Going Forward from COVID-19

THE NEW YORK STATE DENTAL JOURNAL

NYSDJ

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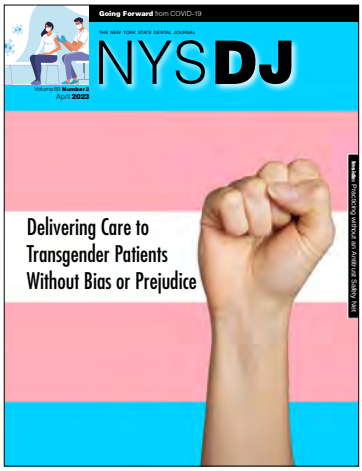

Cover: There is some evidence to show that dentists are ill-equipped—and in some instances unwilling—to render care to transgender individuals.

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What Dentists Do

Understanding dentists' job description will motivate all payers of oral health services to offer fair compensation.

"But, Doctor, you didn't do anything." Dentists may hear this refrain from their patients in response to a bill for an exam, follow-up evaluation or other non-operative care. "Doctor, find a way to do what you do for less." Dentists receive this implied directive from third-party payers in reply to dentists' criticisms of inadequate and unfair reimbursements.

Dentists could conclude patients do not really know what we do to earn our fee, or they would not question it. We could further suspect third-party payers do not want to know or admit they know what dentists must do to meet current legal, ethical and professional expectations so they can justify paying less. The dental profession must educate all payers of our services regarding everything dentists actually do for our patients to ensure that dentists continue to receive the resources necessary to maintain the quality of what we do.

Legal Mandates

Dentists surmount a myriad of legal demands and meet numerous legal duties to rise from a college student to a practicing dentist. Candidates must complete costly and rigorous undergraduate and dental school curricula and pass exhaustive board and licensing exams to qualify for state licensure. Once credentialed, practitioners must comply with ever-increasing federal, state and local regulations that govern the facilities, equipment and virtually every aspect of the operation of their dental practices, including the hiring, training, supervision and protection, and safety of competent auxiliaries. To complete this process, dentists typically incur the significant personal financial risk of student loan debt and, for those wanting to own, the cost of purchasing and operating an existing practice.

For every practitioner, the formation of each dentist-patient relationship creates a laundry list of a dentist's implied duties to the patient that include, among others, the following:

- Obtain patient informed consent.
- Meet the standard of care in all diagnoses and treatment.
- Treatment plan and deliver care safely with respect to patient's current and changing medical conditions.
- Timely discover and refer potentially aggressive lesions and life-threatening oral malignancies for follow-up care.
- Protect patients from injury due to swallowing or aspirating restorative components, instruments and foreign objects, or from soft-tissue lacerations and burns, etc.
- Respond to medical emergencies during dental treatment.
- Provide emergency care and not abandon patients.
- Keep patients informed of their condition, treatment progress and untoward events.
- Maintain and make available accurate and complete patient records.
- Keep protected health information confidential.
- Make timely referrals.
- Practice legally and ethically.[1]

Laws, regulations and civil duties dictate, to a great extent, how dentists do what we do on a daily basis. Every patient in every encounter can expect that their dentist will successfully negotiate all legal hurdles or otherwise face disciplinary actions, administrative fines or malpractice claims. However, legal mandates alone and vulnerability to punitive measures merely set the stage for the central challenge in the practice of dentistry: how dentists must think.

Transformational Thinking

Everyone must think critically at some level to survive. Nondentists routinely identify problems, gather and analyze data, and make decisions. Scientists develop hypotheses, search for evidence to establish general knowledge and rules about the world over time. Practicing dentists typically do not have the luxury to engage in detailed analysis or ponder the laws of nature before final decisions and action. Rather, clinicians must utilize scientific knowledge to deal with worried, help-seeking individuals in the moment.[2] To best serve patients, dental education must transform lay thinkers into what one author described as "science-using, information-sorting interpreters of timebound circumstances."[3]

Dental schools face two major challenges in transforming lay students to think like dentists. First, not all of the skills are fully teachable. Primary among these is the ability to fuse thinking with action. Dentists must see clinical conditions and immediately perceive patterns and differential diagnoses and, often, immediately do something about it.[4] Professors can try to model problem-solving with speed, using mental shortcuts under pressure, but cannot reliably communicate the mental steps in the process to all students.

Second, not all of the skills are fully learnable. Clinical decision-making involves uncertainty, inconclusive tests, signs and symptoms, ambiguous presentations and subtle complexities. These variables create a Catch-22 for the novice clinician. The novice performing a

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procedure for the first time lacks at least some necessary knowledge that can only be gained by actually doing the procedure. Reliance upon strict logic alone in these situations without the empirical data known to the experienced practitioner can lead the inexperienced dentist to arrive at incorrect conclusions. Hence, successful clinicians must aspire to lifelong learning to meet standards of care and, ultimately, reach their full potential.

Beyond Mandates and Thinking

Legal compliance and the mental acuity to think like a dentist, although essential, serve only as building blocks of the necessary foundation to deliver the levels of care the public deserves and expects. In addition to our minds, dental practice demands that we engage our hearts as well as our souls. Patients will travel long distances and pass multiple other practitioners along the way to receive care from the clinician who meets this demand.

As we think like a dentist, we quickly realize that thinking is inseparable from emotion. In fact, we must actively involve our hearts to adequately care and empathize with patients. Perceiving patients' emotions allows us to better discover and meet their needs. It also provides us with the productive anxiety to optimize our focus. At the same time, we must temper our involvement and remain sufficiently detached to do what we need to do and not allow negative feelings or biases to impair or prejudice our thought process.[5]

Dentists elevate many of our feelings from the heart in each dentist-patient relationship into commitments individually and as a group to aspire to ethical and professional values. We promise society and every individual patient we will act not merely to minimally comply with the law, but affirmatively do good, act in the best interests of patients and society, and regulate ourselves as a profession.

Finally, we achieve our best outcomes when we connect with our patients' souls. We take the time to listen and understand their character and values and incorporate these factors into our clinical judgment and decision-making. Two patients with the same diagnoses may, as a result, receive different care. Both of these patients will attest that they sought and found the right dentist for them.

Find a Way

Society must find a way to fairly compensate dentists for the activities that the law demands and patients want and deserve. Healthcare policymakers and insurers should focus cost-containment tactics on cutting third-party payer administrative costs, not minimizing financial allowances to dentists. Dentists want neither compensation for what we do not do nor overpayment for what we do. We certainly do not want our patients to expect us to do less. The oral healthcare delivery system needs to provide our legal mandate compliant, personal financial risk-taking, transformational thinking, ethical and professional value aspiring, heart-and-soul engaging dental professionals with the resources to continue to do what dentists do.

D.D.S., J.D.

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LETTERS

Are Mid-Level Providers a Realistic Solution?

I must admit I'm a bit mystified at the intent of Dr. Gary's editorial ("The Great Abdication") in the March *New York State Dental Journal*. He seems to be advocating for either leveling up the qualifications of mid-level dental providers to those of dentists, or requiring them to be supervised by dentists. I may be wrong, but I suspect that if there were enough dentists in underserved communities to supervise mid-level providers, there would be no need for mid-level providers. And if a prospective mid-level provider needed to be trained as a dentist, would that person be a mid-level provider?

Access to care is a real problem, but workable solutions must also be realistic. With most dental students graduating a half million dollars in debt, they're going to be seeking out the more lucrative venues, and not the indigent ones. Strategies will likely be implemented by local government regulators—whether that entails nondentist providers, practice incentives or even mandatory

public service. Forgive me, but the concern for quality of care in poorly served populations is disingenuous—let's call a territorial issue what it is.

By the way, Dr. Gary also states that healthcare must uptrain dentists with medical competencies commensurate with physicians to increase this population's access to the appropriate medical standard of care. By all means, emphasize medical knowledge in the dental context, but I don't think physicians will be any happier with the prospect of dentists offering a medical standard of care than we are with mid-level dental providers. The world doesn't need any more medical dilettantes.

Mark Bornfeld, D.D.S., FAAOM
Brooklyn

Dr. Gary responds: Thank you for reading and responding to my editorial. In your letter, you asked "... if a prospective mid-level provider needed to be trained as a dentist, would he be a mid-level provider?" My proposal for unsupervised mid-level providers (MLPs) would require their training be up to the CODA standards for a dentist, but only for the very limited list of procedures formerly restricted to licensed dentists, such as amalgam and resin restorations. This is currently the case for dental hygienists, still a type of MLP, who are trained to the same standards as a dentist for oral prophylaxis and related preventive procedures but who cannot legally perform most other tasks reserved to a licensed dentist.

I disagree with your statement "... if there were enough dentists in underserved communities to supervise mid-level providers, there would be no need for mid-level providers." MLPs not trained to CODA standards as primary care providers could operate as expanded function dental assistants under the supervision of a licensed dentist to enable dentists in or near underserved areas to treat a greater volume of patients in the same time period, thereby increasing access.

I agree with you that dentistry cannot act disingenuously to prohibit MLPs who can meet the standard of care from practicing. I stated that "... unnecessarily mandatory adherence to higher standards when qualified auxiliaries could perform the same function at the same level of quality serves only to protect dentists' turf out of self-interest." On the other hand, it is discriminatory to force the underserved to accept substandard care from an MLP if, in fact, the MLP is not trained to the CODA standards and not able to meet legal standards. I advocated that dentistry "strike the correct balance between patient safety and equity on one hand and access to an acceptable standard of care on the other...."

Finally, you opined, "the world doesn't need any more medical dilettantes" when referring to dentists uptrained with certain medical competencies commensurate with a physician. Physicians, like dentists, cannot act disingenuously to prohibit dentists who could meet the standard of training and care for limited areas of oral medicine to simply protect physicians' turf. One of the main points of my editorial was to identify MLPs with inadequate training to CODA standards for what they do, and possibly dentists in the future, forced to deal with increasing medical complications without the CODA standard training to meet patient needs and the standard of care as the real "medical dilettantes."

DOJ Withdraws Healthcare Antitrust Protections

Are we about to return to the bad old days of being punished for seemingly routine behavior?

Lance Plunkett, J.D., LL.M.

In a major surprise, the United States Department of Justice (DOJ) has withdrawn three longstanding antitrust guidance documents that provided safe harbors for specific conduct in the healthcare marketplace. The DOJ action has thrown the entire healthcare industry into turmoil, leaving doubts as to whether conduct that was previously considered protected from antitrust enforcement action is safe to engage in any longer. This uncertainty poses particular problems for dentistry.

The three DOJ guidance documents withdrawn are: 1) *Department of Justice and FTC Antitrust Enforcement Policy Statements in the Health Care Area [issued September 15, 1993];* 2) *Statements of Antitrust Enforcement Policy in Health Care [issued August 1, 1996];* and 3) *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program [issued October 20, 2011].*

DOJ noted that the statements were overly permissive on certain subjects, such as information sharing, and no longer served their intended purposes of providing encompassing guidance to the public on relevant healthcare competition issues in today's environment. Therefore, DOJ noted, withdrawal best served the interest of transparency with respect to DOJ's Antitrust Division's enforcement policy in healthcare markets. Instead, DOJ claimed that recent enforcement actions and competition advocacy in healthcare provided guidance to the public, and a case-by-case enforcement approach would allow DOJ to better evaluate mergers and conduct in healthcare markets that may harm competition.

The guidance document issued on Aug. 1, 1996, was of particular interest to dentistry because it had created a safe harbor for conducting fee surveys if specific criteria were met. These criteria are: 1) the survey was managed by a third-party, like the American Dental Association; 2) the information provided by survey participants was based on data more than three months old; and 3) there were at least five providers reporting data upon which each disseminated statistic was based, no individual provider's data represented more than 25% on a weighted basis of that statistic, and any information disseminated was sufficiently aggregated such that it would

not allow recipients to identify the prices charged or compensation paid by any particular provider.

The withdrawal of that safe harbor creates doubt and casts a cloud over conducting and participating in such fee surveys. The question now becomes whether participation might subject participants to antitrust enforcement action by DOJ.

Heightening the anxiety over fee surveys is the fact that DOJ went out of its way to highlight "information sharing" as a particular antitrust concern, prompting the withdrawal of the guidance documents. Obviously, fee surveys are the major product of most information-sharing activities. Why the antitrust concern with such information sharing? Before the August 1996 guidance was issued, fee surveys were largely taboo, with antitrust enforcers viewing them as a major tool for facilitating price fixing. Price fixing is seen as the worst antitrust violation, considered automatically—*per se*—illegal under both federal (the Sherman Act) and New York State (the Donnelly Act) antitrust laws. The thinking was that if competitors could share their fees with each other in real time, then it would be that much easier for everyone to align their fees to a higher level.

The irony is that cost transparency is also now seen as a benefit to the public. Thus, there is an inherent tension between the antitrust laws and price transparency for the benefit of the public. In the current age of instantaneous access to information, it is difficult to have open-price information for the public but somehow prevent healthcare providers from also accessing that same information. In an effort to resolve that tension, the DOJ antitrust guidance document had set three months as a form of time limit on how current price information could be in any fee survey. Whether that ever made any sense, it now is no longer a guaranteed safe harbor.

Caps Off

The withdrawal of the DOJ antitrust healthcare guidance documents has other downsides for the entire healthcare marketplace. Another safe harbor that disappears suddenly is the percentage protections for independent practice associations (IPAs) and other similar joint ventures among healthcare providers—and the primary way many healthcare providers engage with managed care plans to form networks with those plans.

The DOJ guidance had set a safe cap of 20% provider participation in an exclusive IPA and a 30% safe cap for provider participation in a non-exclusive IPA. This is a simplified explanation of the basics of the safe harbor, as there were added glosses for markets with limited numbers of specialists available to participate in a network and risk-sharing requirements to qualify for the safe harbors. These percentages have guided the structuring of healthcare IPAs by at-

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torneys for many years and now no guarantees of antitrust safety can be given to healthcare provider clients. It is as if antitrust enforcement is returning to square one in all of these areas and to a time when all IPA arrangements and hospital consolidations were viewed as anticompetitive gimmicks to harm consumers.

Additional antitrust safe harbors involving hospital consolidations and other healthcare entity consolidations also disappear with the withdrawal of the three DOJ guidance documents. There has already been a rash of federal government antitrust actions against hospital mergers. In New York State, the strenuous objections of the Federal Trade Commission (FTC) on antitrust grounds recently scuttled the proposed merger between the State University of New York (SUNY) Upstate Medical University and Crouse Health System, Inc., in the Fifth District. The FTC claimed the merged entity would have had a combined share of nearly 67% of commercially insured inpatient hospital services in Onondaga County, and the proposed merger would have reduced the number of hospital options available for nearly all patients from three to two.

The FTC objected that the deal presented substantial risk of serious competitive and consumer harm in the form of higher healthcare costs, lower quality, reduced innovation, reduced access to care and depressed wages for hospital employees. With the cancellation of the DOJ healthcare antitrust guidance documents, this kind of antitrust enforcement activity will likely become even more common.

Time to Panic?

The suddenness of the DOJ action has thrown the healthcare marketplace for a loop. Practices long thought to be safe from antitrust attack are now left in the lurch, with all healthcare providers, from institutional entities to private practice entities, facing uncertainty as to what antitrust attacks might be coming next.

Should an antitrust panic ensue? Not necessarily. While the specifics of the DOJ safe harbors are gone, the antitrust analysis that went into the now discarded guidance documents still has validity. The concepts expressed in the old guidance documents would still be a good guide to appropriate conduct for antitrust purposes. The key will be to make sure that collective actions are designed to contain costs for the benefit of the public and not to enrich participants collectively by raising prices or eliminating competition. It helps to keep in mind that the fundamental guiding principle of the antitrust laws is to prevent harm to competition itself, not to prevent harm to competitors. Competition necessarily results in harm to some competitors, but the process

of competition is what the antitrust laws seek to preserve. The theory underpinning this is that collusion does more harm than competition. Perhaps this is just another way of saying that the strong should survive and not the weak, who need collusion to survive or feather their nests.

In the early 1990s, antitrust law was a major concern for dentistry. A famous case in 1992 from the United States Court of Appeals for the Ninth Judicial District (Alaska, Arizona, California, Guam, Hawaii, Idaho, Montana, Nevada, Northern Mariana Islands, Oregon, Washington), United States v. Alston, was a rare criminal antitrust prosecution of dentists for conspiring to raise fees with a managed care plan. The dentists were convicted, although it was noted that the managed care plan itself had practically invited the dentists to meet to discuss raising fees that the plan knew were too low. That case sent shock waves throughout dentistry about the antitrust risks of trying to negotiate better fees with insurers.

Nobody wants to see a return to those days. The DOJ antitrust healthcare guidance documents were an outgrowth of the hysteria precipitated among providers from that catastrophic court case. There is lots of speculation in legal circles about where antitrust enforcement is now headed. Caution is the best option in the meantime. New guidance may emerge, and the old guidance isn't completely thrown on the trash heap—one may inform the other—but every healthcare provider will need to review his or her participation in any fee surveys, IPA contracts, mergers or consolidations of hospitals and other healthcare entities, and other potential collective actions undertaken—because the antitrust sharks could come circling again. And this may be just another way of saying that everything old is new again.

Not Done Yet with Employment Law

Finally, following up on last month's *Journal* article on employment law issues:

- The Federal Trade Commission extended its public comment period through April 19 on its proposed ban on non-compete agreements, so there is no final decision on that proposal yet.
- The New York State Legislature did pass the amendments to the new statewide pay transparency law, the key items being that employers need not retain the burdensome compliance documentation the previous version of the law had required and making it clear that the law applies even if a job is only posted internally to your own employees (the law still takes effect on Sept. 17).
- New York City is still studying and debating its proposed law to change to a wrongful discharge jurisdiction—and now a similar law is being considered by the New York State Legislature to apply statewide.

