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Newswire

Washington State Society of Orthodontists

Save the Date!

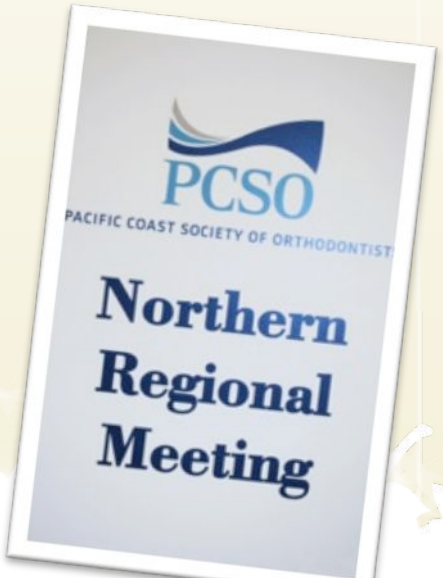
WSSO Component Meeting

Due to budget limitations, the 2013 component meeting has been canceled.

We are looking forward to a tentative 2014 staff meeting with excellent speakers and a great venue! For more information please contact Joni Marts at wsso@comcast.net

PCSO Critical Issues Task Force 2012

1. Identify innovative approaches to doctor and staff education which will create high participation across member demographics
2. Support efforts to promote the PCSO members as specialists who are best suited to perfom orthodontics
3. Develop initiatives to ensure that residents and newer members retain loyalty to organized orthodontics as members of PCSO and constituent societies.



Orthodontic Practices

Periodontal Screening For Orthodontic Patients: Joint Task Force Recommendations

During the past year, the AAO launched its new consumer awareness campaign, targeted for adults. Currently, the percentage of adult patients in the average orthodontic practice is over 20 percent. If the new campaign is successful as we predict, all orthodontists should experience greater numbers of adult patients seeking treatment. This will be wonderful. Or will it?

Although most adults who seek orthodontic treatment have healthy gingiva and periodontal support, some of the new influx of adult patients will have varying degrees of periodontal problems that could become worse if not detected prior to placing appliances on the patient's teeth. Do all adults need a referral to a periodontist? Not really. Only those who have pre-existing periodontal disease and those at risk of developing periodontal problems need to be referred. So, how do you identify the patient who is at risk of developing periodontal problems?

That question was charged to an American Association of Orthodontists-American Academy of Periodontology (AAO-AAP) Task Force that was jointly commissioned by the AAO and AAP Boards of Trustees in 2009. The task force assignment was to create recommendations for practitioners regarding the appropriate periodontal screening methods for adult orthodontic patients.

The AAO-AAP Task Force consisted of four members, two from orthodontics (Drs. Lee Graber and Vince Kokich) and two from periodontics (Drs. Sam Low and Paul Rosen). Their mission was to provide orthodontists with a reliable and systematic method of identifying adult orthodontic patients who are at "risk" of developing periodontal disease.

Over three years, these individuals, with the review and support of AAO and AAP councils and committees, communicated on numerous occasions to arrive at the recommendations that appear in this article. While many practices have developed their own periodontal screening protocols, the AAO-AAP Task Force looked to provide an additional evidence-based, practical option for the dental profession.

Adequate Health and Dental History
All orthodontists routinely have each patient complete a medical history and make note of the patient's previous dental treatment. However, there are four items that help determine the potential risk of developing periodontal disease during orthodontic treatment:

1. *Frequency of prior dental visits*. Is the adult patient seen regularly (every six months by his or her dentist)? If so, underlying periodontal problems have probably been managed effectively prior to orthodontics. However, if the patient states that he/she only visits their general dentist every two to three years, then this could be a potential risk factor for developing periodontal problems during orthodontics.
2. *Is the patient a diabetic*? Why is this a concern? Researchers have shown that patients with poorly controlled diabetes are more likely to develop periodontal disease than those with well-controlled diabetes.
3. *Does the patient smoke tobacco products?* Again, why would this be a concern? Studies have shown that tobacco use may be one of the most significant risk factors in the development and progression of periodontal disease. In addition, after periodontal treatment, the chemicals in tobacco can slow down the healing process and make the treatment results less predictable.
4. *Has the patient had previous periodontal therapy?* We know that for periodontal disease to progress, the patient's oral bacterial flora must contain one or more of the known periodontal pathogens, and the patient must be susceptible to these bacteria. So, if the patient has had previous periodontal therapy for bone and/or tissue loss, it indicates that the patient is susceptible to recurrence of the disease if the bacteria are not removed adequately.

