Treating Autistic People **is Worth the Effort**

THE NEW YORK STATE DENTAL JOURNAL

NYSDJ

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Child Welfare Referrals

Is Your Report Warranted?

Inside: Sepsis Kills

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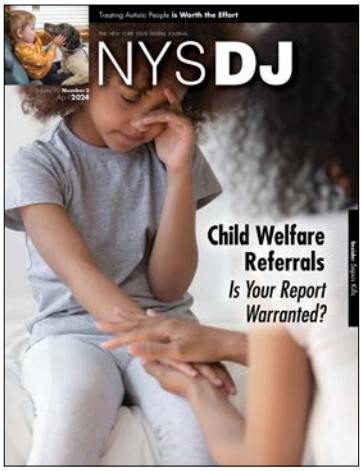

Cover: More needs to be done to train dentists to ensure that only true cases of child maltreatment are referred to child protective services.

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Sepsis is Serious. Recognize the Signs

There can be no delay in seeking treatment if you suspect either you or a patient is afflicted.

Stuart L. Segelnick, D.D.S., M.S., C.D.E.
NYSDJ Associate Editor

A call comes in from an emergency patient soon after you removed a hopelessly infected tooth. Her major concern is having a fever, chills and feeling downright terrible. She has no difficulty breathing or swallowing, though her mouth still feels swollen. Grace is a middle-aged woman who suffers from diabetes and recently finished chemotherapy for breast cancer. She doesn't smoke or drink alcohol. Also, she relates getting home too late to pick up the antibiotics that were prescribed. What should she do?

Grace was fortunate to have gone directly to the hospital emergency room, where she received a CT scan, which didn't show anything unusual. However, sepsis was suspected and IV antibiotics were administered. Feeling much better after a night of observation, Grace went home the very next day with a prescription for oral antibiotics.

Untreated or poorly managed periodontal disease, caries, endodontic and dental alveolar lesions can lead to sepsis. Case reports published in dental literature highlight the morbidity and mortality of dental disease complications. Although rarely reported, post tooth extractions have also been linked to sepsis.[1] According to the CDC[2] and the Mayo clinic,[3] bacterial infections are the leading cause of sepsis (viral and fungal infections have also been implicated). When these microbes overwhelm the immune system, the body fights back, causing overt damage to the organs, which may progress to septic shock and the accompanying free fall in blood pressure, organ dysfunction and ultimate death.

The World Health Organization (WHO) recognizes the severity of sepsis and reported that in 2017, it accounted for 20% of all deaths globally. In America, the CDC reports almost two million adults develop sepsis, and 350,000 "die during their hospitalization or are discharged to hospice." One-third of the people who died in the hospital had sepsis during their stay. What's even more frightening is "among adult sepsis survivors, one in three died within a year and one in six experienced significant, long-term morbidity."[4]

Higher risks of acquiring sepsis are found in older people (>65 years) and children who are under one year old, as well as those afflicted with chronic medical problems, are immunocompromised, sepsis survivors and people recently hospitalized and with severe sickness. Some of the signs and symptoms of sepsis are fever, chills, shivering, sweating, severe pain, fast heart rate, fatigue, hypotension, confusion and altered mental state.

Tests that your patient's physician or the hospital will perform if sepsis is suspected include a physical exam, blood cultures, full blood work up, X-rays, CT scans and ultrasounds to aid in making a diagnosis.[5] High temperature, elevated heart and respiratory rate, and high white blood cell counts are red flags for sepsis.

Sepsis is considered a medical emergency; the most important thing to do is recognize and treat it quickly. Treatment usually includes broad-spectrum IV antibiotics, IV fluids and vasopressors. Monitoring serial lactate measurements is also important. Hospitals must report cases of sepsis to the federal and state government.

According to Mannan et al., "Early antimicrobial intervention is associated with surviving severe sepsis, making it critical for dentists to understand local factors leading to the crisis and the signs and symptoms of the sepsis-septic shock continuum."[6]

In a paper by Sato et al., the authors stated, "When an oral infection is suspected in an elderly patient, antibiotics should be quickly administered, the patient's local and systemic state should be confirmed... If no improvement is observed, medical attention should be quickly sought."[7]

Organizations such as End Sepsis the Legacy of Rory Staunton (https://www.endsepsis.org/) and the Sepsis Alliance (https://www.sepsis.org/) have done amazing work bringing awareness of the seriousness of sepsis. End Sepsis has been successful in advocating for guidelines, regulations and increasing awareness of sepsis.[8] An article in The New York Times by Emily Baumgaertner[9]tells how the CDC has developed new guidelines to help recognize and reduce sepsis in hospitals. It notes that "In 2013, New York became the first state to mandate that all hospitals adopt sepsis protocols, known as 'Rory's regulations.'" Rory Staunton was only 12 years old when he died from undiagnosed sepsis. His parents subsequently started a foundation and the End Sepsis organization. With these wonderful organizations helping to eradicate sepsis, the future looks promising, so much so that even AI is now being used to detect sepsis.[10]

A month after my own gall bladder removal surgery, I had returned to my office on a lighter schedule. I was in the office when I started feeling very fatigued and had pain in my right back flank. After three days of decline and pushing myself through the day, I noticed that my hands had started shaking at the end of a patient examination. At that point, I knew I couldn't continue and had my receptionist cancel the rest of my appointments.

Almost falling to sleep at the wheel, I barely managed to drive home. Once home, I made my way to bed and fell right to sleep. At 1 a.m., I awoke bathed in sweat, simultaneously yet uncontrollably shivering, and feeling downright awful. I knew something was dangerously wrong. I woke my wife and we headed to the hospital ER, where they immediately took my vitals. My blood pressure was extremely low, my heart rate was racing out of control and my temperature was burning up at 103.3 F. The diagnosis was sepsis.

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After a CT scan of the abdomen and blood work, I was placed on IV antibiotics. I won't go into the horrible details of eight miserable days in the hospital and four weeks of IV antibiotics, which were delivered through a PICC line inserted into my arm. I thank God every day that I'm alive and able to go back to caring for my family, friends, staff, colleagues, and patients. I am cherishing every moment I'm still in this beautiful world.

It makes me wonder if I, as a healthcare professional, couldn't make a timely diagnosis of my own sepsis setting in, how could the average person? Sepsis is a major, life-threatening event that dentists must be aware of. Be prepared to advise your patients when sepsis is suspected to head to the hospital ER, because that timely response just might save their lives.

Dr. Segelnick's editorial first appeared in the January/February 2024 Second District Dental Society Bulletin. Queries about his editorial can be sent to him at eperio@aol.com.

REFERENCES

1. Lee JJ, Hahn LJ, Kao TP, Liu CH, Cheng SJ, Cheng SL, Chang HH, Jeng JH, Kok SH. Post-tooth extraction sepsis without locoregional infection--a population-based study in Taiwan. Oral Dis 2009 Nov;15(8):602-7.
2. Centers for Disease Control. What is Sepsis? https://www.cdc.gov/sepsis/what-is-sepsis.html. Updated August 24, 2023.
3. Mayo Clinic. Sepsis. https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214. Published February 10, 2023.
4. https://iris.who.int/bitstream/handle/10665/334216/9789240010789-eng.pdf?sequence=1.
5. WebMD. Sepsis (Blood Infection): Symptoms and Treatment. https://www.webmd.com/a-to-z-guides/sepsis-septicemia-blood-infection. Reviewed December 5, 2023.
6. Mannan S, Tordik PA, Martinho FC, Chilian N, Hirschberg CS. Dental abscess to septic shock: A case report and literature review. J Endod 2021 Apr;47(4):663-670.
7. Sato H, Tamanoi T, Suzuki T, Moriyama H, Abe S, Yoshida K, Kawaai H, Yamazaki S. Risk perception of septic shock with multiple organ failure due to acute exacerbation of an infectious dental disease. Ther Clin Risk Manag 2021 Apr 22;17:365-369.
8. End Sepsis. About End Sepsis. https://www.endsepsis.org/about/. Accessed December 18, 2023.
9. Baumgaertner E. C.D.C. Sets new standards for hospitals to combat sepsis. https://www.nytimes.com/2023/08/24/health/sepsis-hospitals-cdc.html. Published September 22, 2023.
10. Moor M, Bennett N, Plečko D, Horn M, Rieck B, Meinshausen N, Bühlmann P, Borgwardt K. Predicting sepsis using deep learning across international sites: a retrospective development and validation study. eClinicalMedicine Part of The Lancet August 2023;62(102124) https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00301-2/fulltext. Accessed December 18, 2023.