The material contained in this column is informational only and does not constitute legal advice. For specific questions, dentists should contact their own attorney.

Lessons Learned from COVID-19

Why it is important to seek out accurate information regarding the virus and follow scientifically established guidelines to mitigate serious outcomes.

Donald Tucker, D.D.S.

It is hoped that the COVID-19 pandemic will soon transition to endemic. Many of us lost friends, family and patients to this scourge. Lessons are to be learned from this disease and the medical community and society's response to it. In 2005, officials at the United States Department of Health and Human Services developed a Pandemic Influenza Plan, which was updated in 2009 and 2017.

This planning helped our country respond to COVID-19, as well as other disease outbreaks, like Ebola, SARS, MERS and Zika. Many lives were saved by preplanning. We did fall short in our response to COVID-19.[1] We didn't have enough hospital capacity in the early months of the pandemic. Unlike Korea and Australia, we were slow in producing and dispensing COVID-19 tests.[1] Personal protective equipment (PPE) was in short supply and many hospitals had an inadequate number of respirators.

We have a problem with social media and online articles producing claims that are either false or misleading.[13] Dentists need to find accurate sources of information to disseminate to our patients. Sources of reliable health information are advisories posted by the Food and Drug administration (FDA), Centers for Disease Control (CDC) and the New York State Department of Health (NYSDOH).

One example of inaccurate advice from social media concerns the use of ivermectin for the treatment of COVID-19. High doses of ivermectin have serious, and sometimes fatal, consequences.[2] Many trials looked at by the FDA failed to find a benefit from the use of ivermectin for the treatment of COVID-19.[3,4,5] In fact, ivermectin is not approved by the FDA for the treatment of any viral infections.[2]

Trust the Vaccines

COVID-19 vaccines, especially the mRNA vaccines, are among the most tested vaccines in existence.[6] There have been more than 673 million doses of COVID-19 vaccine administered in the United States.[6] "Reports of death after COVID-19 vaccination are rare."[6] "Death after vaccination does not necessarily mean that a vaccine caused a health problem."[6] You are at much higher risk of complications or dying from a COVID-19 infection than you are from the vaccines.[6]

Commonwealth Fund, a nonprofit that conducts independent healthcare research, has estimated that COVID-19 vaccination in the U.S. prevented more than 3 million additional deaths, 18.5 million additional hospitalizations and 120 million more cases from December 2020 through November 2022.[7]

It is estimated that 5% to 10% of COVID-19 infections result in lingering symptoms (long COVID).[6] This includes neurologic and cardiac damage.[6] The same lingering healthcare issues[8] were seen during the pandemic of 1918, an expected outcome of severe viral infections. Considering the number of people who have been infected with COVID-19 in the United States, there are millions of people who have experienced and are still experiencing lingering symptoms. Vaccination greatly reduces that risk.

There have been 715 diagnosed cases of myocarditis in teenagers and young adults out of 63,470,820 doses of vaccine.[9] Most cases resolved with medical care and monitoring.[9] "Studies have largely confirmed that the overall myocarditis risk is significantly higher after an actual COVID-19 infection compared with vaccination, and that the prognosis following myocarditis due to the vaccine is better than from infection."[9]

People wonder why they should get vaccinated if they might get COVID-19 anyway. Data reported in December 2022 found that people 18 years and older and vaccinated with an updated booster (bi-

valent) had a 9.8-times lower risk of dying from COVID-19 compared to unvaccinated people, and a 2.4-times lower risk of dying from COVID-19 compared to people vaccinated without the updated (bivalent) booster.[9] This does not include the reduced risk of long COVID in vaccinated people.[9]

Keep Masking

An article appeared earlier this year in the Cochrane Library entitled "Physical Interventions to Interrupt or Reduce the Spread of Respiratory Viruses."[10] The editor-in-chief of the Cochrane Library, Karla Soares-Weiser, M.D., Ph.D., M.Sc., issued the following statement in March concerning this article:

"Many commentators have claimed that a recently updated Cochrane Review shows that 'masks don't work,' which is an inaccurate and misleading interpretation."

And Lucky Tran, Ph.D., a science commentator at Columbia University, said: "Out of the 78 papers analyzed in the review, only two studied masking during the COVID-19 pandemic. Both of these papers found that masks did protect wearers from COVID-19."

There is strong data showing that "surgical masks or Kn95 respirators, even without fit testing, substantially reduce the number of particles emitted from breathing, talking, and coughing....Our observations are consistent with suggestions that mask wearing can help in mitigating pandemics associated with respiratory disease."[11]

Be Prepared

It is important that healthcare professionals follow guidelines and recommendations from the CDC, FDA and NYSDOH. These organizations review current research and scientific literature to come up with guidelines for practicing healthcare providers. The NYSDOH notified all New York State health professionals on March 16 that health professionals should "promote prevention by encouraging patients to stay up-to-date with all recommended vaccines, including influenza and COVID-19." This is considered "promoting best practice." The DOH also said health professionals should "understand the effect long COVID is having on patients' daily lives and functioning."

Preparing for a future pandemic starts with lessons learned from past pandemics. We need adequate nonpharmaceutical interventions (NPIs) ready to use before the pandemic begins (gloves, masks, gowns, disinfecting solutions, social distancing, etc.). Accurate tests for the pathogen need to be developed as early as possible.[1] People need to be educated about the importance of NPI. If society doesn't believe in NPI, there may not be enough time to produce a vaccine.[8] The science of vaccine fabrication needs more investigation.

The same way dentistry learned that wearing gloves protected dentists, staff and patients from bloodborne pathogens (hepatitis, HIV), dentists need to evaluate ways to protect staff and our patients from airborne pathogens by utilizing masks, air purification, air monitoring and air exchanges. We should be encouraging vaccinations for the health and safety of our patients.

Dr. Tucker is in private practice in Williamsville, Eighth District. He participated in Erie County COVID-19 vaccination pods as a member of Western New York Specialized Medical Assistance Response Team. He is a trustee of the New York State Dental Foundation and a member of the Western New York HPV vaccination coalition. Queries about his editorial can be sent to him at doctucker1954@yahoo.com.

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Association *Activities*


Anthony Cuomo


Prabha Krishnan


Maurice Edwards


Paul Leary


William Karp

Council Approves Nominees for NYSDA Offices

AT ITS MEETING IN MARCH, the NYSDA Council on Nominations approved the advancement of Dr. Anthony Cuomo of the Ninth District Dental Association to the office of president of the State Association, commencing in June. The council also approved the nominations of the following to serve with Dr. Cuomo in 2023-2024:

Dr. Prabha Krishnan, Queens County Dental Society, president-elect; and Dr. Maurice L. Edwards, New York County Dental Society, vice president.

The council was asked to consider several nominees for the offices of secretary-treasurer and speaker of the House. They gave their support to Dr. Paul R. Leary of Suffolk County Dental Society (secretary-treasurer) and Dr. William Karp of the Fifth District Dental Society (speaker).

Both Dr. Leary and Dr. Karp will stand for election during the House of Delegates Annual Session, taking place June 2-4 at the Saratoga Hilton/Saratoga City Center. Also on the ballot will be Dr. Fred Wetzel of the Fourth District Dental Society (secretary-treasurer) and Dr. Robert Peskin of Nassau County Dental Society (speaker).

Hygiene Appointments to Dental Board Announced

AT ITS APRIL MEETING, the New York State Board of Regents approved two hygiene appointments to the State Board of Dentistry. Karl Dixon, R.D.H., of New York City received a five-year appointment to the Board, and Delores Van Auken Belrose of Schroon Lake was reappointed to the Board to serve a five-year term as an extended member. Extended members serve solely for purposes of licensure disciplinary and/or licensure restoration and moral character panels.

Mr. Dixon, a graduate of the dental hygiene program at Montclair State University, is a member of the Dental Hygiene Department at NYU College of Dentistry. Ms. Belrose is employed by Adirondack Dental Health Associates in Ticonderoga. She is a graduate of the dental hygiene program at Hudson Valley Community College and received a degree in health policy administration from SUNY Plattsburgh.

Jay Glat, 1999 President, Dies

PAST PRESIDENT JAY I. GLAT, D.D.S., died March 23, just weeks after his 90th birthday. Dr. Glat was living in Florida at the time of his death.

Dr. Glat served as president of the Dental Society of the State of New York (DSSNY) in 1999. The following year, the name of the organization was changed to the New York State Dental Association (NYSDA).

A 1959 graduate of the University of Pennsylvania Dental School and Navy Dental Corps veteran, Dr. Glat practiced general dentistry in the Bronx. He was active at all three levels of organized dentistry and filled terms as president of the First District Dental Society (now, New York County Dental Society) and Bronx County Dental Society. He is also a past general chairman of the Greater New York Dental Meeting.

Dr. Glat is survived by Eleanor, his wife of 66 years; three sons—Neil, Jeff and Paul and their spouses—and six grandchildren.

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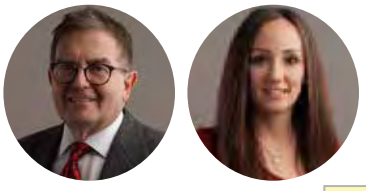

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Association *Activities*

Dental Advocates—On April 18, NYSDA Advocacy Day, members and supporters of the dental profession appeared at the offices of state legislators to impress upon them the importance of measures before them that would protect the profession and health and safety of patients its members treat. Among those carrying NYSDA's banner are, from left, Speaker Steve Gounardes, Assistant Executive Director Michael Herrmann, Seventh District Executive Director Becky Herman, and at far right, Howard Warner of Sixth District, member of Council on Governmental Affairs. The group is meeting with Assemblyman Harry Bronson, Democrat of Rochester.

Ethics Council Issues Ruling

On March 21, 2023, the NYSDA Council on Ethics issued an order for no further action against Dr. Rashmi Patel (License No. 050345). After a full hearing on March 10, 2023, the Council found that Dr. Patel had been disciplined for professional misconduct by the New York State Education Department Board of Regents and, as such, was in violation of Paragraph B of Section 20 Chapter X of the NYSDA Bylaws.

Dr. Patel did not appeal the Council's decision within the requisite 30-day time frame to the American Dental Association (ADA). The decision of the NYSDA Council on Ethics thereby became final and effective as of April 20, 2023.

In Memoriam

NEW YORK COUNTY
Jay Glat
University of Pennsylvania '59
10802 Ashmont Drive
Boca Raton, FL 33498
March 23, 2023

THIRD DISTRICT
H. Stephen Christenson
University at Buffalo '67
15 W Kershaw Drive
Bluffton, SC 29910
March 20, 2023

EIGHTH DISTRICT
Herbert Simon
University at Buffalo '54
59 Briarhurst Road
Williamsville, NY 14221
February 19, 2023

NINTH DISTRICT
Vincent Commercio
New Jersey University of Dentistry '68
40 Laurel Hill Road, #104
Brookfield, CT 06804
February 13, 2023

Nicholas Violino
New York University '65
187 Beech Street
Eastchester, NY 10709
April 1, 2021

BRONX COUNTY
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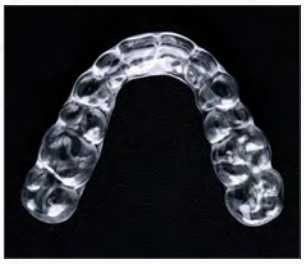

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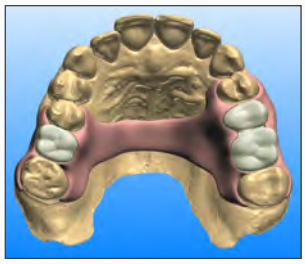

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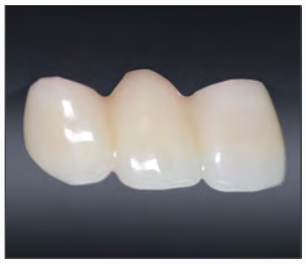

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A Dentist's Role in the Delivery of Culturally Competent Oral Healthcare to Transgender Patients

Laura Rhein, D.D.S.; Michael J. Mand, D.D.S.; Benjamin Solomowitz, D.M.D.

ABSTRACT

Professionals across all healthcare fields understand the importance of delivering patient-centered care. But delivering such care requires knowledge of various patient populations, especially marginalized groups of individuals. Rendering non-biased, non-prejudicial care to marginalized populations is irrefutably critical. It requires understanding the specific needs of these at-risk individuals. The transgender community is one marginalized population that faces inequities in healthcare. This article examines current literature to reveal the inequities that the transgender population encounter in dental care. And it explores the dentist's role in the delivery of culturally competent care to transgender patients.

The ability of healthcare providers to deliver competent care and formulate optimal treatment plans for their patients depends upon a multidisciplinary, patient-centered approach. Healthcare professionals have a responsibility to render non-biased, non-prejudicial care to all patients and to provide care that addresses the specific needs of all patients.[1]

While this is a reasonable objective, the treatment of "all patients" comes with challenges, as there are significant differences between patients when viewed at population, community and individual levels. Rendering non-biased, non-prejudicial care to marginalized populations is imperative, and understanding the specific needs of these at-risk populations is the hallmark of patient-centered care. All healthcare professionals need to be aware of and be able to address barriers to healthcare that are commonly experienced by marginalized populations.

Furthermore, a dentist's ability to provide competent care involves the combination of a thorough clinical and radiographic examination to gather a patient's current oral health status and consideration of a patient's medical, social and dental history.

One specific marginalized group healthcare professionals need to understand better is the transgender community. There are approximately 1.4 million transgender adults in the U.S., 0.6% of the population.[1] Understanding exactly what it means for a given person to identify as transgender is essential. Defining transgender often necessitates reviewing the meaning of the terms sex and gender.[1] Gender identity is psychological and refers to a person's inherent sense of being a man or a woman.[2] The binary categories for gender identity are man and woman, while a third category is recognized as genderqueer or transgender.[2]

Previous literature, media outlets and legislative initiatives have consistently shed light on the inequities faced by the transgender community. Published literature has identified the

transgender community as being at greater risk of stigmatization, discrimination, violence, anxiety, depression, suicide, unemployment, high-risk behaviors, sexually transmitted infections and substance abuse.[1] Transgender individuals have identified a lack of health insurance, denial of treatment and claims due to being transgender, and financial hardship as common barriers to healthcare.[3] High rates of unemployment in this population further exacerbate difficulties in obtaining health insurance.[3]

Fear of stigmatization and discrimination is a commonly reported barrier to care.[1] Discrimination against the transgender community includes behaviors such as assuming a person's assigned sex at birth is fully aligned with that person's gender identity, not using a person's preferred name or pronoun, and making the assumption that psychopathology exists given a specific gender identity or gender expression.[2] Literature has also shed light on the fact that these increased risk factors and barriers to access to healthcare negatively affect the overall health and well-being of trans individuals.[1]

The current literature examining the health of transgender individuals is limited. Furthermore, the data that is available is often from small studies of convenience samples, such as participant recruitment from clinics, rather than population-based samples.[4] However, the health implications among the transgender community are especially unique and important, since medical gender transitioning is often explored by these individuals.

Four main forms of interventions exist in gender transition therapy.[5] One option includes changes in social expression of gender to achieve consistency with gender identity. A second option is to undergo therapy with cross-sex hormones to achieve desired masculinization to feminization. A third, more invasive and risky option, is surgical intervention involving the surgical change of the genitalia and/or other sex characteristics. The final form of intervention pertains to the use of psychotherapy to further explore gender identity, improve body image and promote resilience.[5]

The risks associated with cross-sex hormone therapy have been explored in previous literature. Estrogen-progestin hormones have been found to be associated with thromboembolic disease, while testosterone has been found to be associated with an increase in liver enzyme levels, loss of bone mineral density and an increased risk for ovarian cancer.[6] Despite there being drastic differences between these intervention options, and their associated risks, they all share a similar objective. The goal of psychotherapeutic, endocrine or surgical therapy is to enable the patient to achieve lasting personal comfort with the gendered self in order to maximize overall well-being.[5]

Because the transgender population faces significant inequities and barriers to accessing healthcare, this article aims to discuss the topic of transgenderism in the context of dental care. Its purpose is to explore the role of the dentist in the culturally competent care of transgender patients. A search of current published literature was conducted in order to explore barriers to dental care, and the oral health implications and treatment considerations of transgender patients. Furthermore, this article seeks to determine if the dental education and residency training curricula currently in place are adequate to treat this population.

Methods

A comprehensive search of the current literature was undertaken to find evidence-based data and carry out the objective of this study. Using the database PubMed, a search was conducted using keywords such as "Transgender" and "Dentistry" or "Dental" or "Oral Health." Preference for full-text articles, as well as studies published in the English language, was inputted. Titles of articles were initially reviewed for relevance. Further review of abstracts was conducted to aid in the selection of articles that pertained to the transgender community and one of three main subtopics: barriers to dental care; oral health implications and treatment planning considerations; and dental education and training. Five articles were ultimately selected to be included in this review.

Results & Discussion

1: Barriers to Access Dental Care

Oral healthcare professionals are responsible for ensuring that transgender clients receive care that aligns with their needs.[1] To be able to provide culturally competent care to transgender patients, dentists must recognize the barriers to accessing dental care that transgender patients may face. The most often-cited barrier by the transgender community is related to their perception that their providers lack knowledge of and have pre-existing bias against transgender persons.[3]

A cross-sectional study published in 2017 aimed at evaluating the level of dental fear among transgender individuals and investigating specific predictors of dental fear in individuals who identify as transgender.[7] In their methodology, the authors conducted a web- and paper-based anonymous survey among transgender adults. In their questionnaire, they implemented the various pre-published survey questions to assess different criteria, such as dental fear through the Dental Fear Survey (DFS).[7] They also asked characteristic questions to gather information on patients' sex, gender identity and many other features. Gender transition questions that were previously published were adapted and utilized in this questionnaire.