Appropriate Intraoral Radiographs
Most orthodontists routinely take panoramic radiographs of their patients prior to beginning orthodontic treatment. Panoramic radiographs are wonderful screening tools for certain aspects of dental anatomy. However, panoramic radiogaphs are not sufficient to determine the interproximal distance between the cementoenamel junction and the alveolar crest. This is an important measurement when assessing periodontal health and risk of disease. Normally in adults this distance should be about 2 millimeters. If this distance were between 2 and 4 millimeters, the risk for periodontal breakdown during orthodontics is increased. If the distance were greater than 4 millimeters, the periodontal risk increases even more. It is simply impossible to measure these interproximal distances accurately and in a predictable manner on a panoramic radiograph.

The gold standard for appropriate intraoral radiography for adult orthodontic patients is:

1. Vertical bitewing radiographs of the posterior teeth
2. Periapical radiographs of the maxillary and mandibular anterior teeth

Could CBCT machines be used to create the appropriate bitewing and periapical images? Yes, if the resolution of the X-ray machine is adequate. This factor depends upon the voxel size, the field of view of the specific machine, and the slice thickness. Ongoing research on CBCT imaging likely will provide more information as to the propriety of using CBCT for screening protocols.

Complete Periodontal Charting
Most orthodontists do not perform a complete periodontal charting of their adult orthodontic patients. While trained in such charting during dental school, most orthodontists are no longer highly skilled with the use of a periodontal probe to routinely measure sulcus depths, determine bleeding sites, and identify furcation defects. However, the knowledge of these abnormalities in the patient's periodontal status are of utmost importance in determining the risk of the patient developing future periodontal disease.

Who should perform the periodontal charting? The Task Force agreed that the patient's general dentist would be the most likely person on the dental team to create and maintain an accurate periodontal charting of the patient. Periodontal charting is a part of routine dental check-ups for most adult patients. In addition, in many of the lawsuits that have arisen because of periodontal disease that develops during orthodontic treatment, both the general dentist and orthodontist are often found mutually liable for damages.

When an adult patient schedules an examination appointment with an orthodontist, the receptionist should contact the general dentist and request the most recent periodontal charting and any recent bitewing and periapical radiographs of the patient. Ideally, these should be present at the examination appointment. Then, when the orthodontist compares the charting to the radiographs, areas of concern, such as pocket depths greater than 5 millimeters, bleeding upon probing in several quadrants, mobile teeth, interproximal bone loss, furcation defects, lack of attached gingiva or gingival recession will be noted. The orthodontist must be aware of these periodontal problems prior to beginning orthodontics.

Method of Assessing Risk
The above-mentioned three items (health/dental history, radiographs, and periodontal charting) provide background information for the orthodontist. However, extrapolating the appropriate information and determining the future risk of developing periodontal disease is difficult. But assessing risk is the key to preventing future periodontal breakdown. In other words, how does the orthodontist delineate those patients requiring periodontal surgery from those who only require root planing and scaling? Someone or some system must be used to arrive at these decisions. The Task Force identified two methods for assessing the level of current disease and the risk for future disease.

One method is for the orthodontist to develop a working relationship with a periodontist in his or her local area, and to have a system in place that directs the orthodontist when to refer the patient to the periodontist for treatment. However, some orthodontists are not fortunate enough to have developed this kind of working relationship and/or may not have a periodontist practicing nearby.

The other method of establishing the level of disease and future risk is to use a computer-based system. The Task Force identified a company, PreViser, which has an easy-to-use system of inputting information gathered from the health/dental history, radiographs, and periodontal charting, and arriving at not only a current disease score, but also providing the orthodontist with a risk score for future periodontal disease.

Based upon the levels of disease and risk, the management of the patient's periodontal treatment can be easily ascertained. Although the Task Force does not endorse any particular protocol or product, of the ones currently available, the PreViser system (www.PreViser.com) proved affordable, informative, and reliable for the orthodontist and general dentist.

Summary
The joint AAO/AAP Task Force has achieved its mission. It has developed a set of criteria that are valuable and useful to the orthodontist who treats adult patients. Careful adherence to the recommendations contained in this article will help the orthodontist and the general dentist properly screen their patients for periodontal disease and risk. In addition, this important step will help to avoid lawsuits due to periodontal problems that arise during orthodontics and most importantly improve the oral health of adult patients during orthodontic treatment.