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Workers' Rights Front and Center

New York City takes lead in codifying employee rights and employer obligations.

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

New York City is once again leading the way on employment law reforms that often get picked up by New York State much later. This time, New York City has created a worker bill of rights that all employers in New York City must distribute and post. How did this come about?

The New York City Council passed the law on Nov. 2, 2023. It was sent to Mayor Eric Adams, who did not sign the bill but did not veto it. Therefore, under New York City laws, the bill became law on Dec. 4, 2023, as New York City Local Law 161 of 2023. This is an increasingly common occurrence in New York City, with the mayor taking no personal action on a bill.

The new law required New York City to create a Workers' Bill of Rights document by March 1 of this year, so that all employers in the city could implement it by July 1. Remarkably, New York City government met that March 1 deadline, and the Workers' Bill of Rights can be accessed at: https://www.nyc.gov/site/dca/workers/workersrights/know-your-worker-rights.page.

It is a long document comprehensively covering rights enforced by multiple local, state and federal government agencies. It covers paid sick and safe leave, temporary schedule change rights, independent contractor rights, minimum wage and hour rights, paid family leave rights, workers' compensation and disability rights, rights to a safe and healthy workplace, rights to a discrimination-free workplace, unemployment benefits rights, health insurance rights, correct worker classification rights, Family and Medical Leave Act (FMLA) rights, pay transparency rights, the ban on salary history inquiries, rights when employers use automated employment decision tools, rights when using an employment agency, rights to organize a union, and miscellaneous rights specific to certain employment sectors.

In addition, New York City created the required poster that all New York City employers will need to display. The poster can be accessed at: https://www.nyc.gov/assets/dca/downloads/pdf/workers/KnowYourRightsAtWorkPoster.pdf.

Staying on the Right Side of the Law

What exactly do New York City employers have to do? Employers must provide the Workers' Bill of Rights to each employee no later than July 1 and, thereafter, on or before an employee's first day of work. The

What exactly do New York City employers have to do? Employers must provide the Workers' Bill of Rights to each employee no later than July 1 and, thereafter, on or before an employee's first day of work.

employer must also conspicuously post the Workers' Bill of Rights in an area accessible and visible to employees. It must be provided in English and also in any other language spoken as a primary language by at least five percent of the employees if New York City has made the information available in that language. An employer must also make it available online or on the employer's mobile application for employees to view if such means are regularly used to communicate with employees.

An employer who violates any provision of the requirements for distributing and posting the Workers' Bill of Rights is liable for a civil penalty of $500, except that with respect to a first violation, New York City shall notify the employer of such violation and request that action be taken to correct the violation within 30 days and shall afford the employer an opportunity to contest the finding of a violation. A proceeding to recover any civil penalty authorized under the new law may be brought in any tribunal established within the New York City Office of Administrative Trials and Hearings or within any agency of New York City designated to conduct such proceedings.

Interestingly, the new law also requires that by no later than March 1, there must be outreach regarding the Workers' Bill of Rights to employees, prospective employees and independent contractors in the city. That outreach must include the following: 1) contact information for the immigration legal hotline of New York

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City and the New York City Asylum Application Help Center; 2) resources and contact information for immigration legal services and the mayor's Office of Immigrant Affairs; 3) information on what to expect if immigration enforcement authorities come to an individual's workplace; and 4) information regarding federal eligibility requirements of temporary protected status following designations, extensions and redesignations of such status pursuant to federal law.

Thus, there is a specific focus on letting immigrants know the rights contained within the Workers' Bill of Rights. These community outreach and educational efforts pertaining to the Workers' Bill of Rights must be conducted via Internet, print media, subway advertisements and LinkNYC kiosks. In addition, community outreach on the Workers' Bill of Rights targeted to immigrants must include distributing outreach materials at IDNYC (New York City Identification Card) registration sites, humanitarian emergency response and relief centers, emergency shelters, respite centers, asylum seeker resource navigation centers and via LinkNYC kiosks. The mayor's Office of Immigrant Affairs must create such outreach materials in English, the designated citywide languages and any other designated temporary languages recognized by the City of New York.

The recent immigration scenario, with immigrants coming to New York City in large numbers, gives some context for this new New York City Workers' Bill of Rights, but it does not explain it completely. It also serves as a reminder to all New York City employers of the many new obligations that New York City has been adopting at lightning speed when it comes to employment laws. It serves as a compendium of employer obligations as much as it is a notice of workers' rights.

Expanded Options for Aggrieved Employees

New York City has also amended its Earned Safe and Sick Time Act (ESSTA) so that it now provides a private right of action to aggrieved employees. Employees alleging violations of ESSTA may now commence a civil action in court against their employer within two years of the date of the alleged violation or when the employee should have known of the violation. The New York City Council passed the new law on Dec. 20, 2023, and it became law after Mayor Eric Adams once again returned the bill unsigned but did not veto it.

The law went into effect on March 20. Employees have the option to either file a civil action in court or an administrative complaint with the New York City Department of Consumer and Worker Protection. Thus, New York City is not only making worker rights very public, it is giving employees new weapons to enforce those rights. And more is sure to come from New York City where employment law reforms are concerned. For example, with Gov. Hochul having vetoed the state legislative proposal to broadly ban non-compete agreements, the New York City Council has already taken up three different bills to do so even more broadly for New York City. City government is always on the move, although it isn't always clear where it is going.

What's Next for Paid COVID Leave?

On a different note, what is the current fate of New York State's Paid COVID-19 Leave? The law is still in full effect, although Gov. Hochul has proposed in her State Budget to eliminate it by July 31. It is unknown at this point if that proposal will remain in the final State Budget.

An interesting twist is that on March 1, the Centers for Disease Control and Prevention (CDC) eliminated its COVID-19 isolation recommendations. The application of the New York State law has been tied by the New York State Department of Health to following CDC recommendations—which now no longer exist. One might conclude that this nullifies the Paid COVID-19 Leave Law by making it unenforceable. Not so fast! The Department of Health has yet to say anything about how it will treat this development of completely changed CDC recommendations. Employers should take no risk on this front until this issue is clarified legally. It is perfectly possible that New York State will simply continue this leave until the New York State Legislature definitively says otherwise.

While the Paid COVID-19 Leave is increasingly unpopular among employers, there are still legislators who cling to it like grim death—perhaps, the eternal metaphor for COVID.

What's Private Stays Private

Finally, another state employment law development is the new Section 201-i of the New York State Labor Law. This new law took effect on March 12. It prohibits employers from requesting or seeking access to any employee's personal social media, e-mail or any other electronic devices or accounts, including asking for usernames, passwords or other access information. The same prohibition applies to any applicants for employment. The new law does not apply to the employer's own business media accounts, e-mails or other employer electronic media—the protection for the employee applies only to personal accounts of the employee.

