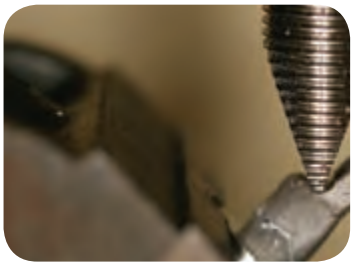

FIGURE 5. Resistance testing. Specimens were loaded in a clamp assembly with external force applied at a 135-degree angle to the long axis and in a palatal-to-buccal direction.

TABLE 2

Reduced-Height Preparation in MM

Dimensions	Group R/PW	Group R/PWG (Groove)	Group R/NPW (No Palatal Wall)
Cervicoincisal	3.0	3.0	3.0
External-labiopalatal	7.33	7.33	7.33
Internal-labiopalatal	5.80	5.80	5.80
External-mesiodistal	6.87	6.87	6.87
Internal-mesiodistal	5.32	5.32	5.32
Palatal wall height	1.53	1.53	0.00
Palatal groove mesiodistal		1.20	
Palatal groove labiopalatal		1.00	

of 10 specimens, the Ivorine tooth was further modified by extending the palatal concavity to the gingival margin. An impression of the Ivorine tooth was made and 10 metal dies were fabricated following the same materials and methods described for the initial group (FIGURE 4).

Next, on the palatal surface of another identical nonprepared Ivorine maxillary central tooth a recipient site for the tip of the universal testing machine was carved with wax (Red Casting Wax, Jelenko). Using the previously fabricated split aluminum tray, a vinyl polysiloxane impression (Affinis, Coltene/Whaledent) was fabricated of the wax-recipient modified tooth. The split aluminum tray with the metal die and impression was assembled in a vise (5-inch Multipurpose Vise; Harbor Freight Tools, Camarillo, Calif.) and molten wax (Red Casting Wax, Jelenko) was poured into the impression. The margins for 30 wax crowns were readapted to the corresponding dies. Crowns were cast with a similar investment-to-water ratio and in a base metal alloy (Wironit, composition: Co 64 percent, Cr 28.5 percent, Mo 5 percent, Mn 1 percent, CO 5 percent; BEGO). The fit of each crown was visually verified under a microscope (Model SMZ-1, Nikon, Kanagawa, Japan). Disclosing material (Occlude; Pascal, Bellevue, Wash.) was used to identify areas preventing complete seating of the castings/restorations.

Areas that were considered to interfere with the complete seating of the crowns were adjusted using a rotary diamond instrument (X118C, Two Striper, Abrasive Technology). The intaglio surface of the castings and metal dies were subjected to airborne particles abrasion using 50-µm Al_2O_3. The castings and dies were cleaned with an ultrasonic unit for 10 minutes in distilled water (Jelsonic, Jelenko, New Hyde Park, N.Y.).

The metal castings and corresponding crowns for all groups were then air-dried and cemented with a resin-modified glass-ionomer luting agent (RelyX; 3M, ESPE, St. Paul). A 5-Kg vertical load was applied to each of the crowns for 10 minutes while the luting agent was setting. The cement was then allowed to set for 24 hours at 37-degrees Celsius in an incubator (Model 4; Thelco Inc, Waltham, Mass.) in a 30 percent relative humidity environment.

Resistance of the cemented crowns to tipping forces (N) was evaluated by loading the metal dies in a clamp assembly with an external vertical force applied at 135-degree angle to the long axis and in a palatal-to-labial direction using a universal testing machine (Instron, Model 4204; Instron, Canton, Mass.) at a cross-head speed of 0.5 mm/s (FIGURE 5).

The force required to dislodge the crown was expressed in Newtons (N). There was no peak load detected by the universal testing machine (Instron, Model 4204; Instron) and there was no visually detectable cement failure for any specimen tested with tipping forces of 1,400 N. Therefore, testing was discontinued.

The cemented crowns were removed form the corresponding dies by a tensile force in the universal testing machine and were subjected to airborne particles abrasion using 50-µm Al_2O_3. The dies were measured with a caliper (Darby Dental Supply Inc.,) and points 3 mm incisal to the finish lines were marked. The dies were then reduced vertically to the level of theses marks with a grinding instrument (Model 257.191501; Craftsman, Chicago) (TABLE 2) and were identified as group R/PW (palatal wall), group R/PWG (palatal wall with groove), and group R/NPW (no palatal wall). This measurement determined the radius of the boundary circle within which the preparation design would not offer any resistance form.[10] The 30 reduced-height dies received corresponding crowns that were fabricated, cemented, and loaded to dislodgement

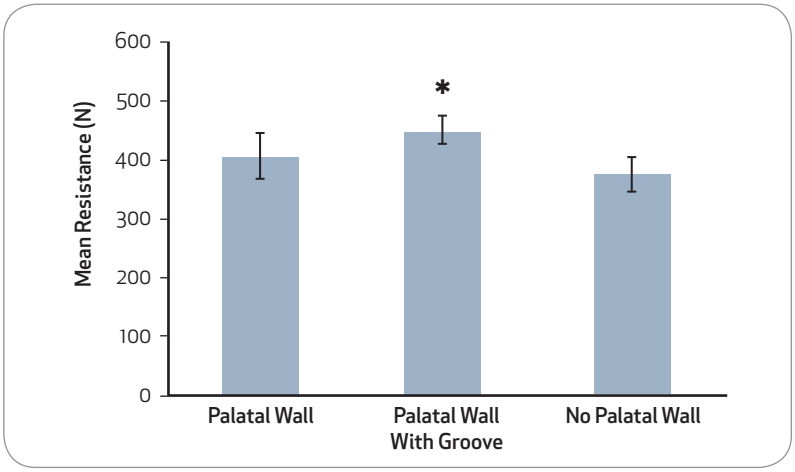

FIGURE 6. Mean resistance strength of reduced height preparations. Symbol (*) indicates statistically significant difference from other means (*P*<.05).

TABLE 3

One-Way Analysis of Variance of Resistance (N) for Reduced Height Crown Dies

Source of Variation	*df*	Mean Square	F Ratio	*P* Value
Preparation	2	13199.64	10.35	<.001
Error	27	1274.76		

with the same approach as for the 30 ideal preparation dies. The force required to dislodge the crown was expressed in Newtons (N). Statistical analysis, using one-way ANOVA and Tukey's Studentized Range test was performed to determine statistical differences between the means of the three groups (α=.05).

Results

During testing, in the ideal preparation groups, at 1,400 N the metal dies were distorting apical to the preparation finish lines and there was no evidence of any crown dislodging. Subsequently, testing was discontinued for these dies.

In the reduced-height group, the preparations with the groove produced higher mean (SD) resistance 457 (23) N compared to the group without the groove 412 (46) N and group without the palatal wall 384 (34) N (**FIGURE 6**). The Tukey's Studentized Range test demonstrated a significant difference in mean resistance between the group with the grooves and the other two groups (P<.05). An analysis of variance of the values can be seen in **TABLE 3**.

Discussion

In the present study, the palatal wall with and without auxiliary groove did not increase the resistance of the maxillary anterior crown to labial tipping forces in preparations with the ideal height. However, the use of an auxiliary palatal groove provided additional resistance to crown dislodgement in the reduced-height preparations.