Northern Component Meeting 2012

Featured Staff Speaker

We were pleased to welcome Lee Ann Peniche of Peniche and Associates. Her informative and fun lecture focused on the practice management aspect of orthodontics.

Featured Doctor Lecturer

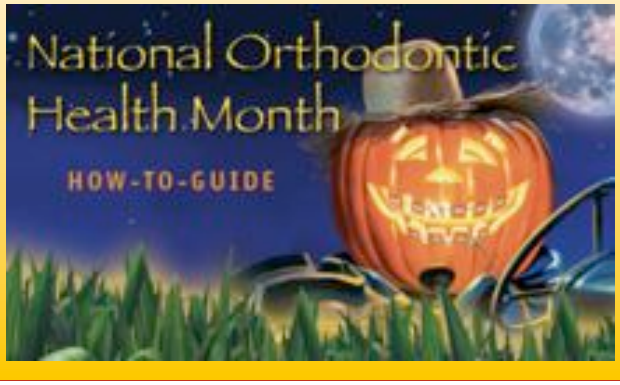
Dr James Mah, associate clinical professor at USC, is a recognized expert on 3-d imaging, visualization, and modeling.

Expert Lee Ann Peniche guided doctors and staff through a morning session designed to increase case acceptance and profitability, ensure marketing success, and help practices soar. She focused on perfecting the new patient process, taking a team approach to patient care and implementing systems for growth and success.

The special afternoon sessions was designed to help staff take the practice to new heights! Unique marketing ideas focused on patients, professional partners, and community organizations were discussed. Communicating these marketing ideas both internally and externally guided staff to help build their practices' reach and reputation.

National Orthodontic Month- How to Guide

https://www.aaomembers.org/MyPractice/Marketing/2011-National-Orthodontic-Health-Month.cfm



Use NOHM to build goodwill among patients, create visibility for yourself and your specialty among potential patients, and enhance professional relationships with colleagues in dentistry and throughout the healthcare community.

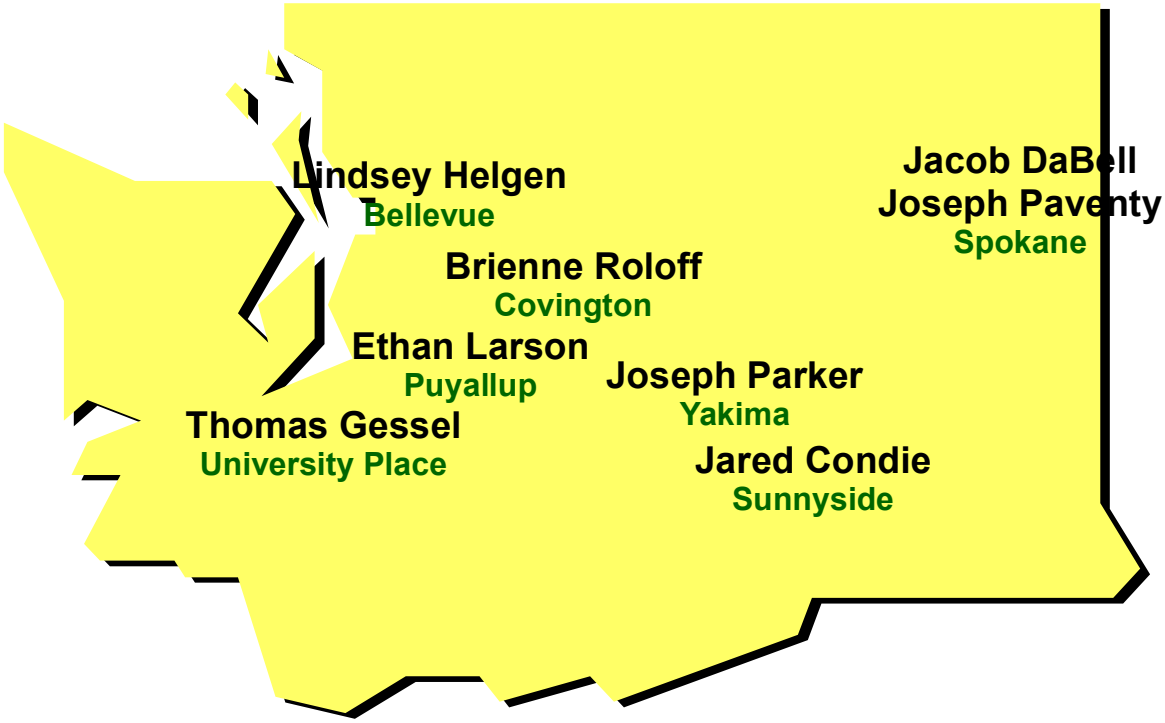
When you celebrate NOHM, you join a coast-to-coast observance. Not only do thousands of AAO members participate in this event, the AAO also conducts a major public relations campaign. AAO's public relations efforts target print, broadcast and online and social media at the national level and in local

