



The Westerner

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President's Message

from the desk of Dr. MacDonald...

While commenting to a friend recently about our upcoming 40th wedding anniversary this August, he asked if I ever considered how I got to the point in life I am enjoying now. It made me think.

When I entered Gonzaga University (I only mention this because of the success of our basketball program in the recent past), I wanted to go into medicine or dentistry. When I made that decision I am not quite sure. Next thing I knew I had applied and been accepted to dental school. Again, I am not sure when I chose dentistry over medicine. I graduated during the Vietnam era when medical personnel could be drafted through age 35, so it was logical to volunteer and serve your time. I applied for both the Army and Air Force internship programs and, when selected by both, I opted for the Air Force. On completion of the one-year internship, I was assigned to a small base in Italy with two other dentists (two and six years senior to me). While we all did general dentistry, one liked prosthetics and one liked periodontics, so that more or less left me as the local surgeon (three months of surgery during my internship). Next thing I knew, I had applied and was accepted for an oral surgery residency. It was



DR. GERALD B. MACDONALD

several years later the Oral and Maxillofacial designation was adopted.

When I entered my residency, our hospital-based procedures were primarily more difficult dento-alveolar procedures, trauma, pre-prosthetic (vestibuloplasties with skin grafts), fractures, orthognathic surgery and many third molars. In those years, third molars and more-involved exodontia was often covered by medical insurance if done in the hospital but not as an outpatient status. Not very cost effective.

We had to compete with plastics and otorhinolaryngology (or was it ENT) for fractures of the maxilla. Hospital protocol was that the services share maxillary cases. Fortunately, ENT let us have theirs, and plastics would have us scrub in with them and we basically did theirs. Neither were interested in mandibles. We also covered a VA hospital and a hospital in a ghetto neighborhood. No competition in

either of these places for any of the procedures we did.

Orthognathic surgery at the time was primarily mandibles and anterior segmental procedures in the maxilla. Mandibles were primarily done through extra-oral incisions or with the Gigli saw. Yes, I know that sounds scary, but many successful cases were done that way. You have to remember that, at the time, the description of the sagittal split osteotomy was just coming from Europe and Bill Bell's excellent article on the Le Forte I osteotomy was several years away. Very few program directors were willing to attempt many of these new procedures until they had firsthand experience. We had a couple of progressive part-time attendings that worked with us, so soon we were doing intraoral sagittal-splits for retrognathic cases and intraoral vertical obliques with the Wilbank's technique. It was only later that the sagittal osteotomy was also used for prognathic cases. All these procedures were initially accomplished with retractors and osteotomes made from modified stainless steel table knives, spoons and dental cement spatulas. Soon, Walter Lorenez developed more suitable instrumentation. Later, I was led through my first Le Forte I procedure by Bob Walker from Dallas. Those were exciting times.

(Cont. on page 5)



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CALIFORNIA'S ALTERNATIVE PATHWAYS TO LICENSURE

FOR OMS AND SCOPE OF PRACTICE

NEWTON C. GORDON, DDS, MS
HEALTH SCIENCES CLINICAL
PROFESSOR, OMS UNIVERSITY
OF CALIFORNIA SAN FRANCISCO
FORMER PRESIDENT, DENTAL
BOARD OF CALIFORNIA

From 2003 to 2006, seven bills with major impact on the practice of oral and maxillofacial surgery and anesthesia were introduced in the California legislature. Five bills have completed the process and are currently law, while two bills are slowly moving through the legislative process. Five of these bills are designed to provide alternative pathways to licensure while the other two are directed to the scope of practice issues.

1. License by credential (SB928-Aaenstad) became effective January 1, 2003. Practitioners from other states having practiced for five years and with a clean record may obtain a license without further examination. The practitioner must have practiced for at least 1,000 hours a year. Residency training, faculty contract and community clinic contract may be used as part of the five years of practice.

2. In September 2004, the Governor signed a bill (SB 1 865-Aaenstad) which became effective in March 2004. The bill provided that as an alternative to the California Dental Board Examination, passing the Western

Regional Board Examination would suffice.

3. On January 30, 2006, a new bill (SB299 Chesbro) became effective, providing that the entire five-year clinical practice requirement is met if an applicant agrees to practice dentistry full-time for two years in a qualifying clinic, teach or practice dentistry full-time for two years in an accredited dental education program.

4. AB 1143, Emmerson. Special Permit: Became law on October 5, 2005 a bill which provides a special permit to practice dentistry to a person who furnishes satisfactory evidence of having a pending contract with a California dental college approved by the Board as a full-time professor, meeting specific educational and certification requirements, who pays a fee and applies to take an examination (not enforced for more than 15 years).

5. Further refinement is needed of SB 683, Aaenstad bill providing the option of bypassing the dental board examination if the applicant has completed a CODA (Commission on Dental Accreditation) accredited one year postdoctoral general dentistry program or a CODA specialty accredited ADA recognized program. Activation on this bill is pending development of mechanism for auditing.

There are two other bills of interest to our specialty:

1. AB 1336 Laird. Dentistry: This bill is now in effect and mandates regulations for conscious sedation. The on-site inspection has been

changed from every six years to five years. Increases the number of anesthesia related CE hours to 24 for biennial renewal. There are several other changes in the bill from the past bill; however, these are the main areas. Dr. John Yageila and his panel were instrumental in establishing these new guidelines.