Seventy individuals who identify as transgender completed the survey. Specifically, there were 36 transgender males who were assigned female at birth (AFAB) and 34 transgender females who were assigned male at birth (AMAB). Statistical analyses were performed with a significance level of 5%.[7] All combinations of the fear of maltreatment in a dental clinic with DFS scores and subscales indicated a significant positive relationship, with p values ranging from p=0.014 to <0.001. Furthermore, regression model analysis revealed that significant predictors of dental fear (DFS) are the fear of being maltreated in a dental clinic (p=0.017) and experience of maltreatment in a dental clinic (p=0.041). Therefore, individuals who had more fear of experiencing maltreatment in a dental clinic reported significantly higher dental fear.[7]

2. Oral Health Implications & Treatment Plan Considerations

Oral healthcare professionals are responsible for ensuring that transgender clients receive care in a culturally competent manner.[1] This requires an understanding of the basics of gender nonconformance and its impact on oral-systemic health.[1] Dental practitioners must understand the effects of relevant medical history or medication use on dental care and screen effectively for oral infections and diseases for which parts of the transgender population may be at higher risk.[8] These include oral lesions that result from STIs, as well as oral complications of other health disparities, such as decreased healthcare usage and increased substance abuse.[8]

Because recent evidence suggests that, when compared to their cisgender counterparts, transgender youth exhibit more unsafe sexual behavior that may elevate their risk for sexually transmitted infections, a 2020 study aimed to better understand oral sex knowledge and experience of transgender youth.[9] Specifically, the authors sought to explore the knowledge that transgender youth have regarding oral sex, the consequences of oral sex, the mechanisms of protection and where they obtained this information.[9] The study took place at a U.S. academic pediatric medical center in 2017, and participants were recruited at a Transgender Research Day event and during Transgender Clinic sessions. The participants in this study included English-speaking transgender adolescents 14 to 24 years old, who were invited to participate in a previously validated survey about their knowledge and behaviors related to oral sex.

Of the 138 transgender youth invited to participate, 57 completed the surveys, yielding a 41% response rate. A majority of the respondents reported feeling they understood the necessity of protection and consequences of oral sex; however, most participants reported not using a form of protection.[9] Over half of the participants (58%) said they had not had a physician, dentist or parent speak to them about oral sex.[9] The 2020 study examining oral sex knowledge and experience of transgender revealed the lack of standardized, evidence-based sex education provided to at-risk youth populations, in particular, transgender youth.[9] The authors concluded that it is imperative that adolescents, particularly in highly vulnerable populations

like transgender youth, receive accurate information about oral sexual contact.[9] Dental schools should prepare future practitioners to address these issues with youth using a culturally competent, evidence-based approach.[9]

The long-term effects of hormone treatment on mineral density, bone metabolism and bone resorption are not well understood. In men, testosterone plays a vital function for skeletal equilibrium, and estradiol is required for skeletal development.[10] Whereas, in women, estrogens participate in bone homeostasis; the effect of androgens is less clear. This insinuates that bone metabolism may differ between transgender men and transgender women undergoing hormone therapy.

During hormone therapy, bone changes are evaluated periodically through the analysis of bone mineral density (BMD) and bone turnover marker (BTM). Bone mineral density (BMD) analysis involves the use of dual-energy X-ray absorptiometry (DEXD), which represents active bone remodeling. Bone turnover marker (BTM) analysis is done using a sample of serum and/or urine.[11] Monitoring of these values allows for the prediction of the risk of osteoporosis, and observation of treatment progression, as changes in values reflect the effects of the therapy on bone metabolism and structure.

The long-term effects of hormone therapy on transgender individuals have not been fully explored, thus Delgado-Ruiz et al[11] suggest that it may hinder osteointegration of titanium implants. Therefore, the purpose of their 2019 systematic review and meta-analysis was to evaluate the bone markers and BMD of transwomen (male to female) and transmen (female to men) patients after long-term pharmacotherapy treatment for feminization or virilization with or without sex reassignment surgery.

Furthermore, the researchers aim to provide a theoretical basis for a better understanding of the implications of long-term pharmacologic therapy in the adult transgender patient on therapies involving dental implants.[11] For their methodology, they follow the PRISMA guidelines and examine three primary outcomes: changes in bone metabolism marker levels (calcium, phosphate, alkaline phosphatase and osteocalcin); changes in the BTMs (serum procollagen Type I N-terminal pro-peptide (PINP) [bone formation], and serum collagen Type I cross-linked C-telopeptide (CTX) [bone resorption]); and changes in BMD. The results of their systematic review revealed that calcium, phosphate, alkaline phosphatase, and osteocalcin levels remained stable across transgender patients undergoing hormone therapy. PINP increased in both transwomen and transmen; however, CTX showed contradictory values in transwomen and transmen. The results also revealed a reduced BMD in transwomen patients receiving long-term cross-sex pharmacotherapy.

Due to many limitations in the study, the researchers describe only three conclusions of their study. First, long-term pharmacotherapy for transgender patients does not alter the calcium, phosphate, alkaline phosphatase and osteocalcin bone markers. Secondly, long-term pharmacotherapy for transgender patients will slightly increase the bone formation, expressed with increased PINP turnover markers. Finally, the authors conclude that long-term cross-sex pharmacotherapy for male-to-female transgender patients will produce a slight reduction in bone mineral density (BMD).

Despite their research objective, the results of the systematic review did not allow for the researchers to make any formal conclusions about the contraindications of implant surgery in transgender patients taking hormone therapy. Instead, the researchers recommended that dentists or oral surgeons planning to place implants in transgender female patients taking cross-sex hormone therapy may consider the precautions followed in osteoporotic patients. Similarly, Delgado-Ruiz et al[11] suggest that it would be reasonable to monitor bone parameters in these patients before pursuing dental implant surgery

3. Dental Education & Training

As of 2017, few studies have examined healthcare trainees' perceptions of their preparedness to care for LGBTQ populations, and no studies have compared perceptions of training across medicine, dental medicine and nursing.[8] A 2018 study aimed to understand variations across disciplines in LGBTQ health by assessing medical, dental and nursing students' perceptions of preparedness across three domains: comfort levels, attitudes and formal training.[8] The researchers developed a 12-item survey with an interprofessional panel of LGBTQ students from the schools of medicine, dental medicine and nursing at the University of Pennsylvania, located in Philadelphia, PA.[8] Any student enrolled full time in any of the three schools was eligible to participate in the survey.

The researchers performed descriptive statistical analyses and examined patterns in responses using Kruskal-Wallis tests and an ordered logistic regression model. One thousand ten students from the schools of medicine, dental medicine and nursing responded to the survey, yielding a 43% response rate. Extensive statistical analyses were conducted.

TABLE 1.

Data Results from Comparing Medical, Dental and Nursing Students' Preparedness to Address Lesbian, Gay, Bisexual, Transgender and Queer Health.[8]

Type of Training of Student	Comfort Discussing Sexual Health	Competence of Care of Transgender Patients by Instructors	Incorporation of LGBTQ-related Competent Care into Curricula
Dental	52%, (n = 63)	25%, (n = 32)	13% (n = 16)
Medical	79%, (n = 388)	46%, (n = 227)	58% (n = 287)
Nursing	76%, (n= 295)	59%, (n = 227)	55% (n = 215)

Comparing the comfort levels, attitudes and formal training of dental students versus medical and nursing students yielded statistically significant differences (Table 1). Significantly fewer dental students (52%, n = 63) agreed that they felt comfortable discussing sexual health than medical (79%, n = 388) and nursing students (76%, n= 295). Significantly fewer dental students (25%, n = 32) agreed that their instructors demonstrated competence compared to medical (46%, n = 227) and nursing students (59%, n = 227). Additionally, only 13% (n = 16) of dental students agreed that their curriculum had incorporated LGBTQ-related content compared to 58% (n = 287) and 55% (n = 215) of medical and nursing students, respectively.[8]

The results of the study also reveal that dental students were significantly less likely than medical students to report an interest in receiving formal LGBTQ health education (OR 0.53, p<0.01). The researchers conclude that dental students displayed slightly fewer positive and more stereotypical attitudes towards LGBTQ populations and had fewer positive perceptions of their formal training in LGBTQ health. The authors suggest a possible explanation for these findings is a more significant gap in LGBTQ health content and instructor competency in dental school compared to that of medical and nursing schools.[8]

With an increasing number of transgender individuals seeking gender-affirming surgery, there is a greater need for healthcare providers, including oral and maxillofacial surgeons (OMFS), experienced in the surgical care of transgender patients.[12] In their 2019 study, Ludwig et al[12] aimed to evaluate OMS residents' exposure to the care of transgender individuals, as well as their perceived importance of training in gender-affirming surgery. A cross-sectional study was conducted between July 1, 2017, and July 30, 2018; all 1,174 OMS residents in accredited U.S. training programs were invited to participate. The predictor variables used in this study included: residents' gender, program type, program region and level of training. The outcome variables used in this study included: frequency of exposure to the care of transgender people, aspects of care covered, perceived importance of such training and perceived need for fellowship opportunities in gender-affirming surgery.

The results yielded a 7.4% response rate, with a total of 87 responses. Demographic data was assessed; 81.6% of the 87 respondents were male, while 64.4% were training in combined MD degree-OMS certificate programs. Thirty-one percent of the participants reported having had previous exposure to the care of transgender people during their residency, thus 69% had not had any previous exposure.

A scale from 1=neutral to 3=very important was utilized to examine the OMS residents' perceived importance of surgical training in gender-affirming surgeries; the respondents' mean importance of receiving training in gender-affirming surgery was 1.37±0.94. Additionally, 37.9% of the respondents reported that fellowship training should be offered in gender-affirming surgery, specifically, in facial feminization and facial masculinization surgeries. Thus, the authors conclude that despite the fact that OMS residents had had limited exposure to the care of transgender people, they did perceive that such exposure should be a component of their training.[12] Further research is needed to collect data from a larger sample size and to better understand the role of oral and maxillofacial surgeons in gender-affirmation surgery.[12]

Conclusions

The treatment of the transgender population with respect and nonjudgement is important at all levels of healthcare. The results of this review emphasize the important role dentists play in the delivery of culturally competent care to a transgender patient. Patient-reported fear of discrimination and previous experiences of discrimination and maltreatment are significant, with a positive association with the level of patient dental fear.[7] Educating practitioners to recognize this population's vulnerability to discrimination and reported increased dental fear will allow dentists to be more mindful in their assessment of a transgender patient's anxiety and fear, and to utilize strategies to promote feelings of comfort and security in patients under their care.

In comparison to medical and nursing students, dental students display slightly fewer positive and more stereotypical attitudes towards LGBTQ populations and have fewer positive perceptions of their formal training in LGBTQ health. Dental schools should develop formal content on LGBTQ health and utilize this content as

an opportunity for interprofessional training.[8] More comprehensive, formal training in the care of transgender patients would help overcome discrimination by ensuring that the dentist does not assume a person's assigned sex at birth coincides with that person's gender identity and uses a person's preferred name or pronoun.[2]

It is important that dentists be able to elicit relevant information from their patients by asking appropriate questions and speaking knowledgably about sexual health with all patients.[8] This is especially important for transgender youth, as this population is more likely to engage in high-risk behaviors and contract sexually transmitted infections.[9] Allowing for more thorough education and tailored training to treat this population will help dentists provide quality treatment to transgender patients, treatment that makes them feel respected, understood and cared for.

The results of the 2019 study examining OMS residents' experience with transgender patients and perceptions of gender-affirmation education showed that the OMS residents had had limited exposure to the care of transgender people.[12] Yet, OMS residents perceived that such exposure to the care of transgender patients should be an important component of their training, with over one-third of OMS residents saying fellowship training in facial feminization and masculinization gender-affirmation surgeries should be offered. Of course, this should be limited to procedures within the scope of the practice of dentistry set by state laws.[12]

Adding such advanced surgical training for a group that represents 0.6% of the US population into crowded curricula with limited resources and time has potential impacts, however. Potentially, this could lead to lessening the exposure of training in other critical surgeries, such as trauma repair, that are necessary for these residents to deliver in hospital settings more commonly in the years following their training. Additionally, due to the small transgender population, offering such training in facial feminization and masculinization may be limited depending on the region where care is being provided. Thus, further fellowship training in this category for a more selective group of residents that plan to carry this surgical skillset in their career practice may be preferred.

With limited data on transgender health in general, and specifically regarding oral health, further research is needed. Research on oral health effects of gender-transitioning medications needs to be further explored to identify contraindications to any dental or oral surgery treatment. Continuation of research in this field, and curricula changes to incorporate more formal training on the LGBTQ community, especially the transgender community, will aid in the education and training of dental students into dental practitioners who will be able to treat transgender patients effectively with cultural competence and without stigma or discrimination.

Queries about this article can be sent to Dr. Solomowitz at bsolomow@jhmc.org.

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Oral Health Considerations for Aging Patients Living with HIV/AIDS

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ABSTRACT

People living with HIV/AIDS (PLWH) have an increased life expectancy due to advances in antiretroviral therapy. In 1996, the life expectancy for a 20-year-old living with HIV was 39 years. Today, it is >70 years. As life expectancy increases, PLWH are burdened with age-associated comorbidities. This paper reviews the interaction between aging and HIV and how it affects social, physical and oral health issues. The shift in demographics presents new challenges for clinicians in how to identify, address and manage these complex manifestations. This review summarizes how to approach HIV-related changes when providing care as a dental clinician.

Advances in antiretroviral therapies are allowing people living with HIV/AIDs (PLWH) to live longer than ever before.[1] Early initiation and increased effectiveness of antiretroviral therapy have increased the life expectancy of PLWH to nearly that of the general population.[2] In 2018, the majority of people in the United States with an HIV diagnosis were over 50 years old.[3] Given increased life expectancy and incident HIV infections in older adults, it is estimated that over 70% of PLWH will be over 50 years old by 2030.[4]

Antiretroviral therapy is recommended for all PLWH, but it is especially important for older PLWH, because they are more likely to present with comorbidities and a weakened immunologic response to treatment.[1] Current combined antiretroviral therapy (cART) for PLWH typically includes two nucleoside reverse transcriptase inhibitors with a third drug: an integrase strand transfer inhibitor; a non-nucleoside reverse transcriptase inhibitor; or a protease inhibitor with a pharmacokinetic enhancer.[1] The most recent data also support the use of a two-drug regimen: dolutegravir and lamivudine.[1] The most common cause of treatment failure is poor adherence to cART, so clinicians should identify factors, such as neurocognitive deficits or hormonal changes, that might cause older patients to miss doses.[1]

As the rates of morbidity and mortality decline, the prevalence of older PLWH increases, presenting a shift in demographics and a new set of challenges clinicians must face. The complex interaction between aging and HIV presents unique challenges for older PLWH, including social, physical and oral health-related issues. Dentists can play an important role in identifying these issues in older patients living with HIV, referring for appropriate care and services and mitigating oral symptoms and discomfort.

Social Issues Affecting Older PLWH

Oral health–related quality of life (OHRQoL), as measured by the well-validated and frequently used Oral Health Impact Profile, is

a measure of the perceived effect of oral health on physical and social functioning and self-image.[5] There is strong evidence indicating OHRQoL is most negatively affected by dental caries and periodontitis.[6] Older age, unmet dental needs, smoking, loneliness and depression are also associated with worse OHRQoL.[5] For PLWH, health-related quality of life is most negatively affected physically, followed by psychologically.[6]

Studies have shown that PLWH experience unmet dental needs twice as frequently as unmet medical needs, a problem exacerbated for patients without dental insurance.[10] PLWH who have been exposed to long-term antiretroviral therapy are more likely to experience medication-induced xerostomia, which leads to dental caries, as well as halitosis, candidiasis and gingivitis.[6] Recent data demonstrate that, in addition to decayed teeth, prosthodontics treatment needs and drug use have the most significant negative impact on OHRQoL for PLWH.[7]

OHRQoL is negatively impacted by aging, as dental problems that inhibit chewing and negatively impact esthetics are more common in older patients.[5] Older PLWH are also more likely to present with comorbidities, which are also associated with lower health-related quality of life and poorer oral health.[8] Given the importance of oral health in daily functioning, socialization and nutrition, there should be an increased emphasis on early preventive dental care for older PLWH, such as reducing levels of plaque.[9]

Depression and loneliness are major issues for older patients living with HIV. Patients with depression have worse oral health indicators, such as DMFT index (the sum of the number of decayed, missing due to caries, and filled teeth in the permanent teeth) and mean missing teeth, and lower OHRQoL, even after controlling for age and comorbidities.[8] Older PLWH experience an estimated 39% to 58% higher rate of loneliness, which correlates with an increased likelihood of using cigarettes, alcohol or other substances.[4]

In addition to worsening quality of life and increased likelihood of depression, loneliness causes stress-induced cortisol dysregulation, which increases total peripheral vascular resistance and lowers cardiac contractility, contributing to increased odds of an early death.[4,11] Fortunately, loneliness is a modifiable condition; developing protective factors, such as wisdom, resilience and nostalgia, may help patients lessen the negative effects of loneliness.[4] Dentists may be able to identify elderly patients who are experiencing social isolation and loneliness and refer them to appropriate mental health and social resources.