Anterior tooth preparation modifications can have an impact on the resistance form of a complete coverage crown. Modifications affecting the resistance form include the use of auxiliary groove, varying the convergence angle or TOC, and the preparation height together with the faciolingual dimension at the gingival finish line.[2-17] In this study during the testing of the first group of modified preparations, none of the crowns were dislodged at forces of 1,400 N. Since this level of loading exceeds all the recorded intraoral force measurements, testing was discontinued at 1,400 N.[21-23] This finding is in agreement with previous studies of posterior tooth preparations, which report the increase in the height and diameter of tooth preparations reduce crown dislodgement under function.[2,4-8]

A possible explanation could be the line angle preservation of the preparation resulting in the engagement of the crown. Hegdahl and Silness recommended preservation of the facioproximal and linguoproximal corners of a tooth preparation to provide adequate resistance form.[12] The other explanation for the resistance to the dislodgement could be the effect of the palatal concavity. The incisal third of the palatal concavity, unique to anterior tooth preparations may affect resistance on palatal-to-labial dislodging forces.

Furthermore, when specimen preparation heights were reduced to 3 mm, crown dislodgement occurred with significantly different mean load values for each of the three groups in this experimental category. As discussed previously, the group with palatal wall grooves recorded a higher mean resistance compared to the group without the grooves and group lacking palatal walls. These results verify the findings of previous studies emphasizing the importance of groove and box placement for increasing the resistance form of tooth preparations.[4-5] In the present study, auxiliary grooves provided increased resistance to dislodgement on maxillary anterior tooth preparations with reduced preparation height.

All of the specimens in this study had a 10-degree TOC. The inability to determine the effect of various TOC on

resistance values is a limiting factor to this study. The current study measured only the influence of a single preparation feature with loads in a single direction. Further research is needed to determine the effects of multidirection dynamic cyclic loading on the preparation features particularly for preparations lacking an ideal vertical height and TOC angle.

Conclusion

Within the limitations of this study, the following conclusions are drawn:

1. The resistance of the ideally prepared maxillary anterior crown to a labial tipping force is not improved by tooth preparations having palatal walls with or without auxiliary grooves.

2. When the preparation height is reduced, the use of an auxiliary palatal groove provides additional resistance to crown dislodgement. ■■■■

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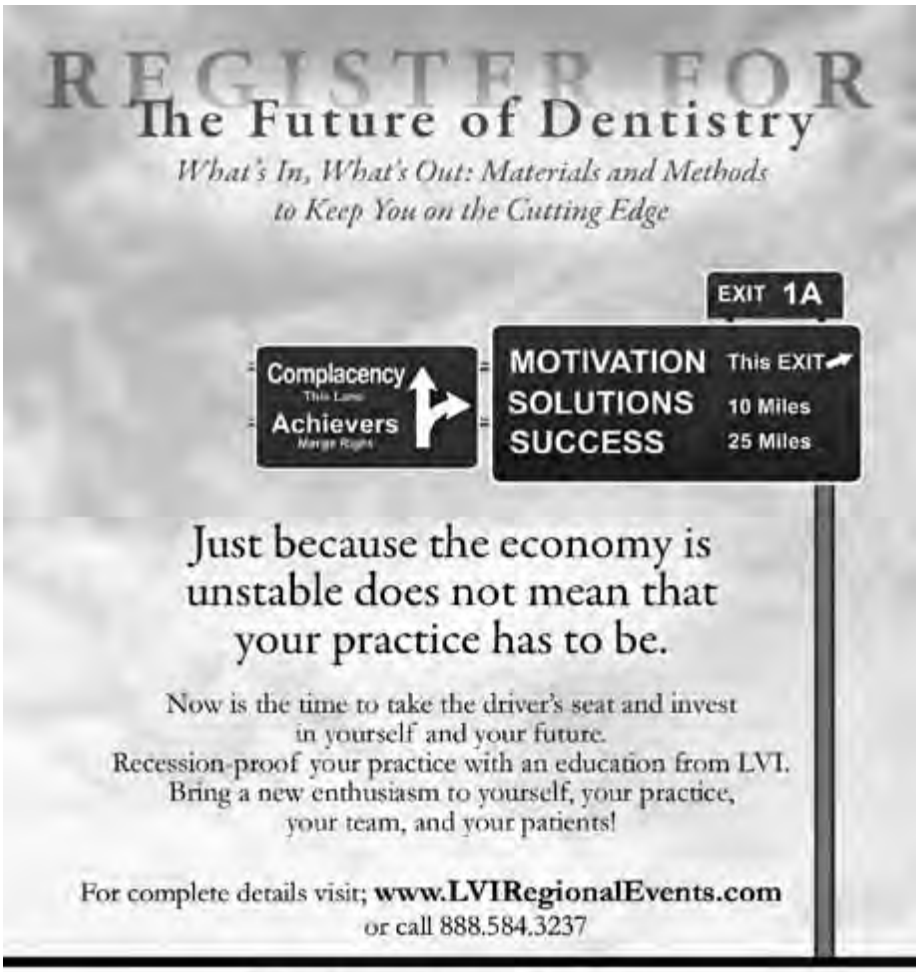