2. Lastly, the Elective Facial Cosmetic Surgery bill (SB 436 Migden) has passed the Senate and is presently in the hands of the Assembly Business and Professions Committee, pending an occupational analysis. The analysis has been completed and is pending release by the Department of Consumer Affairs. If the analysis is positive, the bill will be activated.

Our specialty should note that Dr. John Yagiela and his panel effectively modernized the regulations for general anesthesia and conscious sedation, bringing our regulations into the 21st century and ensuring that the dental profession maintains its status as a major provider of anesthesia service in the State of California. I am sure you will join me collectively in commending Dr. Yagiela for his efforts in leading this panel and his relentless determination in the development of outstanding regulations for the provision of general anesthesia and conscious sedation with a focus on public protection for the citizens of California. The same level of plaudits must be accorded to Dr. Sam Aaenstad, an oral and maxillofacial surgeon, who has opened the doors to freedom of practice in the United States (LBC and WREB examination which is accepted in 34 states) for oral and

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WSOMS Officers 2005–2006

President

Dr. Gerry MacDonald

3109 Budding Oaks Ct.

Sparks, NV 89436

Voice 775-626-4480 Fax 775-626-4479

e-mail: MACOMFS@aol.com

Vice-President

Dr. Rodney Nichols

2001 SE Jefferson St.

Milwaukie, OR 97222

Voice 503-654-3530 Fax 503-654-3490

e-mail: Wizedoc@aol.com

President-Elect

Dr. David Howerton

280 Liberty St. SE

Salem, OR 97301

Voice 503-375-2000 Fax 503-375-3125

e-mail: DWHSurg@aol.com

Secretary-Treasurer

Dr. Andrew Harsany

2945 The Villages Parkway

San Jose, CA 95135

Voice 408-270-9450 Fax 408-270-9454

e-mail: harsanydds@earthlink.net

Past-President

Dr. Gary Carlsen

17822 Beach Blvd. #342

Huntington Beach, CA 92647

Voice 714-847-6044 Fax 714-842-3145

e-mail: JAWSSDOC@aol.com

WSOMS Board 2005–2006

Dr. Steve Beadnell

11786 SW Barnes Rd. #110

Portland, OR 97225

V 503-924-2323

F 503-601-0569

e-mail: drbead@drbead.com

Dr. John Bond

15215 National Ave. #202

Los Gatos, CA 95032

V 408-356-3151

F 408-356-1004

e-mail:

jsbond@johnsbondmd.com

Dr. Jack Buhrow

4202 N. 32nd St. #A

Phoenix, AZ 85018

V 602-957-0332

F 602-957-3282

e-mail: Jaws2200@hotmail.com

Dr. Todd C. Liston

469 E. Medical Dr. #202

Bountiful, UT 84010

V 801-299-8531

F 801-299-9667

e-mail: Maxfacedoc@aol.com

Dr. John Tidwell

1801 NW Market St. #108

Seattle, WA 97225

V 206-783-9672

F 206-784-4812

e-mail:

johnt@seattleoralsurgeon.com

Dr. Larry Moore (Dist. VI Trustee)

19000 Hawthorne Blvd. #222

Torrance, CA 90503

V 310-371-6900

F 909-606-4061

e-mail: drljmoore@aol.com

Dr. Donald Devlin

(Westerner Ed.)

2545 Humbolt Dr.

San Leandro, CA 94577

V 510-351-3410

F 510-783-7296

e-mail: donald_devlin@msn.com

Dr. Henry Windell (Caucus Chair)

24850 SE Stark St. #100

Gresham, OR 97030

V 503-665-7882

F 503-665-6983

e-mail: windellhc@aol.com

WSOMS Office

Linda MacDonald, Exec. Sec.

3109 Budding Oaks Ct.

Sparks, NV 89436

V 775-626-4478

F 775-626-4479

e-mail: WesternOMS@aol.com

About Our Members

PRESIDENT'S MESSAGE CONT. FROM P. 1

I later went into private practice in San Jose, California. While it varies throughout the country, in San Jose the norm was solo practice. Fortunately, surgeons in San Jose were very friendly and helpful. It was not a problem enlisting another surgeon as an assistant surgeon for major cases, and you could always meet and discuss cases on which you wished someone else's opinion.

While I recall battles throughout my career, it seems we always prevailed, only to have to repeat the battle at a later date. Initially, it was the right to admit patients to the hospital, the history and physical, outpatient anesthesia, orthognathic surgery, and trauma surgery. Expanded scope added temporomandibular joint surgery, implants and cosmetic surgery. We have always shown we have the training and the ability to accomplish these procedures for the betterment of our patients. We may not be the only specialty able to accomplish some of these procedures but it is certainly within our abilities to do so.

All in all, I believe I made the correct career choice. I have thoroughly enjoyed it and the organizations and people involved with it. I have especially enjoyed the members involved in the Western Society of Oral and Maxillofacial Surgeons and have appreciated the opportunity to serve as your president this past year.

DR. NEWTON GORDON CONT. FROM P. 3

maxillofacial surgeons. Imminent passage of SB683 (licensure without examination for specialists and PGY- 1) will provide the ultimate glory.

Editor's Note: I wish to give my sincere thanks to Newt Gordon for informing us of these changes in our licensure act, which will have a profound effect on oral and maxillofacial surgery in California. Perhaps those OMS in other states will benefit from the experiences here in California regarding licensure.



YOU KNOW WHEN.....



.....IT'S BEEN ONE OF THOSE
DAYS

Are You Reading Your Journal of Oral and Maxillofacial Surgery?