The law also does not prevent an employer from accessing items that are already available in the public domain. In many respects, this new law seems like basic common sense—keep the private life of the employee safe for the employee and keep the employer-controlled elements of employment safe for the employer. Nevertheless, the need for the new law was precisely because employers were unable to stop themselves from intruding into the personal lives of their employees.

Employers were beginning to use various types of new tools in decisions dealing with hiring and disciplinary actions regarding prospective and current employees. Recently, there have been reports of employers demanding login information, including username and password information, to popular social media websites, such as Facebook, X, e-mail accounts and other extremely personal accounts. This information was being used as a condition of hiring, as well as for promotions, lateral movements within business and in matters relating to disciplinary actions, including, but not limited to, firing of individuals. These types of requests can lead to issues of unfair and discriminatory hiring practices and constitute a serious invasion of privacy on the part of the employer. Employees have the right to make this information either public or private through websites at their personal discretion and have the right to maintain their chosen privacy when it comes to their workplace or during an interview process.

In these economic times, many people do not have the option to walk away from a job and are forced to submit to employer requests for fear they will otherwise be terminated or not be hired. The new law remedies this issue and leaves employees with their right to privacy and reduces the risk of unfair and discriminatory hiring. Sometimes, the law has to remind people of the obvious.

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

Everyone Deserves a Dental Home

With knowledge and preparation, dental practices should be able to accommodate the growing population of people on the autism spectrum.

Loren C. Baim, D.D.S.

Currently, 1 in 36 children in the U.S. have some form of autism, and 2.2 percent of the U.S. population are on the autism spectrum. These numbers have been growing, partly because screening efforts have grown. But there also may be genetic and environmental factors adding to the increase.

There is an insufficient number of pediatric dentists and specialized dental clinics to meet the oral healthcare needs of this large and expanding population. However, my strong feeling is that most people diagnosed with autism spectrum disorder can be treated successfully in the majority of general dentistry practices. While it is true that patients on the autism spectrum are varied in their needs, fears and personalities, and while some are on the advanced end of the spectrum and are, indeed, difficult to treat, most are not. My impression is that many people with ASD have not found a dental home because of the mental rigidity of dental providers. I hope that we can work together to change this.

April is Autism Acceptance Month

I suggest that our goal should be to assess each patient as an individual, dentally and mentally. Just as we develop a unique treatment plan for each patient's dentition, we must develop a singular plan to cope with any behavioral characteristics that prove to be challenging in the dental environment.

With that being said, there are some traits that are commonly manifested by people with ASD that are important to understand. I have listed the most common ones below, along with ideas for how best to cope with them in a dental office.

1. They tend to have poorly developed social skills.

It is best not to rely upon these patients to directly communicate with you about how to make them feel comfortable in the dental environment. Instead, reach out to a family member or caregiver for tips on what might make the patient more "at home." Ideas could include playing or singing a favorite song; bringing along an object of comfort, like a favorite pillow or blanket; or even having the patient watch a favorite movie during a dental procedure.

2. Repetitive behaviors or mannerisms are common.

These could include gestures such as arm flapping or head banging, repetitive speech or, perhaps, the desire to listen to the same song over and over. Again, taking the time to know what particular stories, songs and movies a patient

Figure 1

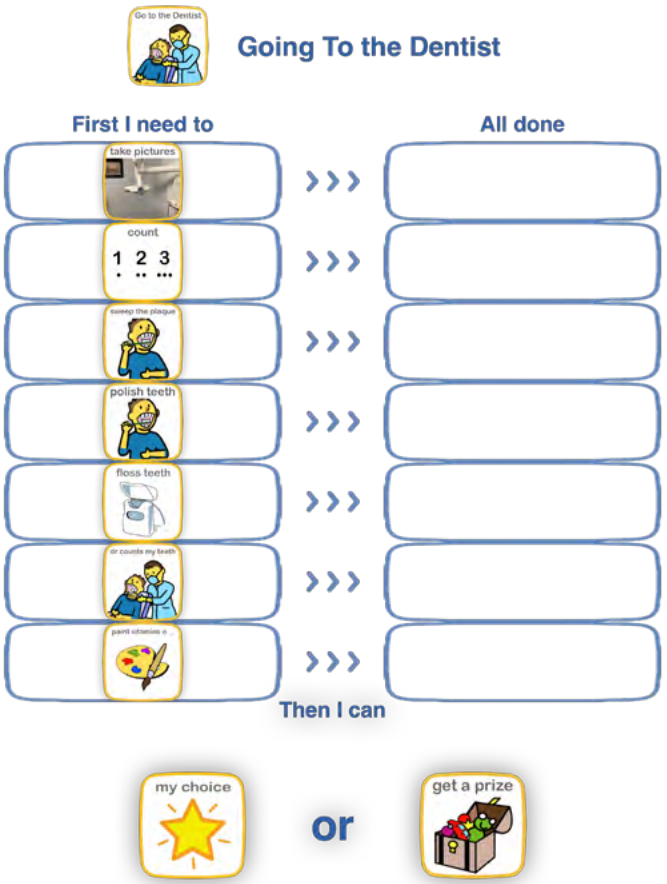


Figure 2

enjoys, and having them available during a dental visit, can go a long way toward making your patient comfortable and cooperative.

3. Dependence on excessive adherence to routines.

People with ASD do not like change! Clearly, if the same dental staff members can see the patient on each visit, that would be optimal. Also, adhering to the same routine at each visit is beneficial. I have often made a written "routine" for such patients and have the patient "check the box" at each step of the dental appointment. I also find that for many patients, it is easier to process things that have associations with pictures rather than words (Figures 1,2).

4. Visual input sensitivities are common.

Many people on the autism spectrum have photophobia and are particularly sensitive to dental florescent lighting. In these circumstances, it might be helpful to avoid the dental chair light and, instead, carefully use a light attached to loops or, even, a small penlight to visualize the oral cavity.

5. Auditory input sensitivities are also common.

For a patient who is sensitive to loud noises, use of the dental handpiece can be problematic. Ways to make these patients more comfortable include the use of headphones or earbuds, incorporating the patient's favorite music. Noise cancelling headphones could be a valuable investment.

6. Taste and smell sensitivities are frequent.

So many items that we use in dentistry have strong tastes or smells, but with a little forethought, we can often mitigate these sensitivities. Ideas include using unflavored prophy paste, choosing a favorite flavor for fluoride varnish and having an extra dental assistant to make sure that the patient's tongue is kept away from any dental materials with a strong taste, such as etchant.

7. Tactile sensitivities are common.

People on the autism spectrum often respond differently to sensations of touch and pressure. While light touch might be annoying, something like a weighted blanket or, even, a papoose wrap may be comforting. Again, it's best to ask ahead. In my office, staff members will often wrap their arms around a patient with more severe autism and "corral" them into the treatment room. We also make use of our therapy dog Matilda. She will, upon request, lie on top of a patient to make them feel more secure. She quietly allows them to touch or pet her. Her position on the patient, in turn, helps keep the patient in position. We are able to treat younger and/or smaller patients on their parent's lap. This

Matilda, Dr. Baim's therapy dog, is a 5-year-old Aussiedoodle, trained to help calm anxious patients.

allows the parent to physically restrain the patient, while also providing tactile security.

8. Patients with ASD struggle with concepts involving time.

Plan ahead to avoid having these patients wait for their appointment. With this being said, some patients need a few moments to "regroup" after arriving at the dental office, but before treatment begins. This transition can often be aided by an object of transition, such as being given a stuffed animal to hold and being shown a picture of what is next.