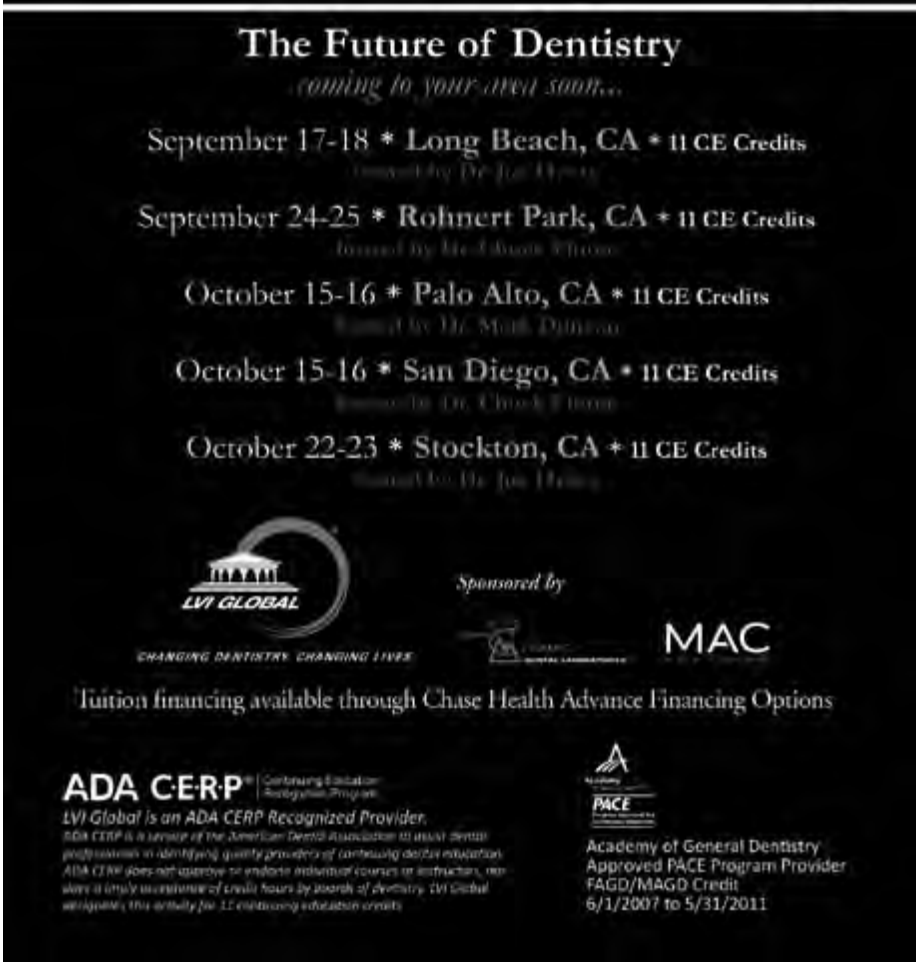

CDA JOURNAL, VOL 38, Nº7

Foreign Body in the Mouth and the Dilemma in Diagnosis: A Case Report

ANAND K. TAVARGERI, MDS; CHAVA BHASKER RAO, MDS; AND SRINATH THAKUR, MDS

ABSTRACT Foreign bodies impaled or stuck in the oral cavity have been reported in literature. The purpose of this case report is to document an embedded foreign object in the maxillary tuberosity region of a 6-month-old baby, mimicking features of a tumor leading to a diagnostic dilemma. This report cautions the clinician faced with diagnosis of tumor in infants to consider the possibility of a foreign body.

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According to Dr. Sigmund Freud, the oral cavity is one of the most sensitive areas for a child, especially during the oral stage of the growth and development. Infants frequently place the foreign objects they find around them in their mouths to test them.

Growths in the oral cavity are usually cellular in origin but can be caused by foreign objects. The latter is difficult to diagnose because the embedment of foreign object may never be known.[1] Foreign objects impaled or embedded in a child's oral cavity have been reported in the literature.[2-5] These objects include toothbrushes, plastic plugs, sticks, toys, and pencil caps. According to Hellmann et al., impalement injuries in young children can result from falling on an object held in the mouth, applying direct force on an object held in the mouth, falling, and running into a stationary object with the mouth open.[6] These foreign objects can be mistaken for growths if they mimic a tumor surface in the mouth. This case reports a similar dilemma when a foreign body was stuck on the maxillary tuberosity of a 6-month-old baby.

Clinical Report

A pediatrician, concerned about an unusual growth on the left posterior region of the upper jaw of a 6-month-old baby girl, referred the newborn for consultation at the Department of Pediatric Dentistry at SDM Dental College. The baby's mother had become concerned when she noticed an unusual growth while feeding the baby; the mother was uncertain about the duration of this growth. The child was in otherwise good health.

On inspection, the growth appeared to be reddish-yellow, mimicking a tumor-like

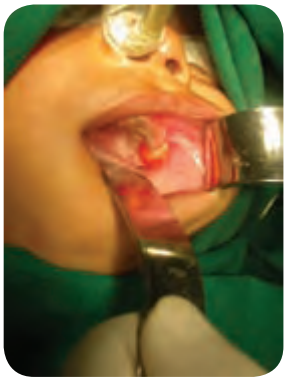

FIGURE 1. Intraoperative appearance of the foreign body.

FIGURE 2. Removal of the foreign body.

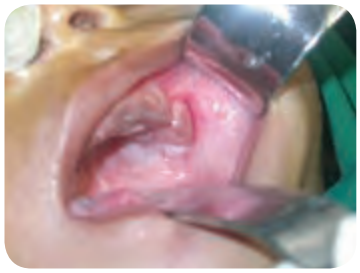

FIGURE 3. Postoperative revealing normal oral tissues.

growth on the left maxillary tuberosity region. Palpation of the growth was not feasible as the child was uncooperative and the parents were apprehensive.

The authors considered congenital epulis or hemangioma, based on its appearance. The oral and maxillofacial surgeon involved in the case had the same opinion (FIGURE 1). As the child was uncooperative, the authors considered placing the child under anesthesia to examine the growth.

During evaluation of the growth, while the child was under general anesthesia, margins and borders appeared sharp, well-defined, and the surface firm in consistency. The authors were surprised they could slightly displace the growth from its position and it was easily picked up with the help of tweezers. The object was later identified as a plastic material that had gotten stuck to the maxillary tuberosity (FIGURE 2).

The reddish-yellow appearance on the retrieved foreign body may be due to the absorption of color from the medication given to the child prior to the retrieval. The underlying mucosa beneath the foreign object was normal (FIGURE 3). The observed growth was part of a plastic toy that the parents subsequently remembered had been missing. Fortunately, the foreign object was in situ, and that aspiration or ingestion would have caused serious complications; radiographs would have been of no value to locate this plastic object.

Discussion

Growths in the oral cavity are usually cellular in origin, but foreign objects mimicking tumor-like features can be misdiagnosed as a growth. Congenital epulis of a newborn and hemangioma were considered in provisional diagnosis as these are a few growths that are congenital in origin and clinical features resemble a foreign body.[7,8] The other differential diagnosis includes solitary neurofibroma of infant, melanotic neuroectodermal tumor of infancy, and granular congenital cell tumor of newborn. Therefore, the clinicians' should consider the possibility of a foreign object in the oral cavity in the differential diagnosis of growths.

A similar case was reported with a foreign body on the palate of a 6-month-old child. The baby was misdiagnosed with a tumor-like lesion.[1] Several reports have described artificial fingernails and pistachio nutshells embedded in the palate and mistaken for a tumor.[9-11]

Conclusion

When clinicians are faced with diagnosing a tumor in oral cavity in infants, he or she should consider the possibility of a foreign object. ■■■■

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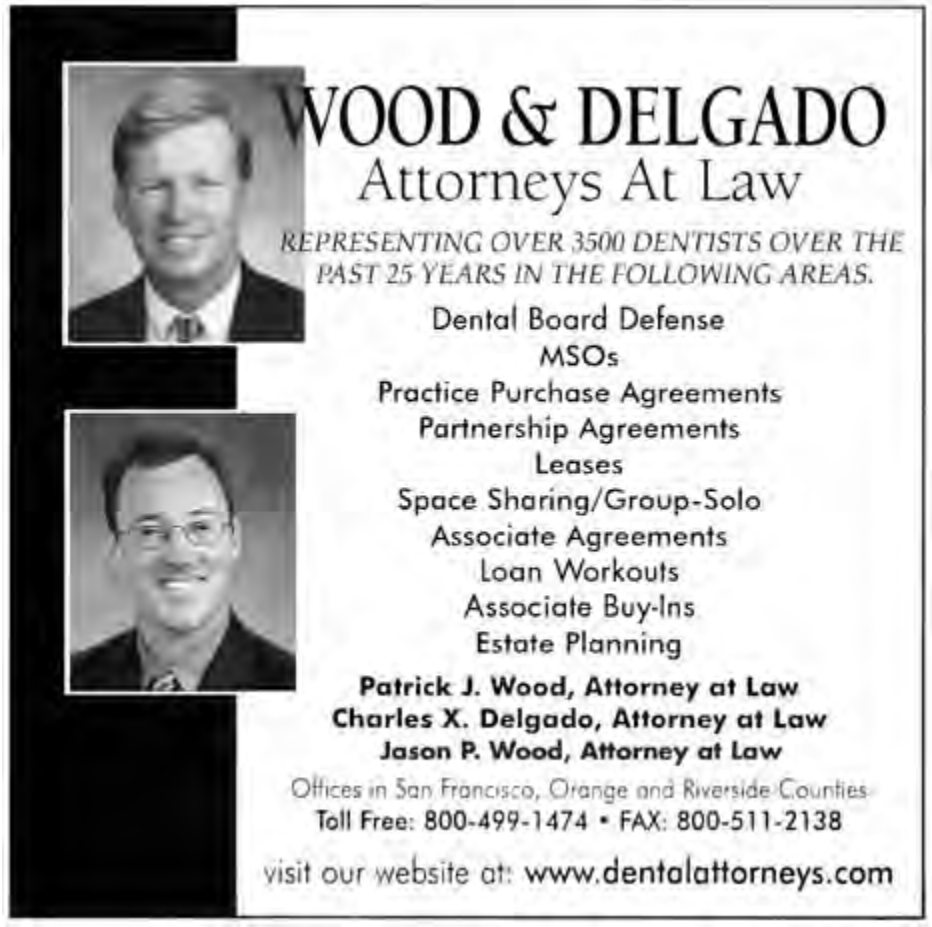

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ASSOCIATE NEEDED — PALM DESERT CALIFORNIA — Part time associateship, must have five years experience. High quality restorative group practice. Contact Dana at 760-568-5928 or e-mail drmac@dc.rr.com.