Don Devlin, Editor

The January issue of the JOMS arrived in our spacious Westerner editorial office located high atop the TransAmerica Building, overlooking beautiful downtown San Francisco and the entire San Francisco Bay. My attention was taken away from the breathtaking view and directed to the new cover of our Journal. What a refreshing and pleasant change from our past issues! This should stimulate us to spend more time in reviewing these contributions to our specialty.

Here are some questions from recent issues of this great Journal.



1) A patient presents with a squamous cell carcinoma located in the floor of the mouth. You know the following to be true.

- a. The use of histologic grade from a tissue biopsy frequently provides misleading information regarding the biologic activity of a tumor.
- b. In the postoperative high risk advanced stage oropharyngeal tumor patient, there is no survival benefit with the use of concurrent single agent chemo-radiotherapy.
- c. The presence of lymph node metastasis as a marker of overall patient prognosis is valuable in predicting patient survival.
- d. The indication for postoperative radiotherapy is not present in tumors of high-grade histology.



2) A 56-year-old gentleman presents with severe maxillary bone resorption and is desirous of having dental implants. The need for a bone grafting procedure is evident. You consider the following to be true.

- a. Bio-Oss along with demineralized freeze dried bone allograft as a maxillary graft material is subject to uncontrolled resorption.
- b. Using autogenous bone alone than when using a combination of autogenous bone with a xenograft mixture provides a high survival percentage rate for maxillary implants.
- c. Non resorbable graft materials such as glass ceramic has the ability to remodel.
- d. An allograft like marine derived HA material ACA shows comparable and in some cases better results than autogenous bone alone when using in sinus lift procedures.



3) You choose to remove some primary teeth on an intellectually disabled child in a day-stay general anesthesia facility. The anesthesiologist may use sevoflurane or halothane as an anesthetic agent. You know the following to be true.

- a. Sevoflurane is as effective as halothane in providing smooth rapid induction of anesthesia.
- b. The use of midazolam as a premedication agent is contraindicated for children when sevoflurane is to be used.
- c. Recovery is considerably slower in children when recovering from sevoflurane anesthesia as compared to recovery from halothane.
- d. Post anesthetic vomiting and nausea was considerably higher in the sevoflurane anesthetic children than in the children receiving halothane.

Are You Reading? (cont.)



4) A 37-year-old lady arrives at your office presenting a history of having a pharyngeal foreign body sensation. You suspect she may have Eagle's syndrome. You know which of the following to be true about this condition.

- An infiltration of 1% Lidocaine into the tonsillar fossa seldom affords relief of pain in the case of Eagle's Syndrome.
- The turning of the head seldom will exacerbate pain in the case of Eagle's Syndrome.
- If you suspect the presence of vascular injury a better approach to the styloid process is that of the external approach.
- The 3-dimensional computed tomography (TDCT) scan frequently presents distortion and has now been given up in favor of the open mouth odontoid view.



5) An 18-year-old female is in need of a mandibular setback procedure. Pharyngeal airway space is of concern since you know to be true:

- That mandibular setback surgery has mainly an effect at the hypopharynx level.
- That there is a good correlation between the airway dimension measured on lateral cephalograms and on 3-dimensional computer tomography.
- To use a cephalogram which is only providing a 2-dimensional image of the pharyngeal airway is usually not satisfactory.
- Obstruction of the upper area is greatest at the nasopharynx level in mandibular setback procedures.



6) A 59-year-old male patient presents in your office with a fractured maxilla along with several other facial bone fractures. Obviously bone plates would be appropriate to maintain the bones in proper position. You realize the following is true between poly-lactide (PL) bone plates and those made of titanium.

- The use of biodegradable material in pediatric facial fractures has not yet shown to be favorable.
- It is usually necessary to tape bone prior to screw placement when using biodegradable screws.
- There is a difference in stability between patients undergoing mandibular advancement stabilized with titanium screws and those stabilized with biodegradable screws.
- Sterile abscesses are not uncommon with the use of 70/30 poly (L/DL lactide) plating systems.



7) Bonus question.....but not from the Journal. How many basic ways are there to score points in a professional football game.

- Three
- Four
- Five
- Six



HOW DID YOU DO?

Six Correct Board President
Five Correct Professor
Four Correct Assistant Professor
Three Correct Lecturer
Two or Less Let's spend more time on the Journal!

The Resident's Corner

Bisphosphonate-associated Osteonecrosis of the Jaw, an Emerging Disease in Oral and Maxillofacial Surgery
Daniel C. Martin, DDS*; A. Thomas Indresano, DMD**

*Resident Oral and Maxillofacial Surgery
University of the Pacific/Highland Hospital
Oakland, CA

**professor and Program Director Oral and Maxillofacial Surgery
University of the Pacific/Highland Hospital
Oakland, CA

The association of bisphosphonate use and osteonecrosis of the jaw was discovered by oral and maxillofacial surgeons and is an emerging concern for our specialty. In 2003 two articles, Wang¹ and Marx², reported on cases of osteonecrosis of the jaw in a population of patients who had been treated with intravenous bisphosphonate medications as part of their cancer chemotherapy. The patients had been treated for multiple myeloma, metastatic bone diseases, and osteoporosis using intravenous pamidronate (Aredia) or zoledronate (Zometa). Since 2003 a number of articles in the oral surgery literature^{3,4,5,6,7} along with oncology⁸, and osteology⁹ journals have noted the increasing numbers of patients with bisphosphonate associated osteonecrosis (BON) of the jaw. A recent review by Ruggiero et al. found 224 cases in the literature, 215 associated with intravenous bisphosphonate (pamidronate or zoledronate).⁸ The remaining 9 cases were associated with oral bisphosphonates use. This is alarming because in 2004 alendronate (Fosamax) and risidronate (Actonel) were the 29th (21 million prescriptions) and 76th (9.7 million prescriptions) most prescribed medications, respectively. In the last year our residency program at Highland Hospital, Oakland we has three cases of osteonecrosis related to bisphosphonate, one which is related to oral bisphosphonate use.