TABLE 1

Select Educational and Support Resources for Clinicians and Patients

Resources for Clinicians		
HIV Guidelines	Screening guide to identify depression, social support, substance use, polypharmacy, and cognitive status, as well as tips for communicating with older patients	https://www.hivguidelines.org/hiv-care/selected-resources/quick-reference-guides/hiv-in-older-adults/
HIV and Aging Toolkit	Toolkit for clinicians who care for people aging with HIV; provides links to additional screening/assessmeent instruments and to programs and papers that offer clinically useful materials	https://aidsetc.org/sites/default/files/resources_files/NECA%20AETC%20Aging%20Toolkit%20%28NEW%29_V4.pdf
Resources for Patients		
HIV Service Locator	Find mental health, substance abuse, housing assistance, STI testing, and health service locations around the country	https://locator.aids.gov/
Collection of Resources for PLWH	Find resources relating to HIV care, housing, employment, and legal issues, as well as risk reduction tools and downloadable materials on living with HIV	http://www.cdc.gov/hiv/basics/livingwithhiv/resources.html

TABLE 2

Relative Risk of General Health Conditions and Related Dental Manifestations among PLWH

General Health Conditions	Among PLWH
Atherosclerotic cardiovascular disease	Increased risk[19]
Diabetes	Increased risk[21]
Osteoporosis	Increased risk[24-27]
Dental Manifestations	**Among PLWH**
Dental extraction and restoration complications	No difference[40,42,43]
Periodontal disease	Slightly increased risk[39,44,46]
TMD	Unknown
Alveolar bone loss and success rate of dental implants	No difference[31,37,38]

Certain behavioral risk factors also are associated with lower OHRQoL, including smoking, cocaine use and IV drug use.[9] Patients with a history of substance addiction and mental illness have reported experiencing stigma in the dental setting and stress and anxiety relating to dental treatments; patients reported more perceived stigma when they were negatively stereotyped, excluded from the decision-making process and felt powerless.[13] Conversely, patients reported positive experiences when their providers emphasized good communication, empathy and rapport building.[13] Dentists can reduce patient anxiety by involving patients in a shared decision-making process and may discourage patient drug use through motivational interviewing or harm reduction strategies.

Many older PLWH report experiencing both ageism and HIV-associated stigma.[14] Broadly speaking, older PLWH experience social discrimination, institutional discrimination and anticipatory stigma, with many of these patient reporting instances of rejection, stereotyping, violations of confidentiality and internalized ageism.[14] Understanding these, dentists can work to eliminate discrimination in the dental office and ensure that PLWH feel that they are in a safe, confidential environment.

Successful aging with HIV/AIDs requires resilience strategies and social and environmental support.[15] For older PLWH, there is a correlation between not working or volunteering and feelings of isolation, suggesting an opportunity for intervention for those without current employment.[16] Across all ages of PLWH, there is a high rate of reported unmet basic needs, relating to food, clothing or housing.[17] Studies have found that when basic needs are not met, more than one-third of HIV-positive people in the United States were unable to keep their medical appointments.[17] Dentists may play a crucial role in identifying patients who are lacking social support, basic needs or resiliency strategies and referring those patients to appropriate services, so that they might be able to thrive while aging with HIV/AIDs. Links to select educational and support service resources for the clinician and patient are provided in Table 1.

General Health Issues Affecting Older PLWH

PLWH commonly experience accelerated aging and comorbid conditions. The relative risk of general health conditions and related dental manifestations among PLWH, discussed below, is summarized in Table 2. Certain cART, such as zidovudine, didanosine and early protease inhibitors, can cause mitochondrial toxicity and other metabolic effects, such as insulin resistance, lipohypertrophy, lipoatrophy and dyslipidemia.[18] These metabolic effects contribute to chronic inflammation and hyperactivation of the coagulation system, leading to vascular and endothelial dysfunction.

The effects of ART (antiretroviral therapy) increase the risk of hypertension, venous thromboembolism, atherosclerosis and myocardial infarction.[19] Evidence suggests an association between periodontitis and cardiovascular disease.[20] While causality

has not been determined, research suggests that periodontal disease increases the risk of cardiovascular disease.[20] The effects of ART can also lead to an increased risk of insulin resistance and the occurrence of Type 2 diabetes mellitus.[21] Diabetes is associated with an increased risk of periodontal disease due to poor wound healing and increased susceptibility to infection. Diabetic patients with poor oral hygiene often have gingival inflammation, bone loss, deep periodontal pockets and periodontal abscesses.[22] Of the ART, protease inhibitors are most commonly associated with diabetes. Fortunately, the metabolic effects and hyperglycemia generally resolve once the protease inhibitors are discontinued.[21]

PLWH on ART are also more susceptible to chronic pain conditions. Myalgia and arthralgia are the most common symptoms, affecting 1% to 17% of PLWH.[23] Fibromyalgia syndrome (FMS) is a chronic pain syndrome that affects 20% of PWLH and is characterized by an increased pain response to non-painful stimuli. Patients may have chronic fatigue, difficulty concentrating, weakness and generalized pain.[23] Oral health providers should be aware that PLWH may also be at increased risk of temporomandibular joint disorders (TMD) because they are more susceptible to chronic musculoskeletal pain conditions. However, it has not been studied.

With a longer life expectancy, PLWH have a higher risk of osteoporosis, which is significantly expedited in women transitioning into menopause.[24] Premenopausal women are also at risk, although bone loss is more modest. Women with HIV have an estimated osteoporosis prevalence rate of 15% and a 58% higher fracture rate compared to the general population.[24,25] Accelerated bone loss has a multifactorial cause, including HIV, ART-related factors and traditional risk factors. Uncontrolled viremia can impact bone mineral density (BMD), mediated by effects of systemic inflammation on bone remodeling. HIV proteins increase osteoclastic activity and decrease bone formation by promoting osteoblast apoptosis. Inflammatory markers, such as tumor necrosis factor (TNF) and interleukin-6 (IL-6), also cause accelerated bone loss due to hyperactivation of osteoclasts.[26,27]

Certain ART, such as tenofovir disoproxil fumarate (TDF), are most closely associated with osteoporosis, although the cause is still unknown.[27] TDF may affect bone indirectly through proximal tubule toxicity, causing phosphate wasting and increased bone turnover.[27] The effects of TDF on BMD appear to be most significant during the first one to two years of therapy and eventually stabilize. A newer formulation of tenofovir, tenofovir alafenamide (TAF), has been shown to have less of an effect on bone loss. In several randomized trials of patients initiating therapy with either a TAF or TDF-containing regimen, those receiving TAF had smaller BMD decreases at the spine and hip at 48 weeks compared with TDF.[27] In subsequent trials, switching from a TDF regimen to a TAF regimen resulted in improved bone outcomes. Some data suggest protease inhibitors may have a negative effect on BMD, specifically, atazanvir and darunavir.[25]

Overall, bone loss is most accelerated during initiation of ART, with BMD decline of 2% to 6% during the first two years. Once a patient is on an established ART regimen, BMD seems to stabilize. This may be due to improvement of hormonal and nutritional factors with effective ART.[28] BMD scanning is recommended for all women aged 65 and older, postmenopausal women of any age, women transitioning to menopause with certain risk factors (including low BMI, prior osteoporotic fracture, use of glucocorticoids or current smokers), patients with fragility fractures, and all men aged 50 and older. Patients on ART are also recommended to supplement with calcium, vitamin D or bisphosphonates depending on their other comorbid conditions and baseline BMD score.[24,25]

Oral Health Issues Affecting Patients Living with HIV

Before cART, some of the most common oral problems for PLWH included xerostomia, oral candidiasis, oral hairy leukoplakia, herpes simplex virus (HSV) infections, human papillomavirus (HPV) infections, oral ulcers, oral Kaposi's sarcoma, salivary gland diseases, mucosal hyperpigmentation, gingivitis and periodontitis.[32,33,34]

A comprehensive review of oral health-related conditions among PLWH in the era of cART indicates that the prevalence of oral candidiasis, oral hairy leukoplakia and salivary gland diseases has, overall, decreased among PLWH since the widespread utilization of cART, while HIV-related oral ulcers, HSV and HPV infections, and Kaposi's sarcoma continue to be frequently reported.[35] It is important to note that the prevalence of many of the opportunistic oral infections among PLWH vary widely based on geography.[36] Developing countries with limited resources have reported no significant reduction of oral manifestation among their PLWH,[37] whereas developed countries with better access to cART have observed a change in epidemiology of HIV-associated oral conditions since 1992.[36]

Concerns regarding dental implant placements in PLWH have been raised, as PLWH may lack adequate means of healing after the dental implant is placed. A systematic review demonstrated that the immunocompromised condition of PLWH had negligible effect on the survival rate of dental implants, with 93.1% survival rate.[37] A recent study published a comparable success rate of dental implant treatment among PLWH to that observed in the control population in a 12-year follow-up period.[38]

Periodontal disease prevalence among PLWH has been frequently studied and debated with contradicting and inconclusive results. Recent studies have compared the prevalence of periodontitis in PLWH and healthy controls and found lower prevalence among PLWH (i.e., 16.4% in the former and 19.2% in the latter).[39,40] Similarly, no difference and complications were associated with dental extractions[42,43] and restorative procedures[40] among PLWH, suggesting the same sequence and standard of care when planning and rendering dental treatment for PLWH.

Although ART have reduced the overall prevalence of oral manifestation of HIV in the general population of PLWH, not

much is known about HIV-associated oral conditions that occur in the aging PLWH population.[32]

A recent study reported higher prevalence and severity of periodontitis in older PLWH who are male as compared to the age-matched controls.[44] This can be further explained by the observation that P. intermedia, one of the most potent periodontal pathogens associated with aggressive forms of periodontitis, is significantly more prevalent in older PLWH.[45] This finding suggests that periodontal disease in older PLWH can be attributed to the augmented bacterial burden in the oral cavity, coupled with altering patterns of microbiota composition. Dentists working with older PLWH should monitor their patients' periodontal health more frequently to prevent irreversible periodontal damage and initiate early therapy when the first signs of periodontal disease are observed.

The prevalence of chronic periodontal disease among older female PLWH has not yet been reported. Studies of periodontal disease progression among HIV seronegative postmenopausal women have shown that periodontal disease progresses more rapidly in women with a history of severe periodontitis or osteoporosis.[46] Since PLWH have a higher likelihood of developing osteoporosis, older women living with HIV/AIDS may experience accelerated alveolar bone resorption due to the decline of endogenous estrogen levels, which may affect dental implants.

Several studies have shown a weak association between skeletal BMD and mandibular alveolar bone.[29] In a recent cross-sectional study, it was determined that increased alveolar bone loss was due to external factors not related to HIV infection.[30] Another cross-sectional study concluded that there was no significant association between HIV, long-term use of ART and alveolar BMD. However, longitudinal studies should be performed in the future to monitor changes in the alveolar bone BMD.[31]

In addition, some studies have correlated an increased risk of human papillomavirus (HPV)-related oral and oropharyngeal cancers in PLWH with effective cART, possibly due to HIV-induced immunosuppression, aging and HIV/HPV synergistic effects.[47]

Conclusion

Dentists should understand these considerations when working with PLWH; monitoring alveolar bone status, in addition to probing depth and clinical attachment level, may be advised. Furthermore, dentists could engage in interprofessional collaboration to provide individualized and holistic care that fits the unique needs of the patient.

Queries about this article can be sent to Ms. Byington at era2125@cumc.columbia.edu.

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An Osteoma Embedding an Ectopic Wisdom Tooth within the Maxillary Sinus

A Rare Occurrence

Kayvan Fathimani, D.D.S., FACS, FAACS, FRCD(C), FIBCSOMS

ABSTRACT

Osteomas are frequently reported in the maxillofacial region, with much lower incidences in the maxillary and sphenoid sinuses. An unerupted third molar within the maxillary sinus coexisting with a maxillary sinus osteoma is an extremely rare pathologic finding. Such cases can be managed endoscopically or intraorally through a Caldwell-Luc approach. The following case report deals with a patient who presented with an uncommon pathological finding: an osteoma embedding an ectopic tooth within the maxillary sinus.

Osteomas are benign bony tumors consisting of mature cancellous and cortical bone.[1,2] They are found exclusively in the craniofacial and maxillofacial regions, most commonly in the paranasal sinuses and less commonly on the surfaces of bones such as the cranium and mandible.[3]

When found in the paranasal sinuses, the frontal and ethmoid sinuses are most commonly involved, with a 60% to 70% and 20% to 30% incidence, respectively.[4] On the other hand, osteomas involving the maxillary sinus occur less than 5% of the time, and diagnosis is usually made incidentally on radiographic findings, as most patients are asymptomatic.[4] Ectopic eruption of a third molar within the maxillary sinus co-existing with an osteoma is a rare occurrence.[2]

The following case report deals with a patient who presented with an uncommon pathological finding: an osteoma embedding an ectopic tooth within the maxillary sinus.

Case Report

A 24-year-old female presented to the Oral and Maxillofacial Surgery Clinic complaining of persistent pain, intraoral odor and rhinorrhea. She presented with no facial asymmetry and had no vestibular fullness. Mild tenderness was noted in the upper left maxilla, with mild intraoral purulence. She was otherwise healthy, with no underlying medical concerns.

The panoramic film showed a well-defined radiopacity in the maxillary sinus associated with an unerupted third molar (Figure 1). A cone beam computer tomography (CBCT) image showed an ectopically positioned wisdom tooth within the maxillary sinus surrounded peripherally by a radiopaque rim (Figures 2-5). The entire left maxillary sinus was fluid-filled, attributing to the patient developing sinusitis, rhinorrhea and foul intraoral odor. She

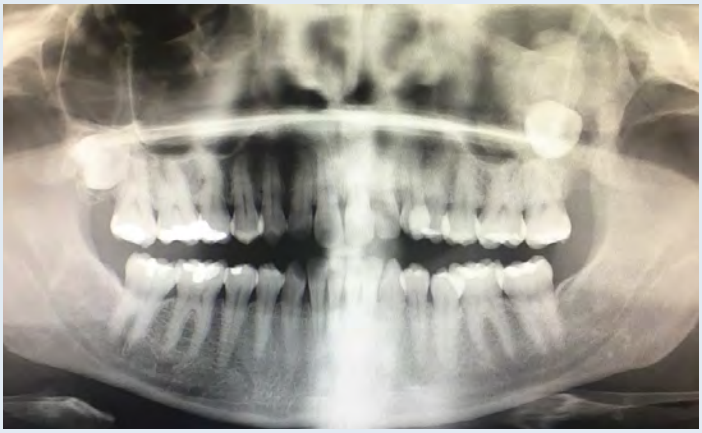

Figure 1. Panoramic image showing large radiopaque lesion within maxillary sinus associated with impacted wisdom tooth within maxillary sinus.

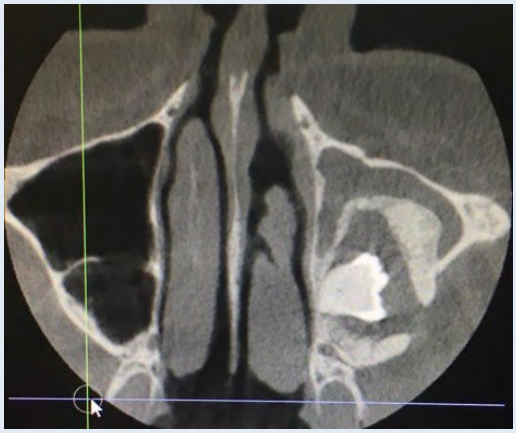

Figure 2. CBCT axial view: bony window showing centrally positioned wisdom tooth surrounded by radiopaque rim within maxillary sinus. Fluid level appreciated in maxillary sinus.

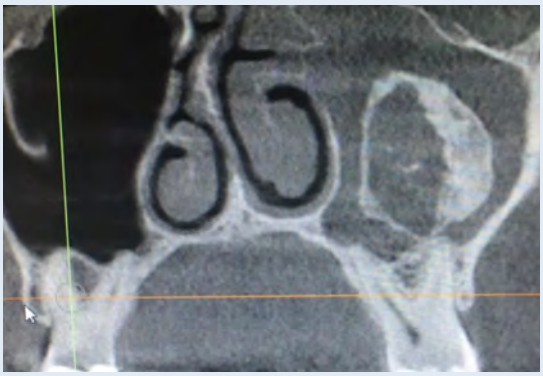

Figure 3. CBCT coronal view: bony window showing anterior extent of lesion.

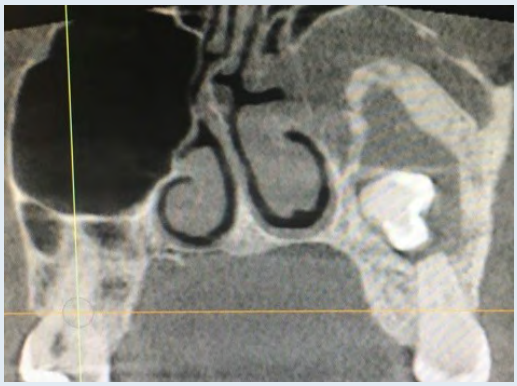

Figure 4. CBCT coronal view: bony window showing posterior extent of lesion.

was scheduled for an excisional biopsy, extraction of the wisdom tooth and sinus debridement under intravenous sedation (IVS). After consent was obtained, IVS was titrated to effect using 5 mg midazolam and 25 mg ketamine. Local anesthesia was infiltrated using 2% lidocaine 1:100,000 epinephrine. A Caldwell-Luc approach to the maxillary sinus was used to expose the maxillary sinus cortical wall. A buccal corticotomy in the posterior left maxilla was created to enter the maxillary sinus (Figure 6). Upon entry, discharge was evident, and the peripheral extent of the lesion was identified and curetted (Figure 7). The lesion was removed entirely in multiple pieces with the impacted wisdom tooth found embedded within the lesion (Figure 8). The specimen was sent in 10% formalin for histopathological analysis. The maxillary sinus was curetted, removing all debris and pathology. Copious irrigation of the sinus with 3g Unasyn and normal saline solution was performed. A close examination of the sinus noted no further pathology, and closure was completed with 3-0 chromic gut.