ASSOCIATE WITH POTENTIAL BUY-IN — Stable, profitable, family general dental practice in the Dayton/Carson City/ Minden area. E-mail resume to p.managementgroup@yahoo.com.

DENTAL ASSISTANT PROGRAM DIRECTOR WANTED — Program director wanted to develop curriculum/teach at new center in Tarzana, California. Experience required. Call Laura 818-758-3557.

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- **APTOS:** *For Sale* - General Dentistry Practice. Highly desirable location. 2008 Gross Receipts over $1Mil. w/adjusted overhead at 51%. 3 operatories in 1,000 sq ft. Pano & Modi computerized software. 9-hygiene days per week. Practice operated for past 33 years in same location. Open 5 days a week. Owner willing to work back for new owner 2 days/wk. #14305 SOLD
- **ATWATER:** *For Sale* - General Dentistry Practice. Gross receipts $177K with adjusted net income of $67,495. Practice has been in its present location for the past 30 years. 1,080 sq ft. 2-equipped operatories. Owner to retire. #14307 SOLD
- **CENTURY CITY:** *For Sale*-Office Space, equipment and leaseholds only. Opportunity for low cost startup practice and or satellite. Asking $100K.
- **CITRUS HEIGHTS:** *For Sale*-General Dentistry Practice. Well-designed 6 operatories with 1,500 sq. ft. office in professional building. Desirable location. 2-3 days hygiene. Owner is retiring. #14311 SALE PENDING
- **COSTA MESA:** *For Sale*-Office Space, equipment and leaseholds only. Opportunity for low cost startup practice and or satellite. Asking $155K.
- **EL DORADO HILLS:** *For Sale*-General Dentistry Practice. 2009 GR $790,758 adjusted net income of $312K. Intra-oral camera, pano, Softdent software, 4-equipped ops. 6-hygiene days. Practice has been in its present location for past 18 years. Owner retiring.
- **EL SOBRANTE:** *For Sale*-General Dentistry Practice: Ideal for recent grad or DDS looking for satellite practice. 3 ops. w/potential of 5. '08 receipts $350K, adj. net income $124K. 3 days of hygiene, Pano, Easy Dental software. 1,300 sq. ft. Seller is retiring after 35years in same location. #14302 SOLD
- **FRESNO:** *For Sale*-General Dentistry IV Sedation Practice. Collections $1,064,500. Seller looking for either an outright sale or a buyer to purchase 1/2 of the practice. Buyer will need IV sedation skills or have been trained to provide IV sedation. Facility 1,500 sq. ft. w/5 equipped operatories & 7 days of hygiene. #14250
- **GRASS VALLEY:** *For Sale*-This Periodontal Practice is located in a very desirable growing community. Practice has been in its present location for the past 28 years. Office consists of 1,500 sq ft 3 ops, Intral-oral camera. Practice has 5 days of hygiene. #14272 SALE PENDING
- **LAGUNA BEACH:** *For Sale* - General Dentistry Practice. 2008 Gross Receipts $898K. 4 operatory (5 ops available) 2,000 sq. ft. office. There are 4 days of hygiene. Practice has been in the same location for approx. 16 years. Owner is retiring.
- **LAGUNA HILLS:** *For Sale* - General Dentistry Practice. Owner aquired practice in 1992. Office remodeled in 2004. 3 days of hygiene, 1,324 active patients, 20 new pts/month, 6 operatories, Eagle Soft software. Receipts were $868 in 2008. Wonderful location.
- **LAKE FORREST:** *For Sale* - General Dentistry Practice. This 4 operatory, 1,200 sq. ft. office had gross receipts of 1.2 million in 2009. There are 5 days of hygiene and approx. 2,000 collective patients. Approx. 10% of receipts are from two HMO plans. Seller has practiced in the same location for approx. 30 years. Owner is retiring. SOLD
- **LOS ANGELES:** *For Sale* - General Dentistry Practice: This practice 80% Dentical and has approximately 2000 active patients. Owner has operated in same location for 31 years. 2009 receipts were $709,000. 6 equipped tx rms, laser, intra-oral camera Pano and Ceph. Call for details.
- **MODESTO:** *For Sale* - General Dentistry Practice. 5 operatories, 32-years in practice. Gross Receipts $884K w/adjusted net income of $346. Dentrix, Cerec, and Intra-oral camera. Owner to retire. #14308 SOLD
- **MURRIETA/TEMECULA:** *For Sale* - 2009 receipts were $648,000. This 4 op, 1,300 sq. ft. office space with 4.5 days of hygiene. Average age of Dental Equip is 7 years. #14313 SOLD
- **NORTHERN CALIFORNIA:** For Sale- Pediatric practice. Owner has operated in same location for 32 years. Approx. 1,760 active patients, 1,160 sq. ft., panoramic X-ray, Dexis Digital and Dentrix software in this 5-chair office. 2009 Gross Receopits $713K with 48% overhead. Owner retiring. Call for details.
- **NO. CA WINE COUNTRY:** **ENDO PRACTICE** For Sale-GR 958K adj net $673K 4 Ops, 1,500 sq ft. Overhead 29% Owner to retire #14296
- **OROVILLE:** *For Sale* - General Dentistry Practice. Owner dentist recently deceased. 2009 collections $770K. Very nice stand alone dental building with basement. 7 ops digital x-ray 5 days of hygiene. Bldg 3,000 sq ft Basement 540 sq ft. Temporary Dentist in place. #14310 SOLD
- **PALM SPRINGS:** *For Immediate Sale* - General Dentistry Practice. 2008 Gross Receipts $906K with adj. net income of $346K. Highly desirable location with 4 ops. Laser, and Intra-oral camera. 5 days of hygiene. Owner recently deceased. SOLD
- **PLUMAS COUNTY:** *For Sale*-3 equipped ops. Space available for 4th op. 1245 sf office in good location. 2009 gross receipts $475K. Practice in present location over 50 years. Owner is retiring.
- **PORTERVILLE:** *For Sale*-One of two partners is retiring in this highly successful General Dentistry Practice. Receipts $2Mil. adj. net $1,257,000. 2,000 sq ft 6 ops. Intra-Oral camera, Pano, Dentrix.10 days of hygiene. #14291
- **RED BLUFF:** *For Sale*-General Dental Practice **"REDUCED PRICE"** Facility overlooks the Sacramento River, 3,500 sq ft, has 8 ops, 10 hygiene days. Appraised Value or Best Offer. Historically Gross Receipts have been over $1 Mil per year. 100% financing available. Sale of Building (optional) #14252
- **REDDING:** *For Sale*-Owner looking for Assoc. trans. into Partnership w/Buy-Out. GR $1 Million dollars income $436K. 5.5 days hygiene, 2,200 sq. ft. #14293
- **ROSEVILLE:** *For Sale*-General Dentistry Practice. 2008 Receipts $834K with adjusted net income of $297,218. 64.4% overhead. Practice has been in this present location for the past 7 years. 13-15 New Patients a month. 6-treatment rooms in 2,100 sq ft. Laser, Intra-oral camera, and digital radiography. Owner relocating out of office. SOLD
- **SAN FRANCISCO:** Financial District 4 ops, 1,500 sq. ft. MERGER - Buyer needs to bring in Pt. base #14288 SOLD
- **SAN FRANCISCO:** *For Sale-Patient Base for Sale*-Owner passed away last June and the practice has continued on 4 days a week with an associate. Lease can't be renewed. There are approx. 1,000 acive patients in the practice. The patient base can be purchased at no risk to buyer since the purchase price is paid according to the receipts collected on the patients that transfer. #14312
- **SAN DIEGO:** *For Sale*-General Dentistry Practice. This office is plumbed for 4 ops. 3 ops. are equipped with Promo Equipment. Lease is $2,200 per month. 2009 receipts were $185,645. PPO and Fee for service practice.
- **SAN DIEGO/CITY HEIGHTS:** For Sale-General Dentistry practice. Owner has operated in same location for 12 years. Approx. 1,000 active patients, panoramic X-ray, Intra Oral Camera, in this 3-chair office.
- **SOUTH LAKE TAHOE:** *For Sale*-General Dentistry Practice. Office is 647 sq ft w/3 ops. Practice has been in its present location for the past 26 years. Owner to retire. #14277 SOLD
- **TORRANCE:** For Sale- General Dentistry Practice: Owner has operated in same location for 20 years. Approx. 1,000 active patients, 1,080 sq. ft., Brican System, and Camsight software in this 2 equipped, 3 available-chair office. 2009 Gross receipts $434K with 38% overhead. Owner relocating.