Bisphosphonate Mechanism of Action

Bisphosphonate drugs have become first-line therapy in treatment of osteoporosis, Paget's disease of bone, and hypercalcemia associated with malignancies. Bisphosphonates are synthetic pyrophosphates that have a high affinity for calcium.¹ This property originally lead to their use as an industrial chelating agent to remove calcium carbonate from plumbing. Bisphosphonates are very effective inhibitors of osteoclastic activity.¹ The drug accumulates over time in mineral bone matrix and, depending on the specific bisphosphonate, can remain in the body for years after treatment.² The suspected pathologic mechanism of BON involves disruption of the physiologic function of bone remodeling. Normally osteoblasts and osteoclasts work in concert to constantly replace microdamage to bone with new osseous tissue. With the suppression of osteoclastic function by bisphosphonates, bone turnover is suppressed and over time, the bone shows very little physiologic remodeling.⁶ Over time the bone becomes brittle and unable to repair microfractures from daily activity.

The maxilla and mandible are constantly stressed by masticatory forces causing microfractures. When infection is present or after an extraction the need for repair and remodeling is increased. The theory is in some patients using bisphosphonates, the bone cannot meet the physiologic need for turnover resulting in osteonecrosis.³ The necrotic bone becomes secondarily infected from the oral flora. The osteonecrosis progressive and can lead to large areas of dehiscence.

Presentation of Bisphosphonate Associated Osteonecrosis

Disphosphonate-associated osteonecrotic lesions of the mouth are similar in presentation as osteoradionecrosis after radiation therapy. Clinically the appearance is oral mucosal dehiscence exposing underlying bone, often in a recent extraction site. It may or may not be associated with pain. In the early stages of DON there are no radiographic findings. As the osleonecrosis progresses, radiographic evidence is observed as mixed radiolucency of mottled bone with sequestra consistent with osteolytic lesions. Histiologic evaluation shows necrotic bone with bacterial infection and granulation tissue.³ Marx review of 119 patients with DON found 68.1% exclusively in the mandible, 27.7% exclusively in the maxilla, and 4.2% in both the maxilla and mandible.³ Marx found the inciting event to be related to tooth extraction (single or multiple) in 37.8%, obvious existing

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The Resident's Corner



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periodontal disease in 11.2%, periodontal surgery in 11.2%, dental implant placement in 3.4%. Interestingly 25.2% of cases occurred spontaneously without apparent dental disease, treatment, or trauma. There are no published epidemiologic studies of the incidence or prevalence of osteonecrosis in patients taking bisphosphonates. An internet based survey by the International Myeloma Foundation of patients taking Zoledronic acid or Pamidronate for multiple myeloma and breast cancer with 1203 respondents showed 75 (6.2%) with osteonecrosis and an additional 77 with "suspicious findings".⁴ More epidemiological studies need to be undertaken to understand the impact of bisphosphonate-associated osteonecrosis of the jaw.

Management

The first step in management is prevention of the sequela leading to DON. The treating oncologist should immediately refer the patient to be treated with bisphosphonates to a dentist or oral and maxillofacial surgeon for examination. Initiation of bisphosphonate therapy should be deferred until oral infection is eliminated and necessary invasive dental procedures, such as extractions, periodontal surgery, and root canal treatment, are completed.¹ After invasive procedures one month healing time before commencement of bisphosphonate therapy will allow adequate time for bone remodeling and healing. Impacted teeth completely covered by bone should be left in place, while those with oral communication should be extracted. Large mandibular and maxillary tori with a thin mucosa covering are removed. Prophylactic antibiotic coverage is recommended for these invasive procedures. If noninvasive dental care, such as cleanings, dental restorations, or dentures, bisphosphonate therapy need not be delayed. Once bisphosphonate treatment has begun a regular 4 month dental check up is recommended.

Patients already receiving IV bisphosphonate treatment should be referred to a dentist or oral surgeon for careful clinical and radiographic examination looking for exposed bone and evidence of osteolysis or osteosclerosis. Diagnosis of carious teeth and the periodontal condition will be evaluated. Extraction of teeth should be avoided. If possible, carious teeth that are non-restorable should have the crown amputated and root canal treatment. Periodontally involved teeth with class I or II mobility should be splinted. Teeth with class III mobility are a likely nidus for infection, possibly leading to osteonecrosis, and should be removed along with antibiotic coverage. Penicillin V-K is the mainstay treatment. In penicillin allergic patients, quinolones and metronidazole or erythromycin and metronidazole have proven efficacy. Dentures should be evaluated for areas of excessive friction and relieved or relined in these areas. Elective jaw surgery is contraindicated.²

As oral and maxillofacial surgeons, we will increasingly have patients with exposed bone and history of bisphosphonate use referred to us. The literature has shown that treatment of BON has proven difficult. Because bisphosphonate therapy affects the entire bone, there is no "clean margin". Attempts at debridement and bony recontouring have often been counterproductive, leading to further exposed bone and worsening symptoms. Hyperbaric oxygen therapy has shown no efficacy. This leaves the patient and oral and maxillofacial surgeon with few options. Marx advises that treatment be directed to controlling pain and preventing the progression of exposed bone.³ This is accomplished by conservatively rounding off sharp projections of bone, analgesics, and long term antibiotic course of Penicillin V-K and 0.12% chlorhexidine rinse. Advanced cases of cellulites may require hospital admission and IV antibiotics of Unasyn and metronidazole. Marx demonstrated satisfactory results with this protocol.