The patient tolerated the procedure well and was prescribed a seven-day course of antibiotic (Augmentin) and a decongestant (Sudafed), to be used as needed. At her two-week follow-up, she was asymptomatic and declared no further rhinorrhea or pain. The histopathology diagnosis was an osteoma of the maxillary sinus coexisting with an ectopically erupted third molar. Her recovery was uneventful, and she reported no further concerns. No recurrence was noted.

Discussion

Osteomas are benign fibro-osseous tumors. The most common benign fibro-osseous lesion is seen in the paranasal sinuses.[3,5] Although not uncommon in the paranasal sinuses, osteomas within the maxillary and sphenoid sinuses have a much lower incidence rate.[4] Males have a 2:1 predilection, with tumors occurring most commonly in the second and third decade of life.[4]

Multiple theories have been proposed to explain the pathogenesis. Infectious, traumatic and developmental are the most common theories.[2,4,6]

Upon a traumatic incident, a reactive process of osteogenesis occurs, activating bony growth.[2] Small osteomas routinely do not need to be removed; however, there are multiple instances where removal is required. Symptomatic patients refractory to conservative measures will benefit from surgery. Cases where the osteomas encompass more than 50% of the paranasal sinus volume require removal, since these osteomas may encroach on vital anatomical structures, such as the orbital bones, or block the ostiomeatal complex (OMC).[2,7]

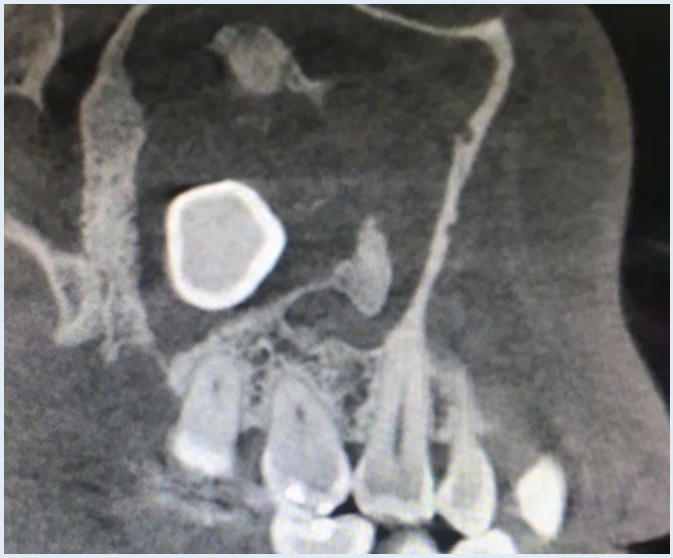

Figure 5. CBCT sagittal view: bony window showing extent of lesion, centrally positioned third molar, embedded by radiopaque rim, fluid-filled.

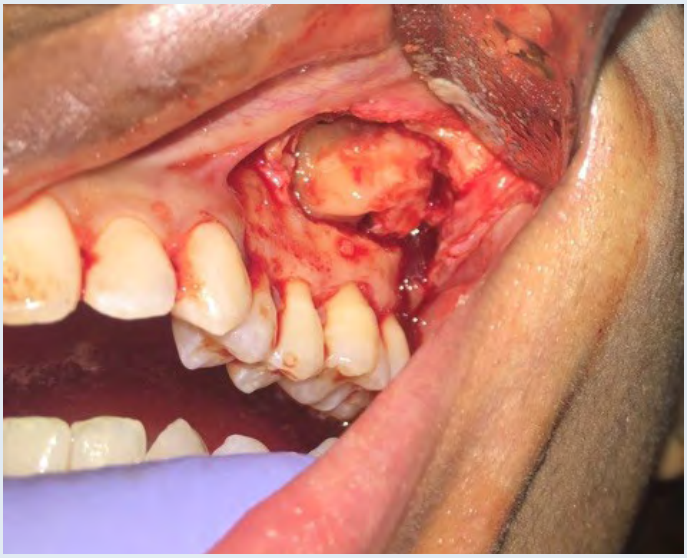

Figure 6. Initial entry into maxillary sinus through Caldwell-Luc approach. Peripheral extent of osteoma identified.

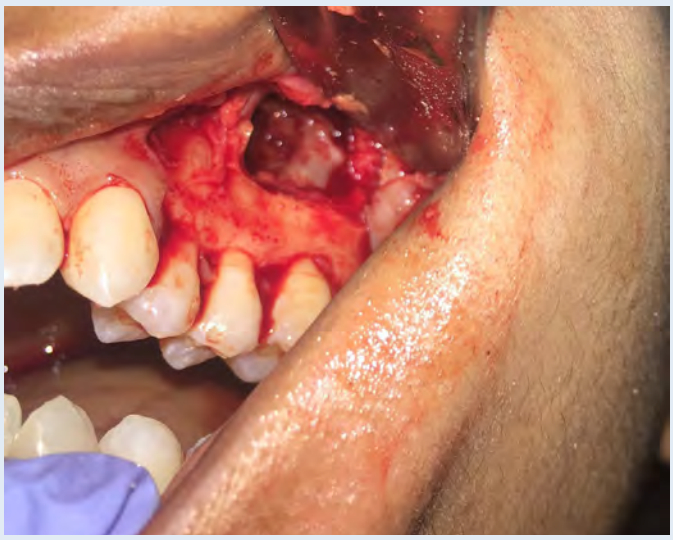

Figure 7. View of maxillary sinus following excision of peripheral portion of osteoma.

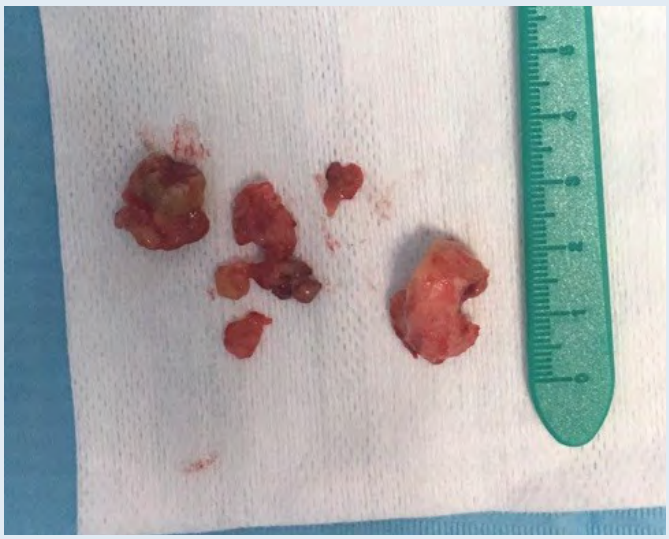

Figure 8. Excised contents of maxillary sinus with impacted wisdom tooth found embedded within.

The coexistence of an osteoma with an ectopically erupted tooth is uncommon.[2] Ectopic teeth occur more frequently in the dental arches than in nondental regions. Although uncommon, typical sites for ectopic tooth eruption in non-dentate regions include the maxillary sinus, nasal cavity and mandibular condyle.[2] Pathologic findings of cysts and benign tumors, or patients with syndromic anomalies and clefts, or traumatic patients, may have ectopically erupted teeth seen in these nondental areas.[2] CBCT is beneficial in localizing the impaction and assessing the extent of pathology.

In maxillary sinus cases, when an impacted tooth is close to the OMC, an endoscopic approach may be utilized to remove the tooth. Removal of osteomas through an endoscopic approach is primarily for frontal and ethmoidal osteomas. For osteomas involving the maxillary sinus, a Caldwell-Luc approach is commonly used to explore the sinus and remove any pathology.

Recurrence rates are rare, and no reports of malignancy have been reported.[5] Due to its benign and slow-growing features, local excision is all that is necessary.[3] Maxillary sinus osteomas are generally asymptomatic; however, patients may have pain, facial swelling, rhinorrhea, congestion, headaches, foul odor and discharge. Osteomas may block the OMC and although rare, even expand into the orbit, causing globe displacement and visual acuity changes.[1]

Radiographically, osteomas are mainly solitary, as in this case. In the presence of multiple osteomas, Gardner syndrome must be ruled out, as this is an autosomal dominant condition characterized by multiple osteomas, epidermal cysts, fibromas, impacted teeth and colorectal polyposis.[1] These patients are at a higher risk of colorectal cancer and will require further screening if multiple osteomas are present.

Conclusion

Osteomas of the maxillary sinus have a very low incidence rate and when coexisting with an ectopic tooth in the maxillary sinus, the pathologic entity is quite unique. Upon review of the literature, only one other study reported similar findings.[2] Patients with maxillary osteomas may exhibit no symptoms; however, surgery will be required in symptomatic patients and those with large osteomas. A Caldwell-Luc approach is commonly used to access the maxillary sinus, preventing worsening of symptoms or further expansion and disruption of the OMC or orbital floor.

The author has no conflict of interest to report. He has read and understands the Helsinki Declaration, agrees with its principles, and has no conflict with the declaration in investigations for compiling this article. He received no funding for this report. Queries about this article can be sent to Dr. Fathimani at kfathima@montefiore.org.

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Araujo Named Dean UB School of Dental Medicine

Marcelo Araujo

MARCELO W.B. ARAUJO, D.D.S., PH.D., an internationally recognized clinical researcher and epidemiologist who currently serves as chief science officer of the American Dental Association and chief executive officer of the ADA Science & Research Institute (ADASRI), has been appointed dean of the University at Buffalo School of Dental Medicine. The appointment is effective May 15.

Dr. Araujo succeeds Stefan Ruhl, PhD, who has served as interim dean of the School of Dental Medicine since December 2021. School officials, in announcing his appointment, noted that he has a broad knowledge and extensive experience in clinical research and medical and scientific affairs, as well as a strong commitment to improving oral health globally through research and public health policy.

Dr. Araujo joined the ADA in 2015 as vice president of its Science Institute and was named the ADASRI's chief science officer and chief executive officer in 2019. He has provided strategic leadership for the ADA's research enterprise, developing collaborative opportunities for the ADA's key scientific initiatives, increasing grant funding and enhancing the ADASRI's impact.

Dr. Araujo earned his Ph.D. in epidemiology and community health and a master's degree in oral sciences from UB, where he also completed a fellowship in periodontology research and teaching. He received his D.D.S. and a certificate in periodontology from Universidade Gama Filho in Rio de Janeiro, Brazil. He previously held faculty appointments in both UB's School of Dental Medicine and the School of Public Health and Health Professions.

Dr. Araujo is an active clinical researcher who has published extensively on impactful issues in dental medicine. He has more than 25 years of experience in clinical practice, academia, regulatory and medical affairs. His current work focuses on developing guidelines for antibiotic prescriptions for dentists and periodontists and is supported by the National Institutes of Health.

Dr. Araujo is a member and upcoming chair of the American Association for Dental, Oral, and Craniofacial Research's ethics in dental research committee, and he serves on the medical advisory board for the HPV Alliance.

In recognition of the strength and impact of his work, he received the International Association for Dental Research and American Association for Dental Research William J. Gies Award for clinical research, the International Distinguished Alumnus Award from the UB Alumni Association and is an honorary member of the American Academy of Periodontology.

Gum Inflammation Parallels Novel Cytokine Score

RESEARCHERS AT NYU College of Dentistry have developed a single score to describe the level of cytokines in the saliva, and this score is linked with the severity of clinical gum inflammation, according to a study published in the journal PLOS ONE.

While more research is needed to test the cytokine score, it could hold promise for measuring how well a patient responds to treatment for periodontal disease, predicting gum disease recurrence, or detecting ongoing inflammation related to systemic diseases.

"Periodontal inflammation is not just apparent upon examination, but is reflected in the patient's saliva," said Angela Kamer, D.M.D., M.S., Ph.D., associate professor of the Ashman Department of Periodontology & Implant Dentistry at NYU Dentistry and the study's senior author.

Periodontal disease results from the complex interaction between an imbalance of healthy and unhealthy bacteria under the gumline and the immune system's response. This response produces high levels of cytokines—small proteins that signal the immune system—in the inflamed gums, especially pro-inflammatory cytokines such as IL-8, IL-1β, IL-6 and TNFα.

Periodontal disease is also associated with systemic conditions, including cardiovascular disease, diabetes and Alzheimer's. Scientists believe that gum inflammation contributes to these conditions through both indirect pathways (cytokines boosting systemic inflammation) and direct pathways (cytokines traveling to a specific organ like the heart or brain), but studying this is difficult due to the challenge of measuring cytokines in the fluid found deep in the pockets in the gums.

Fortunately, cytokines are also found in the saliva, which is easier to collect. In the PLOS ONE study, the researchers wanted to know if clinically detected gum inflammation could predict the level of cytokines found in saliva.

"Salivary cytokines are a window into the molecular makeup of the oral environment," said Vera Tang, D.D.S., M.S., clinical assistant professor of the Ashman Department of Periodontology & Implant Dentistry at NYU Dentistry and the study's first author.

The researchers evaluated the gums and saliva of 67 adults, ages 45 and older, who had some degree of periodontal disease but were otherwise healthy. To measure their clinical periodontal inflammation, the researchers used a formula called the Periodontal Inflamed Surface Area (PISA), which is calculated using measurements of the depth of pockets in the gums and bleeding upon probing. PISA provides a single measure of periodontal inflammation; a higher PISA score indicates worse inflammation.

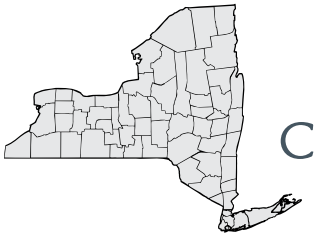
Participants were also asked to spit into sterile tubes to capture saliva samples, which were then analyzed to measure a range of both pro- and anti-inflammatory cytokines: IL-1β, IL-6, IL-8, IL-13, TNF-α, and IL-10. Led by statistician Malvin Janal, Ph.D., the researchers used two different ways (the Cytokine Component Index and Composite Inflammatory Index) to combine these cytokines into a single score.

They found that PISA scores were significantly associated with the new cytokine scores, independent of other factors, including age, gender, smoking and body mass index (BMI). The higher a cytokine score, the greater the periodontal inflammation.

"This demonstrates that a single score encompassing several salivary cytokines correlates with the severity of periodontal inflammation," said Leena Palomo, D.D.S., M.S.D., professor and chair of the Ashman Department of Periodontology & Implant Dentistry at NYU Dentistry, and a study coauthor.

The researchers caution that more research is needed to validate the cytokine score in patients with different health conditions, as well as those with all levels of periodontal disease, including healthy gums and early-stage gum disease. However, if the cytokine score is validated in larger and more diverse patient populations, it could be used to better understand periodontal disease progression and recurrence, as well as the potential connection to other systemic conditions.

Additional study authors include Babak Hamidi, D.D.S., M.P.H.; Cheryl Barber, M.S., M.P.H.; and Benjamin Godder, D.M.D., of NYU Dentistry. This research was funded by the National Institutes of Health (R03-DE023139).



Component NEWS

SUFFOLK COUNTY

Seminar Series Continues

Natalia Elson, D.D.S.

Great seminar on March 1 with Dr. Frank Tuminelli. Thank you, Henry Schein Dental, MLMIC, Neoss, The Smilist and the Keystone Dental Group for the support you provided to make it possible! Join us for other upcoming events . Visit https://www.suffolkdental.org/calendar for details.

New Dentists Hear from Experts

On the evening of March 6, our expert panel took questions from residents, new dentists, a few veteran dentists and dental students. We had lawyers (contract and malpractice), wealth managers, vendors and practice acquisition managers on hand to answer questions posed by those new and not so new to the dental profession.

Food and drink fed an engaged audience who kept the questions and answers flowing. Thank you Straumann, MLMIC, Bank of America Practice Solutions, TargetRock Wealth Management and the ADA for your sponsorship. And thank you Rivkin-Radler and Thomas Brown, CPE, for rounding out our panel.

Don't Miss a Thing

We continue to make a significant push to better communicate and connect with our members in methods that more easily integrate with their lifestyle. You can find us on Facebook, Twitter, Instagram, LinkedIn, and, even, Spotify, in addition to our traditional www.SuffolkDental.Org presence.

QUEENS COUNTY

Prabha Krishnan is Emil Lentchner Distinguished Service Award Winner

The Queens County Dental Society will present the Emil Lentchner Distinguished Service Award, the society's highest honor, to Dr. Prabha Krishnan on Saturday, Jan. 6, at its annual Installation of Officers Dinner Dance being held at Leonards Palazzo in Great Neck. Dr. Krishnan is being honored for her many years of service to the dental profession and organized dentistry.

Dr. Krishnan, QCDS President in 2009, currently serves as vice president of the New York State Dental Association. Over the years, she has filled many leadership roles in QCDS, NYSDA and the American Dental Association. While president of QCDS, she hosted the Women's Dentist Conference, an ADA Golden Apple Award winner. From 2015 to 2019, she served as NYSDA Trustee—the first woman to hold that position from Queens County—and previously served on the Diversity and Inclusion Committee of the ADA Board of Trustees. She now chairs the ADA Council on Communications.

Dr. Krishnan earned her Doctor of Dental Surgery Degree from New York University College of Dentistry in 1991. She completed a postgraduate program in periodontics in 1993 and has been in private practice in Forest Hills for over 30 years. She has been the attending and chief of periodontics in the Department of Dentistry at Flushing Hospital Medical Center since 1995 and previously held the position of associate clinical professor in the Department of Periodontics at NYU College of Dentistry.

Dr. Krishnan is a diplomate of the American Board of Periodontology and a fellow of the American College of Dentists, the International College of Dentists

Audience of dentists, many new to profession, turn to experts for practical advice at March panel presentation.