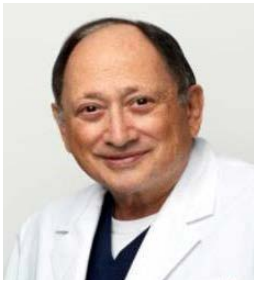
Finally, I'm sure that by far, the most important part of treating patients with autism is having the desire to treat this population. Autistic patients can bring new perspectives and ideas to our practices. Because they see the world in different ways, they can inspire us to take a different approach to what we do every day.

This change in approach can often carry over to our non-spectrum patients and help us to grow, not only as clinicians, but as humans.

I urge you to think differently about your ability to treat people on the autism spectrum. You may be surprised by what you discover about yourself!

Dr. Baim maintains a general practice in Glens Falls where she sees very young children and special needs patients. She is a member of the NYSDA Council on Ethics and sits on the Board of the New York State Dental Foundation. Queries about this article can be sent to her at lcbaim@aol.com.

Elliot Moskowitz, former Journal Editor, Dies



Dr. Elliot Moskowitz

ELLIOT M. MOSKOWITZ, D.D.S., M.Sd, former editor of *The New York State Dental Journal,* and a past president of New York County Dental Society, died March 25 in New York City at the age of 76.

Dr. Moskowitz relished his time as editor (2005-2009), believing he was using his considerable communication skills to enlighten *Journal* readers, serve as an advocate for organized dentistry, and to forge relations between NYSDA, its components and related professional organizations. He gave up his post reluctantly at the end of his prescribed term, but went on to other journalistic endeavours, including serving as editor-in-chief of "Seminars in Orthodontics," a quarterly publication of Elsevier.

A graduate of New York University College of Dentistry, Dr. Moskowitz completed a general practice residency at Catholic Medical Center of Brooklyn and Queens. He returned to NYU to receive his orthodontic specialty training and a Master of Science (in Dentistry) degree.

When he began practicing, in 1975, it was as a member of the family at Eastside Orthodontics in Manhattan, a practice begun in 1937 by Dr. Hyman Moskowitz and the longest family-run practice in Manhattan. In 2018, the Foundation for Orthodontic Research and Continuing Education named him a clinical research fellow in its Orthodontic Practice Research Network of orthodontic offices to help establish a clinical data base for future use by orthodonists everywhere.

Dr. Moskowitz continued his relationship with NYU, serving as clinical professor of orthodontics and providing funding for a new orthodontics wing at the college, named in his honor.

Dr. Moskowitz is survived by a son, Jon.

Dental Foundation Announces Leadership for 2024

THE NEW YORK STATE DENTAL FOUNDATION BOARD approved the appointment of four new members to begin serving on Jan. 1 of this year. They are: Dr. Rory Ogden, Fourth District, to a one-year term; and Dr. Yun-Po Zhang, Colgate-Palmolive, Dr. Katie Rothas, Third District, and Dr. Loren Baim, Fourth District, to three-year terms.

Leading the Foundation in 2024 are the following officers, whose appointments were also approved by the Board: Dr. Maria Maranga, chair; Dr. Ronald Bellohusen, vice chair; Dr. Laurence Volland, treasurer; and Dr. Robert Peskin, secretary.

NYSDA Support Services 2024 Board

DR. JOSEPH CARUSO, Queens County, has been returned as chairman of NYSDA Support Services for 2024, his final year of service. Joining him on the Board are:

Michael Herrmann (NYSDA Assistant Executive Director), president; Mark Weinberger (Third District), treasurer; Lawrence Volland (Eighth District); Minerva Patel (Ninth District); Roxene Gascoigne (Nassau County); Dimitrous Kilimitzoglou (Suffolk County); Tricia Quartey-Sagaille (Second District); Mario Silvestri (Sixth District); Paul Leary (NYSDA Secretary-Treasurer); Greg Hill (NYSDA Executive Director).

ADVOCATES FOR THE PROFESSION

On annual trip to State Capitol to make case to legislators for dental profession and its patients, participants secured audience with Assembly member Grace Lee, Democrat, New York City. Seen, from left: Secretary-Treasurer Paul Leary; ADA Trustee Brendan Dowd; Executive Director Greg Hill; Assembly member Lee; Vice President Maurice Edwards; President-Elect Prabha Krishnan; Mina Kim, New York County; Past President James Galati.

Advocacy Day, held over two days in March, was timed to coincide with World Health Day, March 20. Its many participants included NYSDA Trustees, EDPAC members, council chairs and dental school deans, students, residents, new dentists and engaged members. Contributing to its success were sponsors Laurel Road and Feldman Kieffer Law Firm.

Association *Activities*

In Memoriam

NEW YORK COUNTY
Elliott Moskowitz
New York University '72
11 5th Avenue, #Suite 3
New York, NY 10003
March 25, 2024

Gerald Rosen
New York University '57
372 Central Park West, #16C
New York, NY 10025
February 8, 2024

Harvey Schwaid
New York University '52
5675 Pipers Waite
Sarasota, FL 34235
November 25, 2022

SECOND DISTRICT
Alan Sosnay
New York University '60
16 Wheelock Road
Scarsdale, NY 10583
July 1, 2023

FOURTH DISTRICT
Gerald Benjamin
University at Buffalo '77
18 Division Street, #205
Saratoga Springs, NY 12866
January 6, 2024

EIGHTH DISTRICT
John Vona
University at Buffalo '61
12202 Ludeman Drive
Silver Creek, NY 14136
March 14, 2024

NINTH DISTRICT
Stuart Coleton
New York University '64
8 Apple Hill Lane
Peekskill, NY 10566
February 26, 2024

Wallace Kahan
University at Buffalo '56
2780 S. Ocean Boulevard, #103
Palm Beach, FL 33480
December 20, 2021

Alan Pitegoff
New York University '66
66 Susan Drive
Newburgh, NY 12550
March 20, 2024

NASSAU COUNTY
Charles Berg
New York University '57
221 Delaware Avenue
Island Park, NY 11558
November 19, 2023

QUEENS COUNTY
Stanley Kasow
New York University '57
10 Cortland Avenue
Jericho, NY 11753
February 1, 2024

SUFFOLK COUNTY
John Bogan
Seton Hall University '61
245 Richmond Avenue
Amityville, NY 11701
April 16, 2022

James Donahue
University at Buffalo '55
107 Boney Lane
Saint James, NY 11780
February 15, 2024

Joel Greenberg
Tufts University '75
143 Country Club Drive
Commack, NY 11725
August 17, 2022

Daniel Hensen
New York University '55
193 Radio Avenue
Miller Place, NY 11764
October 28, 2023

BRONX COUNTY
Joel Friedman
Columbia University '68
185 East 85 Street, #33B
New York, NY 10028
February 20, 2024

Sanford Schimmel
New York University '63
561 W. 246 Street
Bronx, NY 10471
March 26, 2023

Challenges and Implications of Mandated Reporting to Child Welfare in Dentistry

Katheryn Goldman, D.M.D., M.P.H., Ph.D.; Daniel Pollack, M.S.W., J.D.

ABSTRACT

Dentists are mandated reporters and at the forefront of screening for child welfare referrals. The laws and systems surrounding reporting practice leave dentists working in pediatric settings with the responsibility for making a quick judgment about child maltreatment, with limited information and, sometimes, limited training. Increased interdisciplinary collaboration and education are necessary to better prepare and support dentists for interaction with children who may present with suspected child maltreatment.