Conclusion

Bisphosphonates are increasingly used in treatment of malignant disease and osteoporosis. Bisphosphonate associated osteonecrosis is a progressive, destructive disease which will increasingly impact our specialty in the future. Since 2003, the literature is showing increasing presentation of the disease in our practice. So far treatment is best directed toward prevention then to limiting the progression of the disease. The few published cases of osteonecrosis following oral bisphosphonate therapy gives cause for great concern. Because of the millions of women taking these medications to combat osteoporosis, the potential affects are far reaching and difficult to predict. Bisphosphonate-associated osteonecrosis of the jaw will be a central issue in oral and maxillofacial surgery for years to come.

Bibliography: contact the authors

.....from The Financial Corner

An Editorial

Many years ago I came across an article by Steve Rubenstein, a clever writer for *The San Francisco Chronicle*. The article caught my eye since it was about dentists. It has always been my intention to bring to our readers current up-to-date original material; however, the other day I happened to rediscover Steve's article, which I had put aside as I felt it worthy of remembering.

Most of us who have been around for a number of years will recall "Tax Shelters." Nevertheless, this example may be of benefit for you younger oral and maxillofacial surgeons.

— Don Devlin, Editor

STEVE RUBENSTEIN Gimme Tax Shelters Or Maybe Not

My cousin isn't sure whether he owns 100,000 apples. It's a tax shelter. That's how tax shelters work. Possibly you own 100,000 apples and possibly you don't. A hundred thousand apples are not big news, but 100,000 possible apples are BIG news. It's a story worth sinking your teeth into, like a possible apple. My cousin and I drove to San Bruno the other night for the meeting inside the tax shelter big top.

Ten years ago, my cousin the dentist sent a lot of money to an apple orchard in Washington because his accountant told him to. Normal people do what dentists tell them to; dentists do what accountants tell them to. My cousin never got any money back and neither did the other dentists who invested. They were sorer than a patient with a

root canal. So the apple orchard people held a meeting to calm the troops. It was one of the great meetings of all time. The audience was full of dentists, and it is always nice to see dentists endure the kind of misery they put everyone else through. The dentists — some of whom have invested more than \$100,000 — understood nothing about apples. The apple people understood nothing about dentists.

"The main thing on your mind is will we lose all our money," said the apple broker. The dentists nodded. The apple broker sought to soothe. These things are complicated, he said, but with any luck everything should turn around, perhaps, and don't forget to stay the course. Brokers often talk about staying the course, when things aren't going so hot. "Some of you believe us," said the apple man. "Others don't." There were more nods. The apple broker introduced the foreman of the orchard, who told the dentist more tales of woe. "We had a lot of weather-related things," the foreman said. "In December, an Arctic cold front came in. The wind was blowing 50 miles an hour." The dentists' jaws opened wide, as if on the wrong side of the drill. No anesthetics were available. There was no shelter from the shelter. "In August, we got hit with hailstones. You should have seen 'em. In October, it went down to 19 degrees. Froze half the Granny Smiths."

Then it was time for questions. A dentist stood up. "Look. I've invested \$120,000 and never seen a penny. Contrary to your thinking, I'd like to get some of this money back during my lifetime."

The broker said he certainly understood. The foreman said he

understood, and he introduced the manager, who said she understood, too. After the meeting, my cousin sidled up to the broker and asked for his money back. "It's complicated," the broker said. "You still owe us. Talk it over with your accountant." Since my cousin isn't speaking to his accountant, for having steered him to the apple orchard, the conversation would be unlikely to bear fruit. The broker shrugged.

"This thing was sold as a super-heavy tax shelter," said the broker. "You weren't supposed to make any money. Don't you understand? Get a book and read up." The meeting was over. By the door was a box of red apples, straight from the orchard. The broker said we could have one apiece on the way out, but my cousin filched an extra one. "I doubled my return," he said.



District VI News

Although it has been only eight months since I was elected trustee at the annual meeting in Boston, I have already come to appreciate the long hours and hard work Rick Crinzi has given to District VI for the past four years as our trustee. We all owe Rick a heartfelt "thank you" for a job well done. Rick continues to serve OMS in his efforts to promote the OMS Foundation's work to raise funds for much needed research like the highly successful third molar study. All of us can and should support OMSF.

I am pleased to say I am enjoying my service to District VI, and I am happy to have this opportunity to communicate with you all. While it is my job to represent AAOMS to you, it is my duty and obligation to represent you to AAOMS.

The annual Dental Implant Conference was held in Chicago the first weekend in December, and registered an all-time record attendance. This implant program is rapidly becoming the pre-eminent venue for hands on and didactic implant training in the United States. Mark your calendars for the first weekend in December 2006, invite your referrals, and register early, as the conference will most likely sell out.