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KERN COUNTY - *New Listing!*
Well established, 6 op GP with a great location for the dentist desiring a rural lifestyle in a friendly community. This practice collected over $523,000 in 2009 with amazing growth potential.

SOUTH SAN FERNANDO VALLEY
3 op GP located in a busy strip shopping center. The office has computers in each op and utilizes a Digital Schick X-ray system. 2009 collections $357,000+.
Pending

ORANGE COUNTY COASTAL COMMUNITY - (Perio)
Busy periodontal practice with a highly desirable location. 5 op, very profitable business with long term goodwill and a great staff. 2009 collections $900,000+. The seller is retiring.

LANCASTER
Long established, 4 op GP with an excellent location in a professional complex. Strong patient base developed over 34 years. 2009 collections exceeded $670,000. The seller is retiring.

SAN JOAQUIN COUNTY (Pedo)
Price Reduction - Motivated Seller!
Long established pediatric dental practice with a fantastic presence in a busy and popular location. The large "child friendly" office includes 11 equipped ops. The seller is retiring.

SAN DIEGO AREA
Multi office opportunity. Contact us for more details.

INLAND ORANGE COUNTY
Motivated Seller!
Newer, 3 op GP start-up opportunity. Located in a shopping mall, the practice is currently open only two days per week and is positioned for growth.

SACRAMENTO COUNTY (Ortho)
Spacious 6 op, well established orthodontic practice in a full service easily accessible office building. 2009 collections $440,000+.

LOS ANGELES (Endo)
Price Reduction!
4 op, long established endodontic practice. Located in an easily accessible professional building next to a major intersection

MORENO VALLEY
Spacious, 2,700 sq ft, 7 op (6 equipped). Set in a busy location, 25 years goodwill, strong patient base & plenty of room for growth.
Pending

VENTURA COUNTY
Long established 3 op GP with a convenient strip mall location. Well trained staff. Collections are consistently growing with 2009 gross $431,000+.
Pending

SOLANO COUNTY
Price Reduction!
4 op (3 equipped) GP with strong patient base. Efficient facility and proven systems.

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ALHAMBRA – (2) op G.P. Mostly cash pts. w some Ins/PPO. 2009 Collect $140K on a very limited schedule. Seller quotes 1,200 active pts. Seller retiring, but will assist w transition. **NEW**
ANAHEIM – (3) op computerized G.P. Low overhead office. Cash/Ins/PPO/Denti-Cal patient base. Annual Gross Collect. $260K+ p.t. Will do more f.t. Seller motivated. **REDUCED**
ANAHEIM #2 – (4) op computerized G.P. & a free standing bldg for sale. Located on a major Blvd. Excellent exposure/visibility/parking. Cash/Ins/PPO/Denti-Cal pt. base. New eqt., Dentrix s/w, & intra oral camera. Digital ready. 2010 projected Gross Collect $240K 3.5 days/wk. **NEW**
ARCADIA – (4) op computerized G.P. Cash/Ins/PPO only. Gross Collect $315K+/yr on a (4) day week. In a well known, easily accessible medical/dental bldg on a main blvd. **SOLD**
BAKERSFIELD #22 – (5) op G.P. (4) eqt'd. Strip Ctr. Gross Collect ~ $200K/yr p.t. **NEW**
BAKERSFIELD #23 – **Partner Wanted! 50% Ownership!** (12) op comp. G.P. in a retail ctr. Cash/Ins/PPO. Digital X-rays & Pano. Paperless office. Annual Gross Collect. $2M+. **NEW**
CALABASAS – "Build to Suit" Dental space avail for long-term lease. 1,200 – 3,600 sq ft **NEW**
FRESNO SUBURB – (3) op G.P. Gross Collect. $375K/yr. No competition. **SOLD**
HIGHLAND #2 – (3) op compt. G.P. in a shop ctr. Mixed Pt. Base. '09 Collect. $447K. **NEW**
SAN JACINTO (HEMET AREA) – (4) op Computerized G.P. Absentee owned HMO pract. w $6K/mos Cap Checks. No Denti-Cal. 2009. Gross Collect. ~ $400K on a (3) day wk. **PENDING**
SANTA CLARITA VALLEY – (11) op comput. G.P. (10) ops eqt'd 11th op plmb. Cap Cks. $14K-$16K/mos. Cash/Ins/PPO/HMO/min Denti-Cal. Annual Gross ~ $1.6M. **SOLD**
SOUTHGATE – (5) op built out DDS office for lease. On a main Blvd. in a free standing bldg. Highly recognizable Gov't Ctr. across the street. Excellent exposure/visibility/signage. **NEW**
TUSTIN – (4) op Turnkey Office w newer eqt. No pts. On a main blvd. Reasonable rent. **NEW**
WESTLAKE VILLAGE – (4) op compt. G.P. in a highly desirable area. (3) ops eqt'd. Digital x-rays. Drop Dead Gorgeous! Cash/Ins/PPO only! '09 Gross Collections ~ $629K. **SOLD**
VALLEY VILLAGE (SHERMAN OAKS) – (4) op computerized G.P. 2009 Collect. $477K. Cash/Ins/PPO pts. Seller is a 1-800-DENTIST. In a free stand. bldg. w visibility. **REDUCED**
VENTURA Multi-Specialty – 5 op comput paperless office, digital x-rays/Pano. Newer Eqt. '09 Gross $623K+. 2 days/wk Pedo, 3 days/mos O.S., 2 days/wk Endo, 1 day/mos Perio. **REDUCED**
VENTURA – (3) op computerized G.P. & a free standing bldg. for sale located in a highly desirable area. Cash/Ins/PPO & small amount of HMO. Seller is a 1-800 DENTIST provider. Dentrix s/w & Pano eqt'd. 20-25 new pts. per mos. Annual Gross Collections $400K+. **NEW**
WOODLAND HILLS – (3) op comput. G..P. Dentrix s/w. Located in a strip ctr. Cash/Ins/PPO only. 2009 Gross Collect. ~ $570K. Newer eqt., digital x-rays/intra oral camera. **SOLD**