It is estimated that in 2021, there were 600,000 victims of child abuse and neglect.[13] The victim rate for child maltreatment is 8.1 victims per 1,000 children in the population.[13] In 2021, it is estimated that nationally 1,820 children died from child maltreatment, at a rate of 2.46 per 100,000 children in the population.[13] Research has found high substantiation rates among reports made by medical staff.[6]

Every state includes dentists as mandated reporters of suspected child maltreatment; however, each state has its own laws on reporting and reporting requirements.[9] States use wording similar to the federal definitions of child maltreatment, with all state statutes covering situations where the reporter has observed evidence of harm as reasonable cause to suspect child maltreatment.[7,9] However, some states also invoke a mandate to make a child maltreatment report based on a judgment of future harm, even if there is no current observation of injury. [9,10]

Human judgment does not occur in a vacuum and is subject to bias and misinterpretation of definitions of child maltreatment. Nonetheless, federal child welfare law does not have specific requirements to ensure that mandated reporters understand their role or what specifically constitutes child maltreatment.[9] Thus, state definitions of child maltreatment, reporting practices, as well associated training, are subject to substantial variation.[9] Therefore, one can see the challenge of ensuring that dentists understand their roles as mandated reporters and are prepared to appropriately identify instances of child maltreatment.

Background

The Federal Child Abuse Prevention and Treatment Act (CAPTA) mandates that states have procedures for requiring certain individuals to report known or suspected instances of child abuse and neglect. Across many scopes of dental practice, dentists have significant interactions with pediatric patients and are at the forefront of identifying cases of child maltreatment.

The laws and systems surrounding reporting practice leave dentists with the responsibility of making quick judgments about child maltreatment, often with limited information. Furthermore, states do very little to ensure that as mandatory reporters, dentists are adequately trained on when or when not to suspect child maltreatment.[9]

Practice Implications

While physical abuse may often be clinically obvious, many situations of suspected child maltreatment are more nuanced and require a strong understanding of what legally and clinically constitutes child maltreatment to avoid inappropriately filing a report or deferring to file.

For example, a new dental graduate who is informed by the hygienist that a 5-year-old girl has presented to the appointment wearing "dirty clothes" with "unkempt hygiene," is the child being neglected, or is the family struggling with issues related to poverty?

A general definition of neglect is offered by the Centers for Disease Control and Prevention (CDC): "Neglect is the failure to meet a child's basic physical and emotional needs. These needs include housing, food, clothing, education, access to medical care, and having feelings validated and appropriately responded to." There is a stark difference between poverty and intent to neglect.

The dentist is told by her supervisor to make a report. If you see something, say something. Right? It's not so clear. If the individual reporter fails to report suspected child maltreatment and an adverse event occurs, not only does the moral consequence and guilt of personal negligence resulting in injury to a child weigh heavily on the individual, so does a potential legal consequence. This may include loss of licensure, which an individual may have worked years to obtain.

If that same individual does make a report, he or she is potentially bringing duress and trauma upon a family for an uncertain cause. There may be a loss of rapport with the family that could further harm the child by isolating the child from resources and services. There is also fear of potential retaliation towards the individual reporter.

Clearly, the system is structured in such a way that it unconsciously coaxes individual reporters to consider their own interests in a scenario where the focus should be directed solely towards the needs of the child. Simply put, in

the current legal scheme, the twin desires of worker self-preservation and child safety are often at odds. We place the burden of the outcome of a potential child maltreatment report/failure to report on the individual dentist. Unwittingly, this makes it much easier to demonize the individual worker.

Unfortunately, misguided decision-making happens. Individuals' personal beliefs and biases surrounding gender, socioeconomic status, race and family structure have the potential to weigh heavily on their decision-making process to report. For example, a recent study conducted by Hymel et al.[14] noted that children from diverse racial and ethnic backgrounds with head injuries were twice as likely to be reported for abusive head trauma compared to white children with similar symptoms.[3]

Absent clinical difference, the individual biases of medical professionals can have significant consequences on families. Racial and socioeconomic disparities in child welfare referrals have been well-documented within the literature and have also posited to be perpetuated by the human decision-making of mandated reporters and other individual decision-makers along the child-welfare referral process who are not subject to peer or committee review.[3] In reality, mandated reporters are specifically instructed that they must only have a "reasonable suspicion" to make a report. However, in instances of suspected neglect, this can be highly problematic.

Here is another example: A child continuously reports to the pediatric dental office for a recurrent abscess on tooth #30. The office has on multiple occasions referred the family to an endodontist for evaluation. The mother says, "She is doing her best." The mother feels that she is sufficiently providing her child care through the emergency visits. The dentist reports the family to child protective services for not following through with necessary care.

The back story that was not obtained before this report was filed was that the only endodontist is located 75 miles from the family's home. The family has only one car, which is used by the sole household earner. The earner works a job where the management is inflexible and routinely denies requests for time off due to "understaffing." Obtaining this information from the family prior to the referral would have clarified the barriers to care and would have eliminated an unnecessarily traumatic experience with CPS involvement. The mother in this scenario is not unwilling to seek care for her child. She needs assistance navigating the barriers to her child's care.

In many dental settings, there is not always an available worker to help families navigate these barriers, which are often exacerbated by poverty, not bad intent. In these instances, mandated reporters incorrectly assume that they can rely on CPS as a means of connecting families to support. While the social services system should function in a way that supports families and does not criminalize poverty, well-intended individuals may make reports not understanding that in some states, an investigation of the family is the only option. Research has found that 7% of children in low-poverty neighborhoods experience a substantiated CPS investigation at some point in childhood using the 2014 and 2015 rates—this risk almost doubled for children in moderate-poverty neighborhoods and was more than triple for high-poverty neighborhoods.[5]

Research also suggests that government programs that reduce poverty, particularly for working parents, may also reduce some forms of CPS involvement.[12] Malintent in the case of child neglect is hard to substantiate and should never be conflated with situational poverty. Limited economic resources may directly affect parental investments in food, clothing, medical care, education, safe and stable housing and childcare arrangements, which could be observationally misconstrued as neglect.[11] Therefore, families who are identified by dentists as having social needs that put the family at risk for child neglect should be referred to internal or external social resources/programming, with follow-up to ensure that the child's unmet social needs are being met.

If follow-up identifies families who are unwilling to provide for the child after appropriate support and material needs have been supplied, child neglect would then need to be considered. This clinical pathway of action would provide support to families who are struggling and desire to support the child, arguably, the majority of families, and would limit unnecessary interface with child welfare.

In reacting to poverty-driven referrals, some states have adopted an alternative response that is applied to low-to-moderate risk cases and involves parents identifying their own individual needs in order to facilitate family engagement with services. This differs from investigating all reports and does not typically require a formal determination of child abuse or neglect or the entry of names into a central registry.[4]

The adaptation of the alternative response allows for families who are struggling with issues of poverty to connect with resources. Ideally, this connection would be made outside of a child welfare setting and points to the strong need for pediatric healthcare practices in community settings to be given tools and resources to provide direction and help to struggling families without utilizing CPS as an interface.

Educating Dentists

The substation rate of all referrals to child welfare in the United States is 15.92%.[8] This means that the majority of

cases do not qualify as child maltreatment or do not have sufficient evidence to demonstrate that child maltreatment occurred. While often no harm is done by being overly cautious, in reality, interaction with child protective services is traumatic for families, particularly in communities that have a pervasive, historic relationship with child welfare. This data also calls into question the effectiveness of the mandated reporting system as a whole, and demonstrates a strong need to better educate professionals, including dentists, on how to identify cases of child maltreatment.

Increased interdisciplinary training that includes legal and social work professionals who work within child advocacy systems should be considered at state and institutional levels to support dentists in practice. In many workplace settings, particularly those that are under-resourced, dentists do not have an available staff person to seek counsel or advice before making a child welfare referral.