This year the AAOMS annual meeting will be in San Diego; don't miss the two-day anesthesia review course starting Tuesday, October 3. The scientific, clinical and practice management programs will be excellent, and the special events will be memorable.

ASI, the for-profit arm of AAOMS, has been a great success, offering



DR. LARRY MOORE
DISTRICT VI TRUSTEE

office and surgical supplies and services to our members at discounts, while producing non-dues revenues to keep the cost of membership down. If you are not currently using ASI, you may be pleasantly surprised to find the quality products and services you are already buying, available at a substantial savings.

As BOT liaison to the Committee on Government Affairs, I attended the 10th annual State Advocates Forum in Tucson, Ariz., on November 11-12, 2005. This meeting brings together the executive directors and lobbyists who represent OMS around the country for a roundtable discussion of the legislative issues that are of importance to OMS both regionally and nationally.

The issues that seemed to generate the most interest and discussion were scope of practice, especially relating to elective cosmetic procedures, the use of botulinum

toxin by dentists, and general anesthesia/conscious sedation. Of these issues, I think the vast majority of us would view the general anesthesia/conscious sedation issues as the most critical to the practice of OMS, but all these issues are important.

It is crucial that our members understand that OMS is a small specialty that is presently enjoying relatively good times when compared to our colleagues in medicine; we simply cannot afford not to be politically active and astute in our state and national legislatures.

A growing problem of massive importance to us is preservation of the single operator/anesthetist model utilizing a team of OMS assistants and the surgeon.

Pressure from nurse anesthetists and other groups have the potential to threaten our pattern of practice if we do not remain constantly vigilant. Compliance with office anesthesia inspection and re-inspection programs mandated by the AAOMS Bylaws has never been more important to safeguard our anesthesia privileges. As always, the answers to these challenges are better handled proactively than reactively.

The training of OMS assistants who comprise part of the anesthesia team has become an issue of great importance. The AAOMS Committee on Anesthesia has proposed a voluntary certification program for OMS anesthesia assistants. Excellent training programs for OMS anesthesia assistants are available through AAOMS, including the

OMAAP and Anesthesia Assistants Review Course. I encourage you to provide this or similar training and continuing education for your assistants.

AAOMS has established a task force on Bisphosphonate-associated Osteonecrosis of the Jaw (BONJ). This task force will conduct meetings to define the diagnostic criteria and possible treatment recommendations for this emerging problem.

AAOMS and OMSPAC recently engaged the Washington, D.C., lobbying firm of Armstrong Teasdale LLP to represent the specialty to legislative committees and appropriate legislators. While AAOMS has, and will continue to, partner with the ADA on issues of mutual interest, the political landscape has changed. There are now many groups with competing views vying with AAOMS for legislative attention. Long-distance lobbying efforts are difficult, and the once-a-year Day on the Hill is no longer enough to assure the specialty's views are heard. Armstrong Teasdale was selected following an intense search that included a Request for Proposals and lengthy interviews with potential lobbying firms. Costs related to the lobbying effort will be shared by AAOMS and OMSPAC.

AAOMS staff, members and fellows are to be congratulated for efforts that eventually led to passage of an amendment proposed by Senator Kay Bailey Hutchison of Texas. The amended bill (S. 1042) will provide incentive special pay to military OMSs. As a specialty, we must maintain close contact

with our federal and state legislators to preserve our scope of practice and to correct discrimination based on degree. Our new lobbyists have informed us the military may resist rapid implementation of the new ISP provision, but they are well positioned to press for attention to this matter through good relationships with congressmen in the appropriations committee for the military.

Finally, congratulations to the California Association of OMS for its endurance and persistence in pursuing scope of practice for facial cosmetic surgery. The recently released Occupational Analysis commissioned by Governor Schwarzenegger vindicates the position of OMS in this arena, and will be helpful to all states that face opposition to this issue.

Best wishes and warm personal regards to all,

— LARRY MOORE, TRUSTEE
DISTRICT VI



JOURNAL ANSWERS

Answers and References:

- 1) c Kademani D, et al: Prognostic factors in intraoral squamous cell carcinoma: The influence of histologic grade. JOMS Vol 63 No.11 1599, Nov. 20, 2005
- 2) d Ewers R, Maxillary Sinus Grafting with marine algae derived bone forming material: A clinical report of long-term results. JOMS Vol 63 No. 12 p1722 December, 2005
- 3) a Ersin NE, et al: Postoperative morbidities following dental care under day-stay general anesthesia in intellectually disabled children. JOMS Vol 63 No. 11 p 1737 December, 2005
- 4) c Beder E, et al: Current diagnosis and transoral surgical treatment of Eagle's Syndrome. JOMS Vol 63 No.12, p1742, December 2005
- 5) b Chen G, et al: Predicting the pharyngeal airway space after mandibular setback surgery. JOMS Vol 63 No. 10, p1509 October, 2005.
- 6) b Bell RB, Kindsfater CS: The use of biodegradable plates and screws to stabilize facial fractures, JOMS Vol 64 No. 1 Jan 31 2006
- 7) c Five. 1-Touchdown 2-A point after touchdown 3-Running or passing the ball after a touchdown. 4- Field goal. 5-Safety.