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CLASSIFIEDS, CONTINUED FROM 516

energetic with a desire to be productive, very personable, people oriented and have great general and specialty clinical skills, fax resume to Otto J. Hanssen at 425-484-2110.

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OPPORTUNITY WANTED — Periodontist with decades of experience in periodontal regenerative surgery, implant surgery and mucogingival surgery seeks a position in high quality clinical setting in Southern California. Contact at perio55@aol.com.

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COASTAL EUREKA PRACTICE FOR SALE — Family practice in beautiful semi-rural area with fantastic outdoor recreation. Production/collection historically near one million per year with high net, a FFS practice with no capitation and doctor only working 14 days per month. Large loyal patient base would support 2 dentists. Great growth potential by adding endo, perio, oral surgery and increasing work schedule. Priced at $625K. Building available for favorable lease or purchase. Call after 6 p.m. pacific time 707-499-9799.

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3028 NAPA-SOLANO COUNTY GP

Owner retiring from well-est. practice in 1,400 sq. ft. facility with 5 ops. All fee-for-service pts. with great word-of-mouth reputation. 2009 GR $731K+, June 2010 FY on schedule for $771K + with just 4/doctor-days. Asking $518K.

3006 MONTEREY COUNTY ORTHO

Est. Ortho practice in 2,668 sq. ft. office with 5 open bay chairs in a professional dental complex. Panorex and Cephlometric X-ray machines. Stable and loyal referral base. Annualized GR as of Oct 2009 are $335K+. Owner retiring and willing to help for a smooth transition. Asking 227K.

2986 SAN JOSE FACILITY & EQUIP

A 3 year-old stunning facility with small pt. base that has all the bells and whistles. 2,000 sq. ft. office. Located in desirable comm./residential neighborhood close to O'Connor Hosp. & Valley Fair Mall. 6 ops and new equip. For the est. GP who is looking to move into a larger facility or for the assoc. GP who is ready to start out on their own. Asking $475K.

3030 NORTH BAY AREA PERIO

Owner retiring from well established periodontal practice with excellent referral sources in a 2,411 square foot state-of-the-art office facility with 4 fully equipped operatories and a dedicated staff. Looking for buyer with high ethical standards and great clinical skills. Great location and owner willing to help for a smooth transition. Asking $600K.

3013 SOUTH VALLEY, GP

Clean air, quiet living and a small town atmosphere are found in this bedroom community to Northern California's San Jose/ Silicon Valley. Quality, well-est. GP offering 31 years of goodwill in a state-of-the-art, fully equipped, attractive 6 op practice in 2,246 sq. ft. Seller is the originator of "Alternative Lightwire Functional" appliances but the practice includes every aspect of whole person dentistry at the cutting edge from Cerec to PRGF augmented surgery. Approx. 2,500 active pts. with a waiting list for new patients to join the practice!!! 2008 GR $870K+. Asking $563K.

3017 SOUTH BAY

Est. Cosmetic and Restorative Practice in desirable area. Sell[PENDING]nd able to help for a smoot[PENDING] sq. ft. office with 4 fully equip[PENDING]ops. 2009 GR $829K+. Asking Price $658K

3016 CONTRA COSTA COUNTY PERIO

Est. 1990 in desirable bedroom community 20 miles from SF. 1,068 sq. ft. beautifully remodeled office w/4 fully-equipped ops., & excellent staff. Ass[SOLD]e 5 year lease w/5 year option. Seller [SOLD]elp in the transition of the practice. [SOLD] GR $441K+, 2009 GR projected to $460K+ as of Oct. Terrific upside potential. Asking $275K.

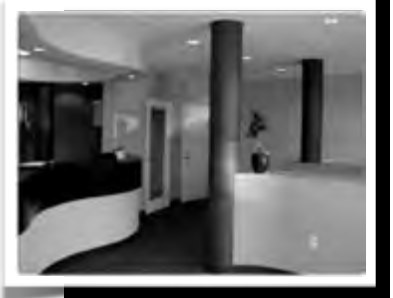
3022 MODESTO GP

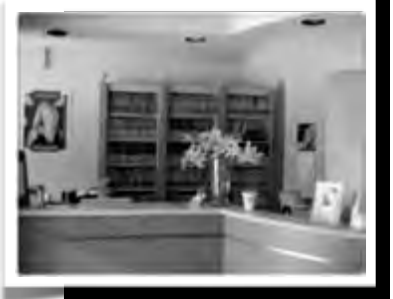
Owner retiring from well est. friendly, family practice w/3 ops. in 1,150 sq. ft. office + spacious storag[SOLD]vg. GR for past 5 years $379K w/4[SOLD]ead & great upside potential. Quality staff. Owner willing to help w/smooth transition. Partnership in building available. Asking $278K for practice.

3023 NORTH BAY

Seller retiring from service oriented practice with loyal patients and seasoned staff. ~2K sq. ft. office w/ 3 fu[SOLD]uipped ops. & excellent lease terms. [SOLD] pts. all fee-for-service. Avg. GR $43[SOLD] Avg. overhead 64% w/ 3.5 doctor days/wk. Great upside potential. Asking $273K.

UPCOMING: SOUTH BAY GP





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BAY AREA

A-807 SAN FRANCISCO - Heart of downtown financial district. Quality, state-of-the-art. 800sf w/2 ops. Plumbed for 1 add'l **$250k**

A-817 BELMONT- Surrounded by dental specialties in 2-story Prof. Bldg. 860sf w/2 ops. Plumbed for 1 add'l. **$210k**

A-829 SAN FRANCISCO Facility – Attractive Office w/traditional décor. 1600sf & 2 ops. **$49k**

A-8911 SAN FRANCISCO— Don't hesitate! One of the areas most prestigious addresses! 2,073 sf, 4 ops + plumbed for 1 add'l op. **$585k**

B-846 OAKLAND- Long-established, fee-for-service practice. 2,100sf w/ 3 fully equipped ops **$325k**

C-7811 SOLANO CO - 2,997 sf w/6 ops + 2 Hyg ops + 1 add'l op! Buy the whole practice for $1.3m or only 50% for $650k. **Call for Info!**

C-869 NAPA VALLEY AREA - Quality, fee-for-service practice. Dental Prof Bldg w/ ~ 1,000 sq. ft. & 2 ops. Option for 3rd op. **$450k**

C-884 FAIRFIELD –2,856 sf & 4 ops w/ possible expansion w/ plumbing of additional op **$350k**