Prabha Krishnan

QUEENS COUNTY

and the Pierre Fauchard Academy. She is an alumna of the ADA Institute for Diversity in Leadership.

Also active in the Indian Dental Association, Dr. Krishnan has been on the IDA Board of Trustees for the past 11 years and has served as the organization's membership coordinator, continuing education coordinator and on its Executive Committee.

We are proud to bestow this honor on Dr. Krishnan in recognition of her many years of dedicated service to the dental profession.

EIGHTH DISTRICT

Practicing without Risk

Kevin J. Hanley, D.D.S.

On Thursday, March 30, the Eighth District held a continuing education course, "Reducing Dental Practice Risk," at the Creekside Banquet Center in Cheektowaga. It was presented by Fortress Insurance Co. and Dr. Michael Ragan, who provided strategies and resources to enhance patient safety and reduce risk in the dental practice. Topics included esthetic restorations, wisdom tooth extractions, oral cancer, endodontic treatment and implants. Risk management topics included documentation, communication, informed consent, technology, patient selection, referrals, prescription practices, patient noncompliance and ethics.

Attendees earned three hours of MCE and a 10% reduction in their malpractice premiums for three years.

Expanding your Practice

Salvatore's Italian Gardens was the venue for the Eighth District's all-day spring seminar on March 31. Dr. Gary Radz discussed "Creating a Cosmetic Practice Within Your General Practice." His presentation provided an overview of the many different procedures and materials for successful enhancement of a patient's appearance, from posterior direct composites to 10-unit porcelain veneers. It included a discussion of case selection, material choices, predictable techniques and pearls of information, allowing dentists to add more cosmetic services to their practice. Dr. Radz also discussed how he markets his practice to include 50% elective procedures, while maintaining a steady flow of new general dentistry patients.

Those in attendance earned seven MCE hours.

Safe Sedation

The Erie County Dental Society presented "Dental Anxiety: Clinical Challenges, Solutions, and Common Concern for the High-Fear Patient" on April 18 at The Eagle House in Williamsville. Dr. Naressa Singh, a board-certified anesthesiologist, outlined the proper medication for procedural sedation based on patient risks. She described the equipment, personnel, preparation and technique for sedation and reviewed potential complications and clinical significance of procedural sedation. She also explained interprofessional team strategies for improving care coordination and communication to advance sedation and improve outcomes.

Warding Off Infection

The Eighth District presented "Infection Control in Dentistry: A Practical Approach" April 27 at the Creekside Banquet Center in Buffalo. Dr. Alyssa Tzetzo, D.D.S., M.P.H., discussed dental office infection control and how it has evolved since the OSHA Bloodborne Pathogens Standard and the New York State training requirement were introduced in 1992. Practices have evolved since then and have incorporated advisories from federal, state and local agencies, including, most recently, COVID-19 directives.

Dr. Tzetzo's course examined conventional, as well as emerging, aspects of infection control. It fulfilled requirements for state-mandated and OSHA infection-control training.

Three MCE hours were awarded.

CPR Refresher

The Erie County Dental Society will present "Basic Life Support for Health Care Providers" on May 1 at the district office on Harlem Road in Cheektowaga. This course will fulfill the NYS requirement for CPR retraining. Participants will need to complete both written and skills tests. Four MCE hours will be awarded to participants.

FIFTH DISTRICT

Future Dental Hygiene Program

Janice Pliszczak, D.D.S., M.S., M.B.A.

Mohawk Valley Community College in Utica is in the process of getting its hygiene program approved. The college received approval from SUNY in February. It's now awaiting word from the State Education Department, which should take a minimum of nine months. At the same time, MVCC is working on the CODA application, which it hopes to submit soon. We are still hopeful that the program will begin in the fall of 2024.

Spring Meeting

The spring meeting will be held May 4-5 at the Hampton Inn & Suites in Cazenovia. There will be a meeting of the Board of Governors on Thursday evening, followed by a general membership meeting and lecture on Friday. Dr. Carla Cohn will be speaking on "What's New in Pediatric Dentistry for the General Practitioner: The Cutting Edge."

Central New York Dental Conference

The Central New York Dental Conference (CNYDC) will take place Thursday evening and all-day Friday, Sept. 21-22, at the On-Center in Syracuse. The state-mandated infection control course will be offered on Thursday, as well as the Fortress risk management course. Back by popular demand is Dr. Harold "Hal" Crossley speaking on "Everything You Want to Know About Street Drugs" on Friday, as well as a course on "Furcation Navigation with Ultrasonic Instrumentation."

Fall Meeting

The fall meeting will be held Nov. 16-17 at the Embassy Suites, Destiny USA, in Syracuse. There will be a meeting of the Board of Governors on Thursday evening, followed by a general membership meeting and lecture on Friday. Dr. Sam Shamardi will be speaking on "Establish Your Foundation: Surgical Extractions with Simultaneous Bone Grafting" and "No More Crowning Around: Mastering Crown Lengthening."

Fifth District *cont.*

More information on these and other courses being offered by the district can be found at 5dds.org.

SEVENTH DISTRICT

Steuben County Meets after Three-year Hiatus

Becky Herman, Executive Director

In-person events are in full swing this spring in the Seventh District. These include the first meeting of Steuben County members since January 2020. The meeting took place March 28 at the Three Birds Restaurant in Corning. It was a social event but also included a brief business meeting to discuss new leadership, events and activities for the year.

EDA Hosts Risk Management Seminar

The Empire Dental Administrators (EDA) hosted a three-hour risk management course on March 29 at Monroe Golf Club in Pittsford for over 75 attendees. This was the first time the event has been held in-person since 2019.

The speaker was Dr. Michael Ragan, a defense trial attorney in Miami, FL, with 25 years of experience. Dr. Ragan is an adjunct professor in the Department of Oral and Maxillofacial Surgery at Nova Southeastern College of Dental Medicine. He practiced clinical dentistry for 15 years and was on the Board of Directors of Fortress Insurance Co.

Careers Program Visits UB School of Dental Medicine

The Monroe County Dental Society's Careers in Dentistry Program traveled to the University at Buffalo School of Dental Medicine on March 31. Twenty-six students from area high schools and local universities, along with three district and MCDS Board members, met with UB dental students and faculty to learn about the dental program and tour the school.

The goal of the program is to encourage students to enter the field of dentistry. This was the third event it has held this year. Participants will meet back in Rochester at the District office in mid-April to hear from an oral surgeon.

MCDS Hears from UW Professor

The Monroe County Dental Society's Semi-Annual Meeting on April 28 addressed "Structural Adhesive Dental Restorations." Dr. Alireza Sadr, director of operative dentistry at UW, presented the topic at the meeting, held at the RIT Inn & Conference Center.

Learn How to Repair your Simple Equipment

The Seventh District has partnered with J&L Dental to offer a new program to members on May 3. Experts from J&L will teach dentists how to fix and maintain their small

High school and university students on tour of UB School of Dental Medicine, sponsored by Monroe County Dental Society to spark interest in the dental program and dentistry as career.

office equipment, saving them hundreds of dollars annually. The program is being offered at a private practice in Farmington, where attendees will rotate between three areas—utility, sterilization and operatory—and learn what can be fixed and when to call a professional.

Implant Presentation at Semi-Annual Meeting

The Seventh District Dental Society's Semi-Annual Meeting is scheduled for May 19 at Locust Hill Country Club. Dr. M.K. (Bobby) Baig, a certified prosthodontist and clinical associate professor at the Eastman Institute for Oral Health, University of Rochester, clinical instructor at Mt. Sinai Hospital and private practitioner in Toronto, Canada, will present on "Dental Implant Restorations: Prevention through Planning—the Fine-Line Between Success and Failure."

View all local and regional events at https://www.7dds.org/resources-faq-pages/events.

NEW YORK COUNTY

April Membership Meeting

Vera W.L. Tang, D.D.S.

The April 3rd General Membership Meeting featured a lecture by Dr. Ronald Kosinski, clinical director of the Oral Health Center for People with Disabilities at the NYU School of Dental Medicine. Dr. Kosinski's lecture focused on the need to improve the dental and medical care of the intellectually and developmentally disabled communities. He detailed specific steps general dentists can take to care for this population, emphasizing that time, patience and humanity were the keys to successful outcomes.

NYCDS was pleased to have NYSDA Executive Director Gregory Hill, New York State Dental Foundation Executive Director Stacy McIlduff and NYSDA President-Elect Anthony Cuomo attend the meeting. Dr. Cuomo shared his vision for organized dentistry in the coming year.

Become a Mentor or Mentee

The NYCDS Mentorship Committee is in the process of initiating a Mentorship Program for the benefit of all members, including residents, newer dentists and established dentists.

If you are interested in participating as a mentor or a mentee, you will find information about the program and instructions for joining on the NYCDS website www.nycdentalsociety.org. The committee will match mentors and mentees based on the information you provide. The time commitment and schedule are extremely flexible and up to each mentor/mentee to establish what will work best for them.

To facilitate the mentoring process, there will be a Mentorship Mixer on May 8 at 6:00 p.m. at NYCDS for all participants. We guarantee that whether you are a mentor or a mentee, you will find this to be a most rewarding endeavor.

Save the Date!

The 7th annual NYCDS Charity Golf Outing is going to be held at a new venue, the Metropolis Country Club (www.metropolislcc.org) in White Plains, on Sept. 27. The golf outing is always a great day to spend time with colleagues out of the office while supporting a worthwhile cause!

NYSDA Executive Director Greg Hill, far left, and New York State Dental Foundation Executive Director Stacy McIlduff are welcomed to April Membership Meeting by NYCDS Treasurer Egidio Farone and Membership Committee Chair David Shipper.

Vice President Vera W.L. Tang, left, and President Mina Kim with Dr. Ronald Kosinski, whose lecture at April meeting focused on improving treatment of disabled people.

New York County *cont.*

Continuing Education

The 2023 Spring/Summer CE program brings new courses and returning favorites. Highlights include the 12-hour sedation certificate renewal lecture on June 28-29, led by Marc M. Gottlieb, D.D.S.

We are also pleased to have a full-day pulp therapy and restorative hands-on lecture on Wednesday, June 14, led by Lance Kisby, D.M.D., FASDC, FAAPD, MAGD. This course will cover the latest pulp therapy techniques in primary teeth and the use of new dental restorative materials in pediatric dentistry. In the hands-on part of the course, attendees will: do a Biodentine pulpotomy on dentoform teeth; restore a dentoform tooth with a new composite material; and use the Garrison Matrix System.

Upcoming Courses

- Monday May 15: **"Ethical Considerations Regarding the Use of Social Media by Healthcare Professionals"**
- Thursday May 18: **OSHA-mandated update for dentists and staff**
- Wednesday June 7: **"Selected Topics in Contemporary Orthodontic Research"**
- Wednesday June 14: **Pulp therapy and restorative hands-on lecture**
- Wednesday June 21: **Basic life support/CPR certification (in-person)**
- Wednesday/Thursday June 28-29: **12-hour sedation certificate renewal**

Visit www.nycdental.org for the latest course and registration information.

SECOND DISTRICT

Past Presidents Dinner

Alyson Buchalter, D.M.D.

On March 30, 16 SDDS President Emeriti met at Gargiulo's Restaurant in Coney Island to honor each other, the men and women, who have served as president of the Second District. They welcomed our current president, Dr. Ray Flagiello, into the "club" with hard-learned words of wisdom. Discussions of how each of them became involved in organized dentistry, reminiscences of their predecessors and mentors, as well as highlights of their presidential years evolved into levity and laughter.

The camaraderie of the group was obvious with one major thing they had in common—a deep commitment to our members and dentistry.

Lobby Day

Each year members of the ADA and ASDA travel to Washington, DC, where they descend on the Capitol to advocate for issues important to our members. At the ADA's Dentist and Dental Student Lobby Day in March, nearly all members of Congress received a visit from us to explain why the issues we are promoting are important, not just to dentists and dental students, but to the public as well.

This year, Drs. John Demas and Alyson Buchalter were proud to represent the SDDS as part of the NYSDA contingent. They praised the way the ADA primed lobby day participants to feel knowledgeable and prepared for their visits to the Hill. Both were among the group of NYSDA members who met with the staff of New York State Senator Kirsten Gillibrand. Dr. Demas also met with representatives Grace Meng, Gregory Meeks, Adriano Espailla and Hakeem Jeffries or their staff, while Dr. Buchalter met with representatives Adriano Espaillat, Hakeem Jeffries, Nicole Malliotakis and Marcus Molinaro or their staff.

Drs. Demas and Buchalter voiced strong support for the value of the Lobby Day experience, saying they found it per-

Past and present meet at Past Presidents Dinner in March. Past President Paul Albicocco, left, and current president, Raymond Flagiello.

SDDS President Emeriti reconnect over dinner. They are, from left, Alyson Buchalter, Michael Donato, Sari Rosenwein, Craig Ratner, Richard Oshrain, James Sconzo, John Halikias, current President Raymond Flagiello, Paul Albicocco, Stuart Segelnick, Howard Lieb, Reneida Reyes, Mitchell Mindlin, Steven Gounardes, Lauro Medrano-Saldana, Babak Bina.

sonally rewarding and well worth the time spent. They recommended anyone who has the opportunity to go, do so.

Dr. Paul Teplitsky

The SDDS congratulates our own Dr. Paul Teplitsky on his nomination to serve as chair of the NYSDA Council on Ethics. He continues the SDDS's proud tradition of high-level service to our organization at all levels of the tripartite.

Dr. Irving E. Gruber Memorial Lecture

Each year, the Second District presents a premier seminar program in honor and memory of Dr. Irving Gruber. This year's program was no exception. On March 10, Dr. Paul Covello, program director, oral and maxillofacial surgery, Geisinger Health and assistant professor, Geisinger Commonwealth School of Medicine, presented "Obstructive Sleep Apnea: A Comprehensive Review and Management Strategies." Attendees were impressed with the breadth and depth of information presented.

Dr. Gruber has a long history of service with the SDDS. His many roles included SDDS President, General Chair of the GNYDM and Executive Director of the GNYDM.

Past presidents Alyson Buchalter, Sari Rosenwein, Reneida Reyes. Dr. Reyes was first SDDS female leader.

SECOND DISTRICT

John Demas and Alyson Buchalter head to Capitol Hill to plead dentistry's case before their representatives on ADA Dentist and Dental Student Lobby Day.

NINTH DISTRICT

The Beat Goes On

Olga Lombo-Sguerra, D.D.S.

Busy, busy, busy. What follows is a roundup of events past and coming in the Ninth District.

- The General Meeting on March 15 was a huge success despite occurring the day after the biggest snowstorm of the year. The presentation by Dr. Al Shetawi was roundly praised.
- The Ninth sponsored a Give Kids A Smile event on April 20 and looks forward to another on May 11. At the April event, member volunteers were assisted by D3 and D4 dental students at the Touro Dental Clinic in providing dental education and screenings to over 300 children. In May, we will welcome a new Head Start venue to the program established by B'Above Worldwide Institute, at which we expect to see about 25 children.
- March was an active month. In addition to convening the General Meeting, we joined in the celebration of Signing Day at Touro on the 21st and hosted our first Shredding Day on the 25th. It was a successful signing day, with a number of students signing on to become ADA members. We look forward to having them join their local components as they settle into the profession. The Shredding Day, which provided members with a HIPAA-compliant records disposal, was so well-received, we will be adding this event at least once to our annual schedule.
- Our spring General Meeting will be held on Wednesday, May 10, at the Sleepy Hollow Hotel in Tarrytown. Dr. Elias Chatah will present "Pain Management, Diabetic Management, Drug Interactions and Cannabis/THC and Patient Interactions," a timely presentation in

Ninth District *cont.*

light of the new MATE Act. The Ninth is excited about having NYSDA Executive Director Greg Hill and Stacy McIlduff, the new executive director of the New York State Dental Foundation, join as our guests. We will also be honoring Susan Seigel, former town supervisor, with the Richard G. Spolzino Access to Care Humanitarian Award for her unwavering efforts in the quest to get fluoride back into the water in Yorktown Heights.

- On May 17, the Ninth will host its annual social event celebrating Frills & Drills. This is an all-inclusive event, providing a beautiful setting for colleagues to meet, mingle and share thoughts and ideas while benefitting from the presence of special vendors specific to this event.
- On Friday, June 30, the New Dentist Committee will host a social and information outing at the Sonesta Hotel in White Plains that will include a panel discussion of the topic "Running a Practice." We're looking forward to providing this added benefit to the newest members of the profession, as well as to our more established members.
- The spring evening CE lineup is underway. It included the first in-person course held at the Ninth's headquarters since 2019. We will continue to offer both in-person and Zoom courses—providing our members with the information they need in the format most comfortable for them.

President Daniel Doyle invites members to dispose of office records securely and legally at association's first-ever Shredding Day.

NYSDA Executive Director Greg Hill addresses dental students participating in Signing Day activities at Touro College of Dental Medicine.

FOURTH DISTRICT

Installation Dinner

Jennifer Kluth, D.M.D.

With the start of a new year, the Fourth District ushered in new officers. On Jan. 7 at Prime at Saratoga National, Dr. Kirk Gleason graciously installed the 2023 executive officers. This year's reception was a slight change in format from a formal dinner, and was enjoyed by the past presidents and attendees. We extend our gratitude to Immediate Past President Dr. Robert Berls and welcome current President Dr. Christina Cocozzo.

Joining Dr. Cocozzo are, President-elect John Milza, Vice President Jennifer Kluth, Secretary Edward Wun and Treasurer Rachel Hargraves.

Schenectady Branch Meets

The Schenectady branch of the Fourth District met March 22 at The Turf Tavern in Scotia. Members from Schenectady, Schoharie and Fulton/Hamilton/Montgomery counties were all welcomed back to an evening of learning and fellowship after a long COVID break.