Support the OMFS Foundation through the REAP Program

Most of you thought that "you'd heard the last of me" but not so! In my "next life" I'm trying to assist a GREAT CAUSE and need your HELP again to better our specialty through support of OMFS and the REAP Program. Last year the OMS Foundation successfully completed a Capital Campaign that raised over \$3.5 million in pledges. Even with this commendable response, OUR Foundation is seriously underfunded. The Foundation awards approximately \$465,000 annually for research grants and awards. With \$8 million currently available in the endowment, our specialty cannot meet the present demand for critical research dollars and requests for support of residency awards. At a minimum, we need to double that. If we do not support the Foundation, OUR specialty and OUR patients will suffer. I am asking YOU to HELP.

Patients aren't concerned about research. They don't discuss the findings of the Third Molar study, nor any other research study funded by the OMSF. They are not concerned about whether their surgeon was a fellow or not. They only want excellent care. Although our patients may not give due thought to research and education, we as surgeons know that the advances our specialty has made through research studies and through exceptional



DR. RICHARD CRINZI

training of surgeons touch each patient we treat.

The Oral and Maxillofacial Surgery Foundation is proud to have funded more than 190 research awards, fellowships and other awards since 1985, for a total of more than \$7 million to support the specialty.

To be able to continue current levels of support for research and education, the Foundation launched a new annual campaign in 2005 called REAP. Participating in **REAP — Research and Education can Advance your Practice** — is as simple as contributing the value of a third molar case each year.

To simplify the campaign, surgeon volunteers have been organized across the nation to help you with your gift. There are six District Chairs, corresponding to the AAOMS Districts. Each District Chair selected Area Chairs to divide up his or her large district. Then each Area Chair recruited Unit Leaders. Unit Leaders will contact 10 to 12

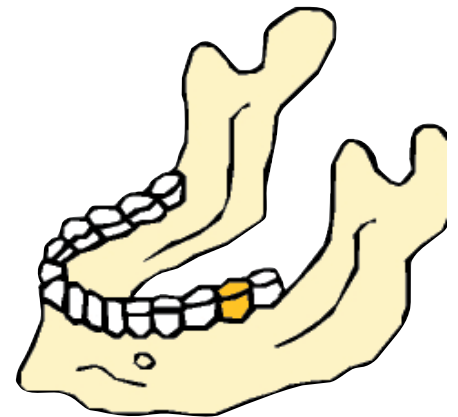
individual surgeons about making a gift.

You will be hearing more and more about REAP — in state and regional society meetings, from Foundation Ambassadors and from your colleagues. *I want to make District 6 a LEADER in support of the Foundation. Everyone will be RECOGNIZED for your contributions and EFFORT. Make your gift now. The future of the specialty is waiting! I REALIZE that I'm asking — again — the same people/friends to continue to support our specialty but YOUR DEMONSTRATED LEADERSHIP and GIVING is the best way to lead by EXAMPLE.*

If you have any questions about REAP, don't hesitate to call Foundation Executive Director Frank J. Kurtz, PhD, at 847-233-4361.

In good health,

— RICHARD A. CRINZI,
DDS, MS



What is REAP?

Patients aren't concerned about research. They don't discuss the findings of the Third Molar study, nor any other research study funded by the OMSF. They are not concerned about whether their surgeon was a fellow or not. They only want excellent care. Although our patients may not give due thought to research and education, we as surgeons know that the advances our specialty has made through research studies and through exceptional training of surgeons touch each patient we treat.

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New avenues of research are beginning to unfold. The completion of the 13-year Human Genome Project in 2003 has opened new doors of research in medical and dental healthcare. We, as a specialty, must take advantage of this research renaissance.

To be able to continue current levels of support for research and

education, the Foundation launched a new annual campaign in 2005 called REAP. Participating in REAP — Research and Education can Advance your Practice — is as simple as contributing the value of a third molar case each year.

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You will be hearing more and more about REAP — in state and regional society meetings, from Foundation Ambassadors and from your colleagues. Make your gift now. The future of the specialty is waiting!

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NEWS

from the Washington State Society of Oral and Maxillofacial Surgeons

WSSOMS held its annual meeting on June 9th at the Bellevue Club. Dr. Vincent Kokich presented two half day lectures on "Surgical and Orthodontic Management of Impacted Teeth" and "Single-tooth Implants for the Adolescent Orthodontic Patient." The Washington State Society of Orthodontics attended. Officers were elected for 2006-2007: Franco Audia, President; Jessica Lee, President-Elect; Manny La Rosa-Craig, Treasurer, and Tracy Johnson, Member-at-large.

Next year's meetings will be held on October 24, January 23, and March 10, all at the Bellevue Club, Bellevue, WA. The annual meeting will be held in conjunction with the WSOMS meeting, June 29-July 2, 2007 at Sun River Resort, Oregon.

Check out our new website at www.wssoms.com. Questions about any of our upcoming meetings or other issues? E-mail sheryl.beirne@wssoms.com

SHERYL BEIRNE, EXECUTIVE
DIRECTOR, WSSOMS

SAVE THE DATE
WSOMS ANNUAL MEETING
JUNE 28-JULY 2, 2007
SUN RIVER RESORT
SUN RIVER, OR (15 MILES SO. OF BEND)

Secretary's Corner

.....from the Secretary's desk

I had planned the "usual" Secretary's Message — the Association is Doing Well; The Annual Meeting is Progressing; We are Financially Healthy; and so on and so forth.

But the weekend of June 2-4, 2006, changed my thoughts completely. When the invitation to attend the Regional and State Leadership Conference at AAOMS headquarters in Chicago arrived late last year, I asked the Society to approve my attendance, which the Board granted. Those three days gave me new insight on how and what the state societies, regional societies and AAOMS need to do to work together for the betterment of all.