D-842 PLEASANTON –General Dentistry. 1,488sf w/ 2 ops **$295k**

D-779 SUNNYVALE - Well established GP in heart of Silicon Valley! 4 ops, 1050sf. **$225k**

D-824 SANTA CLARA- GP - 35+ new pats/mo by word-of-mouth referrals. Just 6 years old w/ 1,500 sf & 3 fully equipped ops. **$485k**

D-845 SAN JOSE - *Facility* -Attractive office. Traditional décor. Retail Plaza. 2,240 sf & 5 ops. **$150k**

D-863 SAN JOSE-Excellent location & Stellar Reputation! Professionally Decorated in Popular Retail Shopping Ctr. 1500sf & 3 ops **$495k**

D-870 CUPERTINO– CAT6 fully computerized. 2100sf & 3 ops. '09 collections over $800k! **$650k**

D-877 LOS ALTOS -Pristine Professional plaza. Office is ~ 2,400sf - 6 ops **2009 Collections - $819k!! Asking only $425K**

D-857 MOUNTAIN VIEW- Quality practice. Busy traffic flow. Significant walk-in patients-continuous growth. Free-standing bldg - exclusive patient parking. 3,400sf - 11 ops **$595k**

NORTHERN CALIFORNIA

E-729 AUBURN - Busy retail shp ctr w/excellent signage & good traffic flow. 1750sf, 4ops. Plumbed for 2 add'l ops **REDUCED! NOW ONLY $250k**

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E-865 FOLSOM–Newly equipped Assoc Driven practice.1650sf, 5 ops **2008 Collections ~ $800k! Asking $525k**

E-872 ROCKLIN– Remarkable opportunity w/ a steady increase in monthly collections! 2450sf w/ 6 ops**. REDUCED $445k**

E-881 SACRAMENTO-State-of-the-art Practice with growing patient base. 2,400 sf & 3 ops. Plumbed for 3 add'l **$250k**

E-888 AUBURN - Highly esteemed FFS practice. Well respected. Doesn't get any better than this! Very desirable free standing building. Practice offers unparalleled dental care! 1,480sf w/3 ops. **This IS your dream practice! Call for Details!**

G-751 RED BLUFF/CHICO- Complete remodel ~5 yrs ago. FFS GP. 2350sf /4 ops. Plumbed for 2 add'l. **Current Lender Willing to Carry Qualified Buyer. Practice Offered at $175k / Real Estate $250k**

G-875 YUBA CITY–Estab. 30 + years, GP, FFS, 3575sf /9 ops, great location. **$1.5m—Associate Buy Opportunity!**

G-882 YUBA CITY - 3 ops, ~ 850 sf. Thriving Practice! Call for Details! **$190k**

F-7651 ARCATA -Near University. Vibrant student/staff population. 2700sf, 6 ops. **$480k**

H-634 WEST OF RENO - 1500 sf/ 4 ops, Lease below market value. **$250k**

G-883 CHICO VICINITY – Quality FFS GP. Attractive Professional plaza. 1,990 sf w/ 5 ops **$535k**

H-668 NORTHEASTERN CA–4 ops 1600sf office. 2007 gr rcpts exceed $650k! **$395k**

H-856 SOUTH LAKE TAHOE Over 50 new patients/mo Respected & Growing! 1568 sf & 4 ops **$425k**

CENTRAL VALLEY

I-772 *Facility* STOCKTON-Desirable, affluent health care area. 2,140sf/4 ops **$250k**

I-685 TURLOCK - 1700sf, 7 ops. Rrecently remodeled. Free standing bldg. Mostly Adec Eqpmt. **$350k**

I-840 TRACY- Must See! Major thoroughfare. 2,165 sf & 6 ops. Plumbed for 1 add'l op. **$345k**

I-889 MERCED- Heart of town, bustling with activity & foot traffic. 3 ops **$265k**

I-893 *Facility* MODESTO- Retail Shopping Center adjacent to a popular Supermarket 1,200 sf & 4 ops **$150k**

J-801 FRESNO– Facility. ~ 1300sf & 4 ops. Traditional Décor. **$70k**

SOUTHERN CALIFORNIA

K-762 INDIAN WELLS– Well Respected practice w/loyal patient base. Newly remodeled, 1400+ sf, 5 ops **REDUCED!! $425k**

K-858 CHATSWORTH– Seasoned Staff supported by Excellent Specialists. Stable Loyal Patient Base. 2150 sf & 4 + fully equipped ops **$295k**

K-887 ESCONDIDO-Beautifully landscaped dental prof bldg 1,705 sf w/5 ops **$225k**

K-885 RANCHO CUCAMONGA- Retail Ctr w/ major anchor store. 1,250 sf w/3 ops **$225k**

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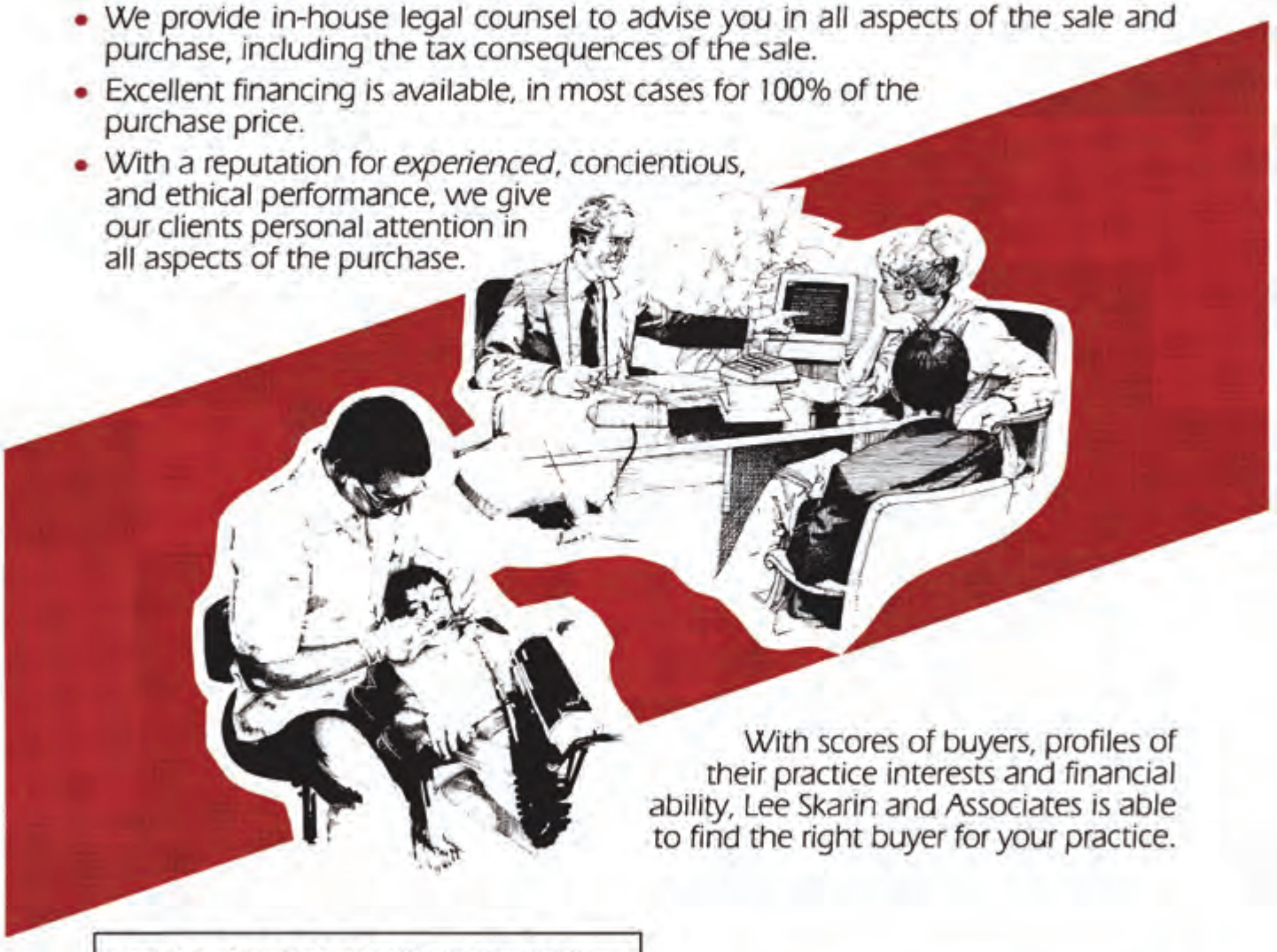