Other remedial steps are:

- Include more in-depth interdisciplinary education during dental school to teach how the child welfare system works. Often, education covers the clinical aspects of child maltreatment, as well as the legal obligation of the mandated reporter, but it does not include how the child welfare systems actually work. Leaving out this key structural piece makes it so that healthcare providers such as dentists can rely on child protective services to provide resources for a family. While some states have adopted this approach, this is not the case in every state. Dentists must be aware that they may be inadvertently launching an investigation of a family they are trying to connect to help.
- Increase and improve licensure training on mandated reporting. Often, child maltreatment training is limited to a required course for professional licensure that does not adequately prepare dental professionals for the realities of mandated reporting in practice. Increased training would particularly benefit new dentists who may not have the practice experience to guide decision-making. The scenarios in these trainings are often very clearly child maltreatment and do not delve into how to handle scenarios that may fall into a less clear-cut action plan.

Conclusion

Ultimately, the question of whether to file a child abuse/neglect report is a legal decision. Unfortunately, dentists acting as mandated reporters, though making a legal decision, may have limited familiarity with the nuances of laws surrounding what constitutes abuse and neglect. And so, regrettably, a child may suffer due to the reporter's ignorance or inexperience.

While there are many flaws within the child welfare system, improving practice through the interfaces of the many professions that interact with it, such as dentistry, can be a means of reducing unnecessary interactions between families and child welfare professionals and ensuring that true cases of child maltreatment are referred to child protective services.

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Queries about this article can be sent to Dr. Goldman at kgoldma2@mail.yuy.edu.

REFERENCES

1. Child Abuse Prevention and Treatment Act. 42 U.S.C. § 5106a(b)(2)(B)(i).
2. Centers for Disease Control and Prevention. (2022, April 6). Fast facts: Preventing child abuse & neglect |violence prevention |injury. https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html
3. Child Welfare Information Gateway. (2021). Child welfare practice to address racial disproportionality and disparity. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/.
4. Child Welfare Information Gateway. (2020). Differential response: A primer for child welfare professionals. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
5. Fong K. Neighborhood inequality in the prevalence of reported and substantiated child maltreatment. Child Abuse & Neglect 2019;90, 13-21.
6. Kesner JE. Dever BV. An inter-reporter analysis of mandated child maltreatment reporting in the USA. Mandatory reporting laws and the identification of severe child abuse and neglect 2015;61-75.
7. Levi BH, Portwood SG. Reasonable suspicion of child abuse: Finding a common language. Journal of Law, Medicine and Ethics 2011;39(1), 62–68. Crossref PubMed. ISI.
8. Mathews B, Bross DC. Mandated reporting is still a policy with reason: Empirical evidence and philosophical grounds. Child Abuse & Neglect 2008;32(5), 511-516.
9. Mudrick NR., Blackwell J., Watts C, Smith CJ, Williams A, Nielsen K A, Clark L. (2022). How do states inform nurses of their policies for mandatory reporting of child maltreatment? Policy, Politics, & Nursing Practice 2022;23(2):109-117.
10. Mudrick NR, Smith CJ. Commentary: Mandatory reporting for child protection in health settings and the rights of parents with disabilities. Disability and Health Journal 2017;10(2):165–168. Crossref PubMed.
11. Pac J, Collyer S, Berger L, O'Brien K, Parker E, Pecora P, Wimer C. The effects of child poverty reductions on child protective services involvement. Social Service Review 2023;97(1):43-91.
12. Raissian KM, Bullinger LR. Money matters: Does the minimum wage affect child maltreatment rates? Children and Youth Services Review 2017; 72:60-70.
13. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2023). Child Maltreatment 2021. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.
14. Hymel KP, Laskey AL, Crowell KR, Wang M, Armijo-Garcia V, Frazier TN, Karst WA. Racial and ethnic disparities and bias in the evaluation and reporting of abusive head trauma. Journal Pediatrics 2028;198:137-143.


Dr. Goldman


Mr. Pollack

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Guiding our Implants

Using Dynamic Surgical Guidance to Maximize Predictability

Shane Endres, D.D.S., M.A.; Ryan Schure, D.D.S., M.Sc., F.R.C.D.

ABSTRACT

Dynamic surgical guidance (DSG) is a recent advance in implant dentistry, used to maximize the efficiency and predictability of implant surgeries. A study, conducted by Navigate Surgical Technologies using the Inliant system, was undertaken in Toronto, Canada, to analyze the success and accuracy of this technology. Twenty-three implants placed in 22 subjects were examined. The results showed that implant placement using Inliant was extremely accurate when compared to the presurgical plan. Additionally, there were no significant errors or deviations in implant placement. The study concluded with the Food and Drug Administration of the United States granting safety approval for the Inliant system. As such, it is reasonable to expect that DSG, including the Inliant system, can and should be safely implemented by more practitioners as the technology becomes readily available.

With constant advancements in medical technologies, opportunities to improve on "older" techniques are continuously emerging. This includes the field of implant dentistry, where there have been numerous steps taken to improve techniques over the past few decades. Studies have shown that implants have over a 96% success rate after 10 years.[1] While impressive and, arguably, one of the most predictable procedures in the dental field, there are still challenges and areas that can be modified with dental implants to enhance the experience for both the patient and the clinician.

Traditional Implant Surgery

Some clinicians prefer to place implants "freehand" or without the use of an external guide. Invariably, this technique is the easiest to execute, as less materials, planning and fabrication time are needed prior to surgery, and a lab is not required. The concern with freehand placement would be a potential lack of accuracy as to where the implant is placed, compared to its intended position.

According to a study conducted by Schnutenhaus et al., freehand implant placement resulted in average angular deviations of 8.7 ± 4.8 degrees, implant shoulder position deviations of 1.62 ± 0.87 mm, mesiodistal deviations of 0.87 ± 0.75 mm, buccolingual deviations 0.70 ± 0.66 mm and apicocoronal deviations 0.95 ± 0.61 mm, when compared to an initial plan.[2] The study also found that these values had large ranges of variation depending on the specific site, with a wider range found in the mandible, as well as the timing of implant placement, with larger deviations in sites with more recent bone grafting.

The most basic form of a surgical guide is an acrylic stent. This requires a model cast of the patient's arch and a wax-up at the edentulous site(s). An acrylic stent can help direct the surgeon in terms of an initial mesiodistal and buccolingual entry point; however, it has little benefit with regard to the angulation and depth of implant placement.

The increased availability and use of cone-beam computed tomography (CT) scans have permitted the creation of surgical guides that are based on patient-specific anatomy and help to ensure that an implant is placed in the proper three-dimensional position. In general, guided implant surgery using this technique is quite precise, with angular variations up to five degrees and positional variations up to 2.3 mm.[3]

Traditional, static implant guides have been used for decades and have proven to be successful. Yet, they still present with significant limitations. Static guides may have compromised adaptation to the dentition due to their rigid form, and although impressions or digital scans are used for their fabrication, there have been concerns about achieving the necessary intimate fit of a guide. This may occur if there are any inaccuracies in the impression/scan, minor shifting of teeth, and/or slight mobility influenced by tissue resiliency. Several dozen studies were analyzed which curated a list of deviations, including tooth-supported and bone-supported guide mean deviations of 1.40 mm and 1.33 mm coronal, 1.8 mm and 1.57 mm for apical, 4.8 and 4.63 degrees for angular and 0.8 mm and 0.47 mm for depth deviations, respectively.[4]

Using a static guide also requires increased space for instrument access, which is, notably, a challenge in posterior regions and in patients with limited mouth opening. Further, there has been concern about reduced levels of irrigation that reach the surgical site when using a static guide.[5] This is a consequence of the tight fit between the drill and guide sleeve, preventing irrigation from reaching the osteotomy, where it is required to avoid overheating and subsequent necrosis of the osseous structures. This intimate fit also reduces tactile sensation when preparing an osteotomy, which has been another critique of static guides. These limitations and concerns, while all with potential remedies, have given rise to the search for new methods of guiding implants during surgery.