New FACES

UW First Year Residents

Past-president Tom Merrill welcomes first year UW orthodontic residents to the WSSO with digital calipers.

The WSSO Welcomes…



Legislative Summary

ADA News-- Members of Congress are urging the FTC to cease intrusion into the practice of medicine and dentistry. Of specific concern is the FTC ruling against the North Carolina State Board of Dental Examiners who were attempting to prevent non-dentist providers from providing teeth whitening services. The members are concerned that FTC rulings will end up overturning established state laws governing the practice of medicine and dentistry. There are similar examples in several other states. Stay tuned.

WSDA News
Thanks to efforts from grassroots dentists in Washington and across the country, the Gosar Amendment, which aims to eliminate the federal antitrust exemption given to health insurance plans/companies passed the U.S. House of Representatives. This legislation will have direct impact on dental insurance companies in Washington State.

ADA Releases Economic Studies of Dental Midlevel Providers

a. Study looked at three different models: Dental Health Aide Therapist (currently in Alaska), Dental Therapists (Minnesota) and Advanced Dental Hygiene Practitioner (proposed by Dental Hygiene Association)
b. Ran 45 different economic scenarios in 5 states (Washington was one).
c. Only 5 models generated positive revenue (4 were DHAT and one was DT)
d. The proposed ADHP model was least economically viable.

SKCDS held emergency meeting on Midlevel Providers on 9/11/12

e. Discussed WSDA Board of Directors' proposal of resolution HD-13-2012 to introduce midlevel provider legislation to the upcoming Washington legislative session.
f. This proposal contains the following responsibilities for midlevel providers as long as there is an overall supervising dentist:
    i. **A supervising dentist can allow a dental midlevel provider to perform some or all of the following procedures under close supervision**: tissue conditioning; administration of local anesthetic; administration of nitrous oxide; placement and removal of space maintainers; cavity preparation; direct restorations of primary and permanent teeth; preparation and placement of preformed crowns; pulpotomies on primary teeth; indirect and direct pulp capping on primary and permanent teeth; extractions of primary teeth with class II or class III mobility; brush biopsies; permanent recementing of permanent crowns; final impressions; limited authority to dispense and administer: nonnarcotic analgesics, anti-inflammatories, preventive agents, and antibiotics; and extractions of periodontally diseased permanent teeth with class III mobility if the teeth are erupted, are not impacted, are not fractured, and do not need to be sectioned for removal.
    ii. **A supervising dentist can allow a dental midlevel provider to perform some or all of the following procedures under general supervision**: oral health instruction and disease prevention education, including nutritional counseling and dietary analysis; preliminary charting of the oral cavity; making radiographs; mechanical polishing of restorations; application of topical preventative or prophylactic agents, including fluoride varnishes and pit and fissure sealants; pulp vitality testing; application of desensitizing medication or resin; placement of temporary restorations; dressing changes; placement of temporary crowns; temporary recementing of crowns; suture removal; oral prophylaxis and removal of deposits and stains from the surfaces of the teeth; supra-gingival scaling; and gross debridement.

~ In Memory ~

- **Dr. John Desposato** (Bremerton)

November 19,1924 - January 4, 2011

- **Dr. Robert Gorder** (Spokane)

d March 19, 2011

- **Dr. Jack Brandon** (Kent)

May 11, 1930 – March 20, 2011

- **Dr. Raymond Manke** (Tacoma)

April 19, 1942 – May 16, 2011

FALL 2012

Newswire

Washington State Society of Orthodontists Board of Directors 2012-2013

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Ms. Joni Marts, *WSSO Executive Director*

WE WELCOME YOUR QUESTIONS, COMMENTS AND SUGGESTIONS!

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