Mark Heiman from Henry Schein spoke to the group of nearly 30 dentists about dental technology. From scanning and CBCT to 3D printing, it is a changing industry with many exciting advancements on the horizon, Mr. Heiman said.

Oral Cancer Screening

With support from NYSDA, the Fourth District came to play at the annual Glens

Christina Cocozzo and husband, William Moore, celebrate Dr. Cocozzo's installation as Fourth District President.

Enjoying reception to introduce and honor society's new officers are, from left, May Hwang, H. John Schutze, Fred Wetzel.

FOURTH DISTRICT

On hand for first in-person meeting of Fourth District Schenectady Branch after long COVID break are, from left, Drs. Chung, Howe, Michalik, Khattak, Ms. Alecia Morgan, Dr. Markose.

Falls Hospital "Stick It To Cancer" weekend at the ADK Thunder hockey games March 24 and 25. Stick It To Cancer is a weekend dedicated to early detection, proper care and honoring those fighting the hard cancer battle. The Fourth District had a dozen volunteer doctors on hand, who screened over 100 hockey fans.

BRONX COUNTY

More than a Father. An Inspiration

Laurence Schimmel, D.D.S.

As many of you know, I've been writing these component reports for over a decade. Each time they are due, I have a moment of stress about what I'm going to write that is interesting and provides value. Preparing this particular report was very different. It was both the easiest and hardest one to write at the same time. Difficult, because I'm going to talk about my father, Dr. Sanford Schimmel, who recently passed away, unexpectantly. And easy for the very same reason.

My father, Sandy, as he was known to his friends and family, was not only my parent but my mentor, business partner and hero. I would not be the man I am today, with the profession I've chosen, if it were not for him.

For as long as I can remember, organized dentistry was a part of my dad's life and something he enjoyed being a part of. He practiced for over 40 years in the small area of Riverdale, Bronx, where my family has lived since before I was born. It was not uncommon for us to run into his patients while out and about, or for my sisters and me to visit his practice and see him at work. Growing up, I would hear stories from others whose parents disliked their jobs or couldn't wait for the time off. That was not my dad. He was wired (no pun intended) to work and loved doing it. In fact, he was still seeing patients six weeks before he passed.

Dentistry also afforded my father the opportunity to fulfill his sense of service. He was a past president of the Bronx County Dental Society; an attending at Montefiore Hospital Orthodontics Program; and he was a dentist in the Army. As I reflect on

Bronx County *cont.*

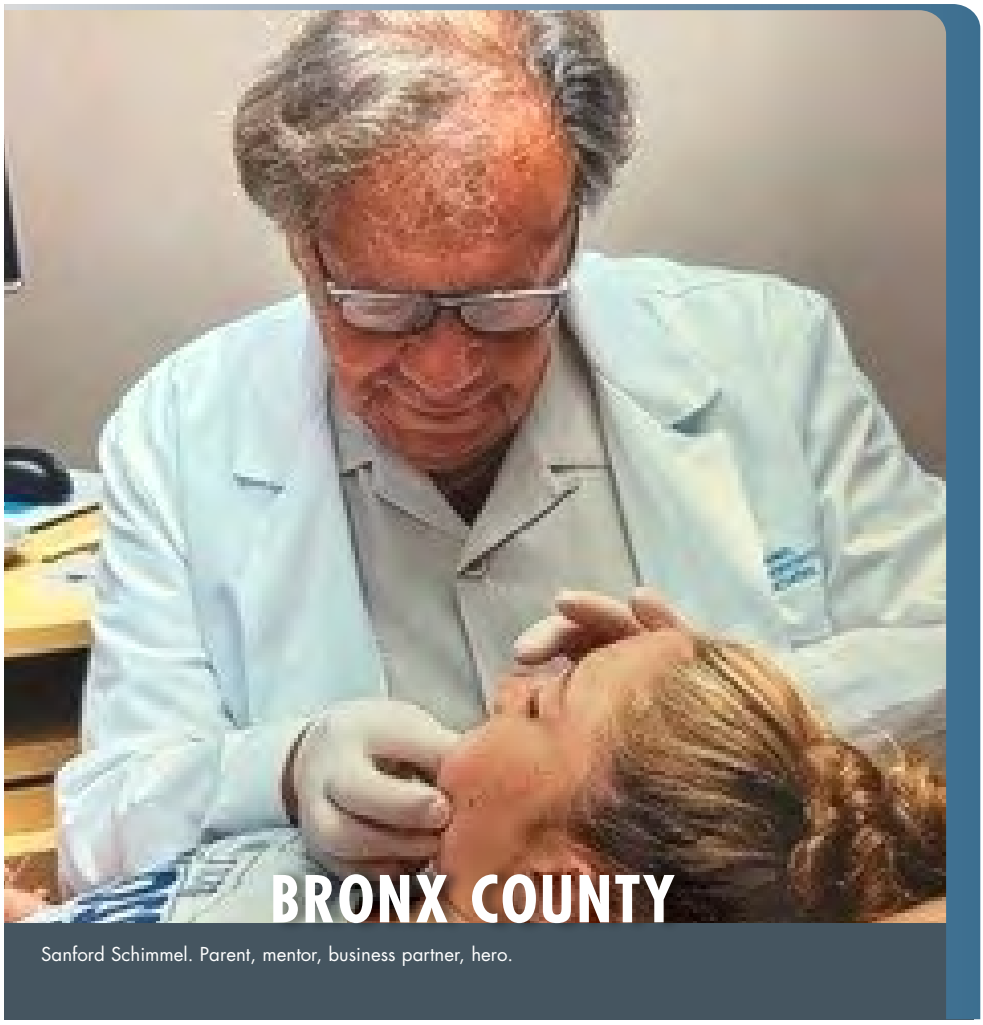
this aspect of his life, it reminds me that one's profession can also be one's passion and purpose.

While sitting Shiva with my family, I was struck by how many local dentists stopped by the house and reached out. Each had a story to tell about my dad that commonly centered around their lunches together. For years, many of the local dentists would meet for lunch once a week to talk about everything from business to family and politics. These were not only referring dentists. In some cases, they were direct competitors. Through their stories and memories of my dad, I felt the sense of community that existed among them and the connection that was greater than just dentistry. I think part of this comradery was certainly based on the people themselves, but it was also a different time in our profession. These days there are fewer single practitioners, and we must work harder for that kind of connection outside of our annual conferences, CME or social media. These stories were a good reminder to us to stay connected both as practitioners and people. And sometimes all it takes is lunch.

The stories his colleagues and patients shared also reinforced one of the biggest lessons I learned from working alongside my dad for 15 years—that we treat more than just a malocclusion; we treat a person. My father responded to everyone with respect, compassion and an open ear. He had this calming effect that put patients at ease and let them know he was listening and cared. I can't tell you how often throughout the years—not just at his passing—people have been compelled to tell me what a great guy my father is. That is the legacy I aspire to leave.

As I'm sure you can imagine, the first day I went back to work after his passing was extremely difficult. He built our practice, and his indelible mark is everywhere. I am driven to honor his memory by serving my patients in a way that would make him proud, and it is my hope that this report inspires you to do the same.

I would be remiss if I didn't thank the Bronx County Dental Society and local dentists for their well wishes and support. We truly felt it. Thank you. And for my next component report, it's back to my regularly scheduled content.



Sanford Schimmel. Parent, mentor, business partner, hero.

Read, Learn and Earn

Readers of *The New York State Dental Journal* are invited to earn three (3) home study credits, approved by the New York State Dental Foundation, by properly answering 30 True or False questions, all of which are based on articles that appear in this issue.

To complete the questionnaire, log onto the site provided below. All of those who achieve a passing grade of at least 70% will receive verification of completion. Credits will automatically be added to the CE Registry for NYSDA members.

For a complete listing of online lectures and home study CE courses sponsored by the New York State Dental Foundation, visit www.nysdentalfoundation.org/course-catalog.html.

Click below

ONLINE CE QUIZ

A Dentist's Role in the Delivery of Culturally Competent Oral Healthcare to Transgender Patients—Page 16-21

1. All healthcare professionals need to be aware of and be able to address barriers to healthcare that are commonly experienced by marginalized populations.
   ❑ T or ❑ F

Visit our online portal for more....

Oral Health Considerations for Aging Patients Living with HIV/AIDS—Page 22-27

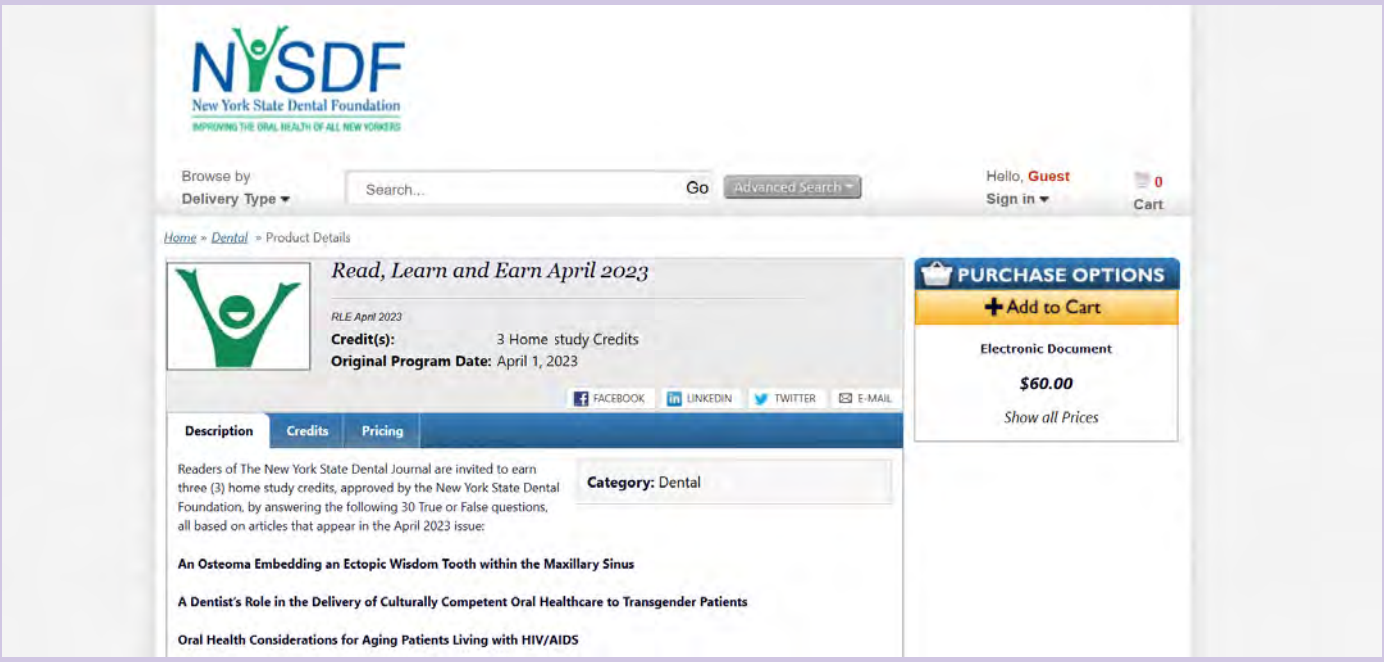
1. People living with HIV/AIDS (PLWH) have an increased life expectancy due to antiretroviral therapy.
   ❑ T or ❑ F

Visit our online portal for more....

An Osteoma Embedding an Ectopic Wisdom Tooth within the Maxillary Sinus—Page 28-31

1. Osteomas are benign bony tumors.
   ❑ T or ❑ F

Visit our online portal for more....



CLASSIFIED INFORMATION

Online Rates for 60-day posting of 150 words or less — can include photos/images online: Members: $200. Non-Members: $300. Corporate/Business Ads: $400. Classifieds will also appear in print during months when Journal is mailed: Jan, March and July.

FOR SALE

ADIRONDACK PARK: Tupper Lake. Nice brick building for sale includes dental equipment and supplies. Running 2 operatories, with room for another. Tupper Lake is located in beautiful Adirondack Park. Price under $200K for all. Contact owner: tlswilso@gmail.com.

NEW YORK CITY: Two-location practice for sale Williamsburg, Brooklyn, and Long Island City, Queens. Modern offices; recently renovated. 4 ops and 5 ops, respectively. 2022 gross revenue–$2.2M. Looking for sale to private practitioner for transition. Not interested in sale to DSO. Contact ianlmapes@gmail.com for further info.

LOWER WESTCHESTER: 2-office general practice for sale; can purchase each individually. Total gross $450-$500K with 30-hour workweek and 12 weeks vacation for last 3 years. Larchmont location: 2 ops and room for third; 800-square-foot condo available for rent or purchase. Bronxville Location: 3 ops, 1,200 square feet and room for 4th op. Both practices FFS and PPO; no HMO. All endo, oral surgery, perio and ortho referred out. Each office has about 1,000 active patients, and both can easily be expanded to full time. Will stay on to help with transition. Contact: esr77@optonline.net.

WATERTOWN: General dental practice for sale. Grossing approximately $1.1M. Located north of Syracuse in Watertown, close to Thousand Islands. Practice has 9 operatories with digital X-ray, CBCT, 3D printing and CEREC. Real estate also available. For more information, please contact Sean Hudson by phone: (585) 690-6858; or email: sean@hudsontransitions.com.

CENTRAL WESTCHESTER COUNTY: Established general practice for sale within co-op apartment of 950 square feet; both practice and real estate for sale. Ground-level facing major road with street parking. Growing city with thousands of new apartments under construction; near RR and major roads. Two ops with room for possible third. Mostly FFS with limited insurance. Gross $445K with high net. Apartment has kitchen and bathroom and zoned legal to live in. Asking 80% of net and $265K for apartment. Inquiries to mollync2022@gmail.com.

ROME: Single-family home for sale with 4-op dental practice. Panorex room and three ops have X-ray. Purchase building and equipment for $150K; zero cost for practice. 2022 collections of $140K working 1 day/week for 40 days. Inquiries to: ericrachadds@gmail.com; or call (315) 794-0527.

BRONX: Architecturally designed beautiful dental office for sale. Well set up and very high potential in heavily populated area of working-class community. Call (718) 379-4800; leave message.

BROOKLYN: State-of-the-art dental office for sale. Fantastic, rare opportunity. Fully equipped, well-established, family practice with 3 ops, private office, reception area and large waiting room. Prime, ground-floor, street-access location in heart of Brooklyn (Park Slope/Kensington). Long-time building tenant with amendable property management. Contact for details: (516) 859-1463; or email: izdds@aol.com.

CAPITAL DISTRICT: Located on main road with ample onsite parking. Thoroughly modern, with Dentrix software, 3 Shape Trios scanner, digital X-rays with Scan X. Open three days/week. Great for satellite practice or to grow. Four-chair office: two hygiene and two fully equipped ops for dentist. Post-COVID headed toward $600K gross. Busy hygiene schedule. Building can be part of package deal. Contact by email: drdave329@gmail.com; or (518) 428-1492.

ROCHESTER: Great opportunity near hospital. Four large ops. Great patient base and 6.5 days of hygiene. Refers out all endo, oral surgery, perio, ortho and implants. Revenue average $450K. One doctor will stay on for transition if needed. Located in busy medical park. Participation in insurance is 80%, with some state insurance. Reasonably priced. Utilizing Softdent. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3080.

BROOME COUNTY: Great opportunity to practice in small community. A "steal" at $250K for practice and $100K for building with two rental apartments and large parking lot with land to add on. Revenue $645K on 4-day workweek. Exceptional practice with committed staff, wonderful equipment, new pan, big windows in each of six 6 operatories. 2,000 loyal active patients and mix of 65% insurance and 35% FFS. Refers out all endo, implants and perio. For details contact Dental Practice Transition Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3137.

ALBANY COUNTY: Bethlehem. Growing community close to downtown Albany on bus line; near major highways leading to NYC. Modern-feel office with four ops, Dentrix Ascend, Dexis, pan, Diode laser and more. Two full-time hygienists, along with valued team working 4-days/week with systems in place and excellent collection policies. No HMOs or State insurance. Excellent opportunity for any dental entrepreneur. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com or call: (315) 430-0643. #NY2712.

SYRACUSE SUBURBS: General practice conveniently located off main road in Liverpool. Open 2.5 days/week with 4 days of hygiene. Healthy patient base with 50% commercial insurance, 20% self-pay and 30% State insurance. Located in small medical building with 4 ops in second-floor rental space and plenty of parking. Grossing $608K, with room to grow with help of longstanding staff. For details contact Henry Schein Dental Practice Transitions Consultant Donna Bambrick at (315) 430-0643; or email: donna.bambrick@henryschein.com. #NY291.

TOMPKINS COUNTY: Well-established, high-quality general practice available to transition to new owner, or seller can stay as part of team. Located in Ithaca suburb, this beautiful standalone, 15-year-old building of 2,544 square feet has five ops, digital X-rays, utilizes Eaglesoft software and is completely paperless. Revenue over $700K. One FT and one PT Hygienist. Real estate also for sale. Growing patient base; practice draws increasing number of new patients with strong mixture of FFS. Great opportunity with doctor willing to stay on as part-time associate. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3071.

ORANGE COUNTY: GP office currently staffed by full-time veteran associate. Minutes from main highway and features 5 ops, 2,000 square feet utilizing Dentrix software, intraoral camera and imaging system. Grossing $630K. 80% PPO insurances and 20% FFS. For information contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3088.

NASSAU COUNTY: Well-established pediatric/ortho practice established 24 years. Six treatment rooms and space to add 3 more. 50% FFS and 50% PPO. Fully digital using pan, digital X-rays and iTero scanner. For details contact Dental Practice Transition Consultant Chris Regnier by email: chris.regnier@henryschein.com; or call (631) 766-4501. #NY3138.