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DR. BOB, CONTINUED FROM 526

tists' research disclosed that chewing gum had a powerful, although inexplicable affinity for forming a permanent bond to leather shoes, hair and the underside of tables and desks. Foreshadowing the later discovery of Nutty Putty, small children took advantage of gum's amazing flexibility by demonstrating how easily gum could be molded to nasal passages and the convolutions of ears.

By 1914 William Wrigley Jr. had become the poster boy for the whole chewing gum craze, thereby earning the undying enmity of mothers, janitors, and teachers across the nation. Stenographers, however, loved Wrigley as they learned how to type and "crack" gum at the same time. Anyone with an ounce of flair could grasp gum between thumb and forefinger, pull it out in a narrow strand up to 18 inches and reel it back in with deft interaction between tongue and lips.

Predictably, by the early 1920s, America was deluged with new brand names such as Beeman's Pepsin, Black Jack, P.K., and Teaberry. The nation was divided into equally vociferous camps: the chewers and the anti-chewers. The latter group was led by schoolteachers who were more or less successful prohibiting gum chewing during class until they received a major setback in 1928. Fleer's Double Bubble Gum arrived with great fanfare and the inclusion of a small comic strip in which the gum was wrapped. Soon followed by Bazooka and Hubba Bubba, the blowing of enormous latex-based bubbles became an art form that, unfortunately, continues to this day.

No treatise on chewing gum can be complete without crediting the city of Seattle, whose other attractions pale in comparison with its infamous "Wall of Gum." This monument to gum, measuring some 50-feet wide and 15-feet high, started in 1993 when patrons waiting in line at the Market Theatre, thoughtfully parked their gum on an adjacent wall. The effect was so mesmerizing, that in a short time it became ***the*** Thing To Do in Seattle. Now, people from all over the world come to express their disgust and stick their own gum. Far more colorful than Ireland's Blarney Stone, it offered the added advantage of not having to hang upside down to participate.

By 1914 William Wrigley Jr. had become the poster boy for the whole chewing gum craze, thereby earning the undying enmity of mothers, janitors, and teachers across the nation.

Dentists have had to tread a thin line between accepting the plaque removal properties of vigorously chewed gum and the arguable benefits of increased salivary flow, or rejecting the grim picture of millions of mouths grinding, blowing, stretching, and popping a substance that bore a chilling resemblance to yesterday's oatmeal. It was clear this represented a retrograde step for civilization comparable only to setting fire to a weed and inhaling the smoke.

Gum manufacturers could do little to downplay the vapidity of the whole cud-like phenomenon, but they played their ace when Wrigley offered Freedent in 1987, temporarily silencing dentists' and patients' complaints that chewing gum made a mess of their acrylic and resin prostheses. Largely missing from the shelves nowadays, it did offer a diversionary tactic while the conversion to "sugarless gum" was mounted to shoot down the last professional objection to the product.

The substitution of the "tooth-friendly" organic compound xylitol, although ruffling the feathers of the sugar industry, was an instant success. Dentists backed off, and, without sugar to blame, were only left with the basic objection that gum got in the way of everything they were trying to accomplish, much like the tongue.

Meet Dr. Craig Johnson. Sponsored by the ever-alert Wrigley Science Institute, Johnson has captained a team out of Baylor University that has produced research confirming the worst suspicions of that last bastion of anti-chewers, Americas' teachers.

Formerly, chewing gum in class would have had the perpetrator subjected to peer humiliation, being sent to the blackboard to write 10,000 lines of "I will not chew gum in class again," or 40 whacks with a ruler on the back of the hand. Swallowing it before being apprehended was not recommended because of the long, lingering death your mother had warned you about since birth.

Some modern teachers with a bent for experimentation, noted that many students who routinely did their homework surgically attached to blaring iPods and simultaneously watching TV, claimed they could accomplish more than in the deadly silence of the library patrolled by a hard-nosed sshushhing librarian. How these distractions helped focus on the job at hand is a mystery to any thinking adult, but Johnson, Baylor, and Wrigley all agree the results of their tests speak for themselves.

Unless you are one of these eternally suspicious people who question the validity of celebrities' hair and bosoms, you might suspect a commercial entity that funds a research project has a vested interest in the results. However, there is convincing evidence that chewing gum is a useful adjunct in increasing math scores with the additional benefits of "focus, alertness, concentration, controlling situational stress, managing appetite and weight." Move over, Red Bull.

Throw in the possibility of scoring a trophy date for the prom with any potential dental health benefits of gum chewing and the anti-chewers might as well throw in the towel as well. ■■■■

CDA JOURNAL, VOL 38, Nº7

Crazy for Chicle

Prior to 1880, the acceptance of chewing gum was limited because its flavor was that of old inner tubes, but less tasty.

Robert E. Horseman, DDS

ILLUSTRATION BY DAN HUBIG

She was sort of reclining in my chair, flip-flops dug into the footrest, knees up, an expression on her face normally associated with Holstein heifers contentedly chewing their cuds.

"You might want to spit out your gum before we begin," I offered.

"Oh," she said, surveying me vacuously, then delicately surrendering an amorphous pink wad about the size of a Titleist NXT Extreme.

Thus, it has been for dentists since Americans went wild for chewing gum back in the 1800s when Thomas Adams patented a machine for its manufacture. He was by no means the first to recognize the importance of extending the chewing time of something that never grew smaller in size and was never intended to be chewed in the first place.

For that we have to thank the ancient Mayans who chewed chicle, the sap of the sapodilla tree for recreation, particularly during ritual sacrifices. Devotees of chicle chomping were referred to as "saps," a term that still applies to certain members of our society who aren't the brightest crayons in the box.

Prior to 1880, the acceptance of chewing gum was limited because its flavor was that of old inner tubes, but less tasty. A pioneer named John Colgan gave a boost to chewers and dentists alike by finding a way to make chewing gum taste better for a longer period of time. This recipe involved sugar in wholesale quantities and indirectly led to the discovery of the temporomandibular joint and the etiology of dental decay.

In 1888, Thomas Adams claimed the dubious honor of being the first to offer his product, Tutti-Frutti, to be sold out of vending machines located in New York subway stations. Shortly after this, scien-

CONTINUES ON 525

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