Introduction of Dynamic Surgical Guidance

A recent advancement in implant dentistry, known as dynamic surgical guidance (DSG), has gained popularity in an effort to overcome the noted limitations of traditional guided and freehand surgery. Dynamic surgical guidance, which can be thought of as a "global positioning system" to place the implants, is a computer-guided modality providing in real time, three-dimensional feedback of the drill and implant location through motion-tracking devices in the surgery.[6]

A literature review conducted by Parra-Tresserra et al., studied the effectiveness of dynamic surgical guidance versus static-guided surgery.[7] They concluded that "dynamic navigation shows a better accuracy and precision of implant placement" when compared to static guides. The importance of three-dimensional placement was emphasized, as it can lead to improved esthetic and prosthodontic outcomes, long-term hard- and soft-tissue stability, and idealized occlusal loading. These were all shown to be more predictably achieved when using DSG.

Inliant, developed by Navigate Surgical Technologies (Vancouver, Canada), is one example of a DSG system. According to the company, the use of Inliant dynamic guidance "delivers real-time surgical navigation for free-hand dental implant procedures."[8]

Inliant utilizes various sources of information to plan and guide the placement of implants. They include: the handpiece; an intraoral fiducial and patient tracker; and the digital connector/reader.

The handpiece is a traditional handpiece in terms of design and feel but is marked with a specific series of laser etchings (Figure 1). The intraoral fiducial is made with a thermoplastic material that is molded to the patient's dentition in an area remote to where the implant is being placed, which then hardens to form a personalized stent, and is worn during a cone-beam tomography (CT) scan.

During the surgery, a patient tracker, also marked with specific laser etchings, is inserted into the fiducial and worn by the patient (Figure 2). The digital connector is stationed

Figure 1. Laser-etched handpiece.

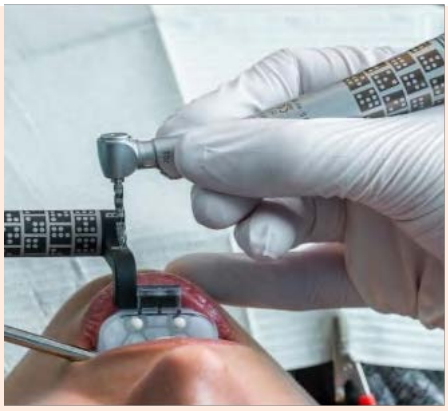

Figure 2. Laser-etched patient tracker attached to fiducial.

Figure 3. Digital connector; digital connection on stand with computer; example of integration of digital connector and stand in operatory setting.

above the surgical space with two cameras angled to read both the handpiece and the patient tracker (Figure 3). Upon recognizing the laser markings, the connector is able to relay the position of the surgical site, as well as the handpiece, and, by extension, the drill, to produce an image on the computer. The resultant image provides a real-time, dynamic representation of where the drill is in the patient's bone.

Numerous aspects of DSG have proven to be advantageous over previous incarnations of guides, including consolidating treatment into a single appointment, increased safety and predictability from real-time feedback, lower preprocedure costs and improved ergonomics for the clinician.[9] An added benefit to this technique is the ease of implementation. One study found that even in novice hands, this technique can be viewed as reliable and easy-to-learn, which may be extremely useful to newer clinicians interested in this technology.[10]

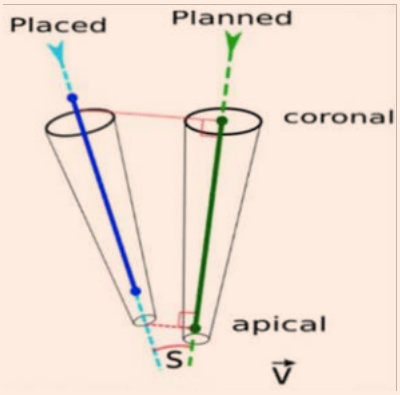

Figure 4. Apical and coronal lateral deviations, where coronal is distance from top (coronal) point in planned to axis of placed implant; apical is distance from apical point in planned to axis of placed implant; and S is angular deviation between placed and planned implant.

	Angle Deviation (°)	Coronal Deviation (mm)	Apical Deviation (mm)
Average	2.91	0.64	0.90
Range	0.746 - 6.542	0.082 - 1.504	0.053 - 1.871

Figure 5. Results from Toronto Inliant study. Angular, coronal and apical deviations were assessed.

The Toronto Inliant Study

From July 2021 to August 2021, an in-office study was conducted at Prosthodontic Associates, a private practice in Toronto, Canada. After appropriate instruction and training with Inliant, a group of surgeons, including three prosthodontists and one periodontist, used this system to place implants. Throughout the study, multiple surgical sites were included, involving all four quadrants and different tooth locations. In total, 23 subjects, aged 19 to 76 years old (average age 55.7 years old), were included. The implant surgeries were planned using the Inliant software, executed using Inliant DSG, and then evaluated with a postoperative CT scan.

Angular deviation, coronal deviation and apical deviation, when compared to the initial plan, were assessed and reported (Figure 4). While the study was not sponsored by a specific company, the implants used were provided to the participants at no charge by Southern Implants Ltd.

The results of the study were obtained by comparing the initial implant plan to the final implant position, assessed on the postoperative CT scan (Figure 5). Angular deviation varied from 1.40 to 2.95 degrees. Coronal and apical measurements ranged from 0.29 to 0.70 mm and 0.32 to 0.89 mm, respectively. These measurements were achieved by comparing the pre- and postoperative CT scans. Comparatively, all the acquired measurements were marginally smaller than the values obtained from the static guide (bone- and tooth-supported) study conducted by Gerhardt et al.

Statistical analysis was completed for each of the three deviations measured. The hypothesis for angular deviation was analyzed via the one-sample Wilcoxon signed-rank test, whereas the coronal and apical deviations were analyzed using a one-sample T-test. All hypotheses analyzed concluded that the Inliant system produced equally successful cases to the predicate LLC.

X-Guide Surgical Navigation System*

To ensure thorough evaluation, ANOVA completed testing to evaluate any difference between the clinicians and found there was no significant difference, but it highlighted that due to the small sample size, it may be difficult to reach a definitive conclusion. Overall, it was concluded that the Inliant system produced implant placements at an equivalent accuracy to that of the predicate device.

The major limitation within this study is the sample size of 23, versus other studies that included anywhere from 20 to 140 implants. However, based on the results of this study, the United States Food and Drug Administration granted safety approval for the device, and it is now available for use in the U.S.

Next Steps

Now that the Inliant system has been approved for use in the U.S., a larger scale study may be of value to provide conclusions with more power. From there, it is reasonable to expect this technology to increase in usage within dental practices across the country, including not only Inliant, but also a surge of alternative companies offering the same ultimate goal of utilizing dynamic surgical guidance to increase surgical precision and accuracy. The short learning curve and minimally required equipment make it quite amenable to anyone placing dental implants.

While not every implant surgery requires a guide, the benefits of DSG compared to traditional static guides for most cases are very transparent. Practitioners wanting ultimate safety, accuracy and efficiency for their surgeries should consider how DSG can potentially help them achieve these goals.

The authors declare no conflict of interest with their manuscript. Queries about this article can be sent to Dr. Endres at sendres1221@gmail.com.

REFERENCES

1. Howe MS, Keys W, Richards D. Long-term (10-year) dental implant survival: A systematic review and sensitivity meta-analysis. J Dent 2019 May;84:9-21. doi: 10.1016/j.jdent.2019.03.008. Epub 2019 Mar 20.
2. Schnutenhaus S, Wagner M, Edelmann C, Luthardt RG, Rudolph H. Factors influencing the accuracy of freehand implant placement: A prospective clinical study. Dent J (Basel) 2021 May 10;9(5):54. doi: 10.3390/dj9050054.
3. Unsal, Gokce-Soganci, et al. Advantages and limitations of implant surgery with CAD/CAM surgical guides: A literature review. Journal of Clinical and Experimental Dentistry April 2020;12(4):e409-e417. doi:10.4317/jced.55871.
4. Gerhardt MN, Kreuzer KB, Shinkai RSA. Literature on the accuracy of guided surgery for dental implants: A scoping review. J Osseointegr 2021;13(3):127-137.
5. Stocchero M, Sivolella S, Brunello G, Zoppello A, Cavallin F, Biasetto L. Bone temperature variation using a 3D-printed surgical guide with internal irrigation. Applied Sciences 2021;11(6):2588. https://doi.org/10.3390/app11062588.
6. Stefanelli LV, La Rosa S. Implant Navigation System: Dynamic Guided Surgery. In: Galante, JM, Rubio, NA (eds) Digital Dental Implantology 2021. Springer, Cham. https://doi.org/10.1007/978-3-030-65947-9_7.
7. Parra-Tresserra A, Marquès-Guasch J, Ortega-Martínez J, Basilio-Monné J, Hernández-Alfaro F. Current state of dynamic surgery. A literature review. Med Oral Patol Oral Cir Bucal 2021 Sep 1;26(5):e576-e581. doi: 10.4317/medoral.24566. PMID: 34023841; PMCID: PMC8412455.
8. Inliant: Navigate Surgical Technologies Inc.: British Columbia. Navigate Surgical https://www.navigatesurgical.com/.
9. Parra-Tresserra A, Marquès-Guasch J, Ortega-Martínez J, Basilio-Monné J, Hernández-Alfaro F. Current state of dynamic surgery. A literature review. Med Oral Patol Oral Cir Bucal 2021 Sep 1;26(5):e576-e581. doi: 10.4317/medoral.24566. PMID: 34023841; PMCID: PMC8412455.
10. Pellegrino G, Bellini P, Cavallini PF, Ferri A, Zacchino A, Taraschi V, Marchetti C, Consolo U. Dynamic navigation in dental implantology: The influence of surgical experience on implant placement accuracy and operating time. An in vitro study. Int J Environ Res Public Health 2020 Mar 24;17(6):2153. doi: 10.3390/ijerph17062153. PMID: 32213873; PMCID: PMC7142455.

*X-Nav Technologies

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Peripheral Ameloblastoma

Case Report and Literature Review

Anna Cappell Cooper, B.A.; Daria Vasilyeva, D.D.S.; Khanh Trinh, D.M.D.; Elizabeth Philipone, D.M.D.

ABSTRACT

Peripheral ameloblastoma is a benign, painless and slow-growing odontogenic tumor, which commonly affects gingival soft tissues or edentulous alveolar areas. Peripheral ameloblastoma is typically found during the 5th to 7th decades of life, with a mean patient age of 52 years and a male predilection. Histopathology features are consistent with those of conventional ameloblastoma. The treatment of choice is conservative surgical excision with minimal disease-free margins and appropriate follow-up.

Peripheral/extraosseous ameloblastoma is a rare and benign odontogenic tumor that affects gingival soft tissues or edentulous areas.[1] The term was first introduced in 2011 by Kuru; and fewer than 200 cases had been reported before 2014. According to the most recent World Health Organization (WHO) classification in 2022, there are four subtypes of ameloblastoma: solid/multicystic; unicystic; desmoplastic; and peripheral/extraosseous.[2] It is believed to be the rarest subtype of ameloblastomas, with a prevalence of 1% to 10%.

Patients typically present between the ages of 40 and 60; and the lesion exhibits a male predilection. Clinically, it is less aggressive than conventional ameloblastomas, typically indolent and painless, although it may rarely cause mild erosion of nearby cortical bone.

Herein we present a case of peripheral ameloblastoma in the right retromolar pad in a 59-year-old male patient.

Case Report

A 59-year-old male in apparent good health was referred to an oral and maxillofacial surgeon by his dentist for evaluation of a lesion of the right retromolar pad. The patient was not aware of the lesion prior to the visit and did not indicate experiencing any associated pain or bleeding. Review of his medical history was noncontributory. Intraoral examination revealed a smooth, well-demarcated red swelling of the soft tissue distal to right mandibular molars (Figure 1). No radiographic changes were noted.

A biopsy of the soft-tissue lesion was performed to establish the diagnosis. On microscopic examination, the lesion consisted of abundant islands and cords of odontogenic epithelium in continuity with overlying surface epithelium. The peripheral cells of these islands and cords were tall and columnar, with reversely polarized hyperchromatic nuclei. The central cores were composed of loosely arranged angular cells resembling stellate reticulum, as well as large polygonal squamous cells with abundant eosinophilic cytoplasm (Figure 2).

Discussion

Peripheral ameloblastoma is a rare, benign, epithelial odontogenic tumor that affects soft tissues of the gingiva or edentulous alveolar areas.[3] In the most recent WHO classification, ameloblastoma was classified into: conventional (formerly, solid/multicystic); unicystic; peripheral (extraosseous); and a newly added adenoid ameloblastoma.[4]

Peripheral ameloblastomas account for 1% to 10% of all ameloblastomas and are nearly twice as common in males as in females.[3] Lesions more commonly occur in the mandible, particularly in the soft tissues of the retromolar pad and on the lingual aspect of the gingiva, with a maxilla-to-mandible occurrence ratio of 1:2.4. When present in the maxilla, the lesions commonly occur on the soft, palatal tissue of the maxillary tuberosity.

Although most patients present between the ages of 40 and 60, the age of presentation can range from 9 to 92 years.[4] All types of ameloblastomas are more prevalent in Asian and African-Caribbean populations, with individuals of African descent typically presenting at a younger age.[5]

Although the etiology of peripheral ameloblastoma is not certain, some probable sources of the lesion include remnants of the dental lamina (glands of Serres), odontogenic remnants of the vestibular lamina, and pluripotent cells in the basal cell layer of the mucosal epithelium.[6] Newer data point to gene mutations as pathogenic factors in the development of all types of ameloblastomas. Genetic mutations that lead to dysregulation of the MAP kinase pathway, including those in BRAF and somatic mutations in NRAS and SMO, have been detected in cases of peripheral ameloblastoma. The most common mutation among them is BRAF p.V600E7.

Clinically, peripheral ameloblastoma appears as a solid or cystic lesion with a surface that is either smooth, granular or papillary. The tumor rarely exceeds 4 cm in size and is asymptomatic.[1] Given its extraosseous nature, most cases do not present with radiographic changes. Some, however, exhibit peripheral and superficial bone erosion due to pressure resorption, known as the cupping effect or saucerization.[3] In order to make a diagnosis of peripheral ameloblastoma, radiographs must be taken to rule out intraosseous ameloblastoma that perforated cortical bone, and histologic evaluation is necessary to establish the diagnosis.[8]

Similar to conventional ameloblastoma, peripheral ameloblastomas most often fall into follicular and plexiform microscopic patterns,[1] with either classic and/or acanthomatous cell morphology.[1,9] Microscopically, follicular ameloblastoma consists of islands of odontogenic epithelium within a fibrous connective tissue stroma. The peripheral cells of the islands are usually cubic or columnar in shape, exhibiting reversed polarity and hyperchromatic nuclei,