FINGER LAKES REGION: Well-established GP family practice with highly motivated seller. Located in standalone 1,350-square-foot building with 5 ops and space to add on. Building available for sale with practice purchase. Full staff, including 2 doctors, each working 2 days/week and referring out most specialty procedures. 5,500 active patients (<2 years) with healthy new patient flow. Hygiene booked out. Beautiful high-visibility area with top school district. Doctor will stay for transition if necessary. Gross collections just under $700K. For details contact Dental Practice Transition Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call: (315) 430-0643. #NY3147.

WHEATFIELD: Niagara County general practice. Profitable, updated, digital practice with mix of 70% PPO and 30% FFS. Three great ops with plenty of room to add fourth. Set in 1,600-square-foot modern building with abundance of off-street parking. Refers out endo, implants, ortho, perio and some oral surgery, which offers great opportunity and upside for new owner. For details contact Dental Practice Transitions Consultant Brian Whalen at (716) 913-2632; or email: Brian.Whalen@henryschein.com. #NY3166.

SYRACUSE: Four-location GP with removable prosthetics lab in one location that takes care of all locations and outside practices. One can be purchased or all four. Practices have 1 or 2 providers with hygienist and supporting staff in leased spaces. Practices are on Dentrix Ascend with digital equipment. Handicap accessible; plenty of parking. Revenues range from $600K to $1.5M+ with mix of PPO/FFS. Great opportunity. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3175.

UPSTATE: Nestled in great family village community. Make offer for well-established Central New York general family practice close to main highways. Located near one of Top 100 Ranked Golf Courses by GolfWeek. 2021 gross collections $544K. Standalone 1,800-square-foot building for sale with practice purchase. Great curb appeal with large parking lot. 3 treatment rooms and space to add on. Refers out specialties. Practice utilizes DEXIS digital X-ray, digital panoramic X-ray, brand new patient chairs. High-profit margins. Healthy new patient flow. Contact Dental Practice Transition Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3235

BROOKLYN: Highly desirable, fully digital office with 3 ops in 1,400 square feet. Features digital Sirona panographic X-ray, intraoral camera, laser and Dentrix practice management software. Real estate also for sale and includes upstairs rental property with monthly income. Seller will also consider buyer-friendly lease. 22 hours/week and features 60% FFS and 40% out-of-network providers. Seller available to stay as needed. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3238

NORTH SYRACUSE: General practice in great location. Main road location with 4 ops in leased space of wonderful, small medical building with plenty of parking. MacPractice Software. All digital with great staff. Doctor will stay for one or two days per week. Takes some insurances; excellent potential for growth adding more days. Great patients surrounded by great neighborhoods. Revenue $325K. For details contact Dental Practice Transitions Consultant Donna Bambrick by email: donna.bambrick@henryschein.com; or call (315) 430-0643. #NY3246

ORANGE COUNTY: Served dental needs of continually expanding area and surrounding communities for past 30 years. Located in 1,500-square-foot office building with mixed tenants. 4 fully equipped ops featuring contemporary, up-to-date equipment, including intraoral camera, imaging scanner, Picasso laser unit and Dentrix & Dexis. Skilled and caring team of experienced and very personable dental professionals. Diagnostic, preventive- and restorative-driven practice with strong hygiene program. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3257

WESTCHESTER: Prosthodontist soon retiring and prepared to sell his 50% interest. Looking for buyer who can step in and maintain ongoing dual-office growth. Both offices sit in professional buildings with privately owned condos in great areas of county. Offices each have 5 ops inside 4,100 and 2,850 square feet, respectively. Both locations upgrading and expanding, allowing revenue and procedure growth. Real estate for sale as part of buy-in or favorable lease will be provided. Seller will stay on as needed. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3283

ROCHESTER: Family general practice in beautiful suburb with 2021 revenue of $255K+ and growth potential. Seller highly motivated. 1,400-square-foot space with affordable lease, great curb appeal and ample parking. 3 ops with potential 4th plumbed op. Single doctor practice utilizes digital pano X-ray and Denoptix phosphor plates. Contact Dental Practice Transition Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3291.

BROOKLYN: Orthodontic practice in prime location. Four treatment rooms, 100% FFS practice with 940 square feet in professional building. Doctor in practice 22 years. Equipped with digital sensors and pan/ceph. Tremendous room for growth for doctor willing to work more than 1 day/week. For more information contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3325.

KINGSTON: 3 ops with Carestream software, digital sensors, digital scanner, CEREC mill and pan/ceph with phosphor plates. Doctor refers out most endo, all implant placements and perio. Great staff, including one highly trained in Sleep Study. Building on large lot also for sale. Rental apartments in building bring in extra income. For more information contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3327.

ERIE COUNTY: Great practice with 3 treatment rooms. All digital, with collections of $413K. For details contact Dental Practice Transitions Consultant Brian Whalen at (716) 913-2632; or email: brian.whalen@henryschein.com. #NY3366.

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QUEENS: Nassau County border. Terrific family-oriented practice for sale. Highly desirable neighborhood of Floral Park, Queens. Located in freestanding building with 1,250 square feet. 3 fully equipped treatment rooms with digital X-rays and utilizing Easy Dental software. Building handicap accessible and offers easy street parking. Diagnostic, preventive and restorative practice, with strong hygiene program. Seller owns building and will provide buyer-friendly lease. Contact Dental Practice Transitions Consultant Mike Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY3370.

ERIE COUNTY: Located on busy road surrounded by established residential population and beautiful town. 3-operatory digital practice, well-positioned for future growth with $307K gross revenue. Crown & bridge, restorative and preventative focus. Some specialties referred out. Strong patient base and mixed PPO. Real estate next to practice owned by the seller and for sale with practice. To discuss details, contact Dental Practice Transitions Consultant Brian Whalen at (716) 913-2632; or email: brian.whalen@henryschein.com. #NY1648

SUFFOLK COUNTY: Mature private general practice at desirable, suburban, downtown village location. Open 26-30 hours/week. 3 operatories in 1,000 square feet. Selling dentist referring out all specialty services. For details contact Dental Practice Transitions Consultant Michael Apalucci at (718) 213-9386; or email: michael.apalucci@henryschein.com. #NY280

JEFFERSON COUNTY: Great opportunity. Long-established, profitable practice is a must-see. Located minutes from downtown Watertown. Well-equipped 4-operatory practice sits on busy road with great curbside appeal. Large private parking lot. Practice fully digital with pano X-ray and utilizes Eaglesoft. Revenue $730K with one FT Hygienist. Doctor only works 3 days per week (20 hours max). Seller refers out all endo, ortho and oral surgery. Practice positioned for growth. Primarily FFS with 2,000 active patients. 2-story building also for sale with vacant apartments upstairs. Contact Dental Practice Transitions Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3385

NASSAU COUNTY: Fee-for-service dental practice. 5 fully equipped treatment rooms and approximately 2,100 square feet. 95% FFS and 5% PPO insurances. Generates all revenue in only two days/week. Practice equipped with Dentrix software, ADec dental chairs and digital pan and sensors. For more information contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3392

ONTARIO COUNTY: Long-established, highly productive practice with 2022 revenue of $1.4M. Nestled in backdrop of beautiful Finger Lakes wine-making country. Fully computerized, fully digital office with 7 well-equipped treatment rooms. Utilizes Dentrix Ascend PMS; Planmeca CBCT and digital impressioning systems added in recent years. 3,500 active patients and combination of insurance and FFS. Strong hygiene program. Well-trained team available for transition. For more contact Dental Practice Transitions Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3395

NASSAU COUNTY: FFS general practice with 3 ops and 4th op plumbed. Doctor practicing 41 years and looking to retire. Located in 1,051-square-foot professional building with plenty of parking. All endo, implants and oral surgery referred, creating room for growth. For more information contact Dental Practice Transitions Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschien.com. #NY3396

ONONDAGA COUNTY: Great family general practice located in desirable suburb minutes from downtown Syracuse. Less than 5 miles from approved site of new major semi-conductor plant, which will bring thousands of jobs. Seller motivated to sell immediately. Located on busy 4-lane road with ample free parking. Well-equipped with 4 ops, digital, Dexis sensors, Sirona 2D pano (upgradable to 3D) and Dentrix PMS. 2022 revenue $673K, with mix of FFS and PPO. Favorable lease terms for 2,400-square-foot space within professional building. Currently open 26 hours/week. Selling dentist refers out most endo/ortho services. For details contact Dental Practice Transitions Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3414

FOR RENT

SUFFOLK COUNTY: Setauket dental suite for rent.1,500-square-foot dental office on first floor of office building on busy main road. 4 treatment rooms, lab, reception area, doctor office and large waiting room. Rent $2,950 includes common area maintenance, gas heat and water. Flexible lease terms. Call landlord directly at (631) 371-3365; or email: mpb312@yahoo.com.

MIDTOWN MANHATTAN: Newly decorated office with windowed operatory for rent FT/PT. Pelton Crane equipment, massage chair, front desk space available, shared private office, concierge, congenial environment. Best location on 46th Street between Madison Avenue and 5th Avenue. Please call or email: (212) 371-1999; karenjti@aol.com.

MANHATTAN: Grand Central location. Modern dental operatory for rent full time or part time. Prime location in professional building with concierge. Front desk space available. Friendly environment. Please call: (917) 446-4058; or email: dr.bberkowitz28@gmail.com.

WHITE PLAINS: Dental operatory for rent in modern and beautiful 4-chair office with panoramic and Ceph units. Free parking in center of White Plains. Very accessible to public transport (Metro North and buses). Open to rental by Specialist or GP. Rent negotiable. Inquire by email: 21eh1997@gmail.com.

MIDTOWN MANHATTAN: Op for rent at East 56th Street. Beautiful operatory with windows and private office available for rental. Elegant, modern, street level; best location. Please call or email for details. Phone: (917) 721 6825; email: esenayny@gmail.com.

MANHATTAN: Central Park South. Two dental operatories for lease in 4-op oral surgery practice with windows facing Central Park in exclusive medical condominium building. Front desk for two, waiting area, laboratory and bathroom. Option to transition to ownership. Work in pristine office in prime location. Tremendous growth potential. Please inquire by emailing: nycentralparksouth@gmail.com.

WHITE PLAINS: Modern, state-of-the-art operatories available in large office with reception. Available FT/PT. Turnkey. Rent includes digital radiology with pan, equipment, Nitrous, all disposables. Start-up or phase down. Need a satellite or more space? Upgrade or downsize. Contact us at (914) 290-6545; or email: broadwayda@gmail.com.

UPPER EAST SIDE: Operatory for rent in UES office (Madison Ave & 60th St.). Modern, quiet, boutique private practice. Endodontic microscope, 2 digital scanners, materials, instruments available for rent. Inquiries by text or email: (646) 648-3242 or pyondds@gmail.com.

MIDTOWN MANHATTAN: Madison Avenue next to world-renowned St. Patrick's Cathedral. Beautiful, large, renovated office with in-house full-service dental lab. Shared front desk space, shared private doctors' office. Fully equipped with CS-9600 CBCT scanner. Large conference room with presentation dual TV/monitor. Please contact doctor directly at (646) 265-7949.

MIDTOWN MANHATTAN: Central Park South. Ready to use, recently renovated dental operatories/chairs available for rent. Flexible lease terms, i.e., per hour, per day, etc. Great street access with lots of foot traffic. Easy to commute to and from with public transport. Can provide dental assistants, billing services and insurance assistance, etc. if needed. Please call/text (917) 605-9496; or email: doc@centralparkdentalservices.com.

MIDTOWN MANHATTAN: Lexington Avenue and 40th Street. Located on 16th floor with 24/7 access. Modern, state-of-the-art practice has 1 op available in 5-op office with reception. Perfect for startup, GP or specialist. Fully equipped and private office. Please contact (212) 697-3999.

MIDTOWN MANHATTAN: 3 dental operatories for rent full time. Renovated, large, bright, modern dental operatories with windows available on Madison Avenue in Midtown Manhattan with full-service, in-house lab. Fully equipped with CS-9600 CBCT scanner and X-ray system. Shared front desk, private Doctor's office, as well as large conference room. Please contact doctor directly at (646) 265-7949; or email: office@madisonavenuesmiles.com.

MANHATTAN: Upper East Side. 1-2 dental operatories for rent, full or part time. Located on 63rd Street between 2nd and 3rd Avenue. Good for specialist or GPs. Street level, close to R, F, Q, N, 4, 5, 6 subway lines. Digital X-rays. Possible partnership. Please contact us for more information. Email: dr.asphaic@yahoo.com; or (917) 697-6865.

EQUIPMENT FOR SALE

X-RAY UNITS: Used X-ray units for sale. In excellent condition. If interested, please contact Jeffrey Maloff by email: drjsm4life@gmail.com.

DENTAL EQUIPMENT FOR SALE: Selling three dental chairs with lights: $200, $350, $500. Two X-ray machines: $300, $700. IntraX X-ray film developer (roller type): $150. Equipment located at 26 Willets Ave., Belmont, NY, 14813. Call for more information: (585) 268-5588.

OPPORTUNITIES AVAILABLE

UPSTATE: Fantastic and rare opportunity to join high-quality and rapidly growing dental group. Our facilities are state-of-the-art with new equipment, digital X-rays and paperless charting. Seeking the right dentists to join team as we expand and grow. First-year and second-year salary minimum guaranteed, with opportunity for earnings well above average. Flexible terms and can be tailored to fit your individual desires if determined to be right fit. Very competitive compensation methodology. Training available for precision-guided dental implant surgery. Very strong mentorship program for new and recent graduates. Find us online at: www.sitwelldental.com. Contact John O'Brien, DDS, by email: jobrien1218@gmail.com; or call (518) 703-5321.

HUDSON: Associate dentist position available full time. Booming upper Hudson Valley river town. 6 operatories for 2 doctors and 2 hygienists. Retiring dentist will provide great opportunity for new Associate to quickly build upon already solid patient base. Abundant new patient flow and hygiene booked for months. Potential for equity position or future buyout. Applicant must have gentle, kind disposition, excellent communication skills with patients and be able to perform high-quality dentistry. Send resume to: karenron94@yahoo.com.

MANHATTAN: As we expand oral and maxillofacial services across Northwell Health, we are seeking Chief of Oral and Maxillofacial Surgery at Lenox Hill Hospital. Exciting position offers opportunity to lead and develop department at LHH, in conjunction with chair and senior vice president for Dental Medicine. Department of Oral and Maxillofacial Surgery at Northwell Health Lenox Hill Hospital provides very best in comprehensive head and neck service in New York metropolitan area. Lenox Hill Hospital, 652-bed, acute care hospital is located on Manhattan's Upper East Side. Staple in community for more than 150 years, hospital has earned national reputation for outstanding patient care and innovative medical and surgical treatments. All candidates will receive competitive salaries, comprehensive benefits package and eligibility for tuition reimbursement. Physicians will be employed as members of Northwell Physician Partners, fifth largest medical group in country. Academic appointment to Donald and Barbara Zucker School of Medicine at Hofstra/Northwell is commensurate with credentials and experience. For further details and to apply, please email Office of Physician Recruitment, Northwell Health, OPR@northwell.edu.

BUFFALO: Periodontal and Implant Specialty office in Buffalo area adding full-time Periodontist. Office equipped with state-of-the-art digital equipment with dependable referral base. With strong marketing program in place, we are looking for someone who has experience, friendly, engaging personality and good long-term fit with other doctors. Our single-doctor-owned FFS practice averages 85 new patients monthly with gross production of $2.5M. Starting 2-4 days/week. Requirements include residency and NYS license with experience recommended. Benefits: health insurance, one work location. High-producing, excellent internal referral system and modern office with well-trained staff and state-of-the-art equipment, including CBCT, TRIOS Scanner, PRF, 3D printer, Schick 33 series, Chrome Guides. Offering IV conscious sedation; 300 implants placed in 2022. Contact Julie Rustowicz to arrange interview. Phone: (716) 626-4427; or email: info@thecornerstonedentist.com. Visit us online at: www.thecornerstonedentist.com.

MANHATTAN: West 57th Street. Retirement-minded dentist with long-established fee-for-service general practice. Seeking associate with practice who wants to grow their nucleus of patients. Three-chair office; good amenities. Helpful staff. Goal is compatible sale and transfer of my practice with lease and equipment. Respond to: dds.midtownwest@gmail.com.

Capitol Hill Visitors

DENTISTS AND DENTAL STUDENTS from around the country converged on the nation's capital in early March for the annual American Dental Association Lobby Day. All had one goal in mind: to meet with as many members of Congress as possible to make their feelings known about pending federal legislation with the potential to either help or hurt the dental profession and the public it serves. New York State fielded a delegation of 66 people to Washington, DC, for Lobby Day, including 22 dentists from across the state, 41 dental students and 3 staff. They are captured at work in photos on this page.

Head, Neck and Oral Pathology

NYSS OMS
NEW YORK STATE SOCIETY of Oral and Maxillofacial Surgeons

Anesthesia

Dental Implant Surgery

Wisdom Teeth Management

Extractions and Other Oral Surgeries

Facial Injury / Trauma Surgery

Oral, Head and Neck Pathology

Corrective Jaw Surgery

Obstructive Sleep Apnea (OSA)

Facial Cosmetic Surgery

Cleft Lip/Palate and Craniofacial Surgery

TMJ and Facial Pain

Do you know where to send a patient with a possible head, neck or oral pathology?

Oral and maxillofacial surgeons (OMSs) are experts at evaluating, diagnosing and treating pathological conditions of the head, neck and mouth. An OMS is trained to provide both surgical and non-surgical management of such conditions. Visit MyOMS.org for more information.

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