On Friday, June 2nd, the Regional and State Executive Directors met for 4½ hours to share the greatest concerns of the members; the greatest challenges to us as Executive Directors; our top priorities for you, the membership; and how AAOMS can assist us in our positions.

Saturday and Sunday added the state society presidents and we all met with the AAOMS executive staff and Board of Directors, including the district trustees. We discussed the organizational structure of AAOMS as well as the structures of the various state and regional societies. District VI was well represented: Sheryl Beirne from WSSOMS; Pamela Congdon from CALAOMS; our trustee, Dr. Larry Moore from California; our OMFS representative, Dr. Gerry Hanson from Nevada; CALAOMS President, Dr. Jerry Gelfand; Dr.

Murray Jacobs from California; Dr. Mark Pogue; and many others. Naturally, our AAOMS President from Oregon, Dr. Jay Malmquist, completed our party. The presentations by the AAOMS staff were exceptionally well done, and the knowledge they have of their fields was TOTALLY AWESOME. The support available from the AAOMS staff is an untapped resource that every OMS and Executive Director needs to use.

The highlights of Saturday were, first of all, the two-hour working lunch we spent with our own district representatives, and secondly, the tour of the AAOMS headquarters personally provided to me by Dr. Malmquist.

The bottom line is that I returned from this conference with a flame that I want to light all over District VI and especially within the WSOMS. Until that meeting, I had questioned the true purpose of The Western Society. I know we have a mission, but what exactly is the purpose? We have an annual meeting, we provide the setting for the political caucus, we have a website and a newsletter, but none of these things are doing what I feel is the true purpose of WSOMS — THE UNITING OF THE DISTRICT.

In order to accomplish this, I do need the help of the state leadership, and not just the Executive Director of all the member societies. My plan includes, but is not limited to:

1. Include news from each state, both in the newsletter and on the website, sharing your frustrations, successes, failures, professional situations, etc.

2. Encourage more joint meetings with our Annual Meeting, especially the states with the smaller membership. With the individual states providing more attendance by having their own business meeting, the WSOMS can be responsible for the planning of the Annual Meeting, speakers and venue on a more cost-effective basis.

3. Encourage all state presidents to attend the annual meeting, and invite them to address the board with their concerns, etc. If the membership sees the leaders attending, they might be more likely to attend also.

Sheryl, Pam and I felt that our district needs to be much more unified, as the problems we face individually we also face as a District. Sharing this information needs to be a priority not just within the individual states, but with the District. We are excited and willing to work together to bring the purpose of WSOMS to the forefront. Please call me (775-626-4478), fax me (775-626-4479) or e-mail (WesternOMS@aol.com), and help us to get our District VI states unified.

HAVE A GREAT DAY AND SEE YOU AT SILVERADO!!

LINDA

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The Western Society of Oral and Maxillofacial Surgeons

Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, Washington

MEMBERSHIP APPLICATION

I hereby make applications for active____ or Resident____ (check one) membership in the Western Society of Oral and Maxillofacial Surgeons. If accepted, I will obey the Constitution and Bylaws of the Society and will attend and contribute in the annual meetings.
Note: For active membership, please include dues of \$150.00 and (if applicable) the voluntary contribution of \$25.00

There are no dues for Resident members. Please include a letter from the OMS Program Director attesting your current Resident Status.

Full Name: _____ Degree: _____

Mailing Address: _____

City, State, Zip _____

Office Phone: _____ E-mail: _____

Pre-Dental Education: _____
(College or University/Graduation Date/Degree)

Dental Education: _____

(School/Graduation Date/Degree)

OMS Training: _____

(Location/Date)

State Licensures _____

Are you a member of your State Society? _____

Are you a diplomate of ABOMS? _____ Date _____

Are you a member of AAOMS? _____ Date: _____

Type of Practice: _____ Solo _____ Group _____ Military _____ Teaching _____ Other _____

With/or Where? _____
(List)

I hereby with my signature pledge myself as a condition of membership in the Western Society of Oral and Maxillofacial Surgeons, to pursue my calling with strict regard for the ethics of my profession; to place the welfare of my patients above all else; to endeavor constantly, to advance in knowledge by study, interchange of thought, and attendance at clinics and association meetings to regard scrupulously the interests of my professional colleagues and render willing to help them.

Signature

Date

YOUR WESTERN SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS
BOARD OF DIRECTORS, AUGUST 20, 2005



For Those of You Who Plan Ahead

*DON'T FORGET TO MARK YOUR CALENDARS
FOR NEXT YEAR'S ANNUAL MEETING AT
SUN RIVER RESORT, SUN RIVER, OR
(15 MILES SO. OF BEND)
JUNE 28-JULY 2, 2007*



**WSOMS
Office Information**

**Linda MacDonald
Executive Secretary**

**3109 Budding Oaks Ct.
Sparks, NV 89436**

Voice: 775-626-4478

FAX: 775-626-4479

E-Mail:

WesternOMS@aol.com

*SAVE THE DATE
WESTERN SOCIETY
OF ORAL AND MAXILLOFACIAL SURGEONS
ANNUAL MEETING
JUNE 28-JULY 2, 2007*

*SUN RIVER RESORT
SUN RIVER, OR (15 MILES SO. OF BEND)*

The Westerner

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& Maxillofacial Surgeons
3109 Budding Oaks Ct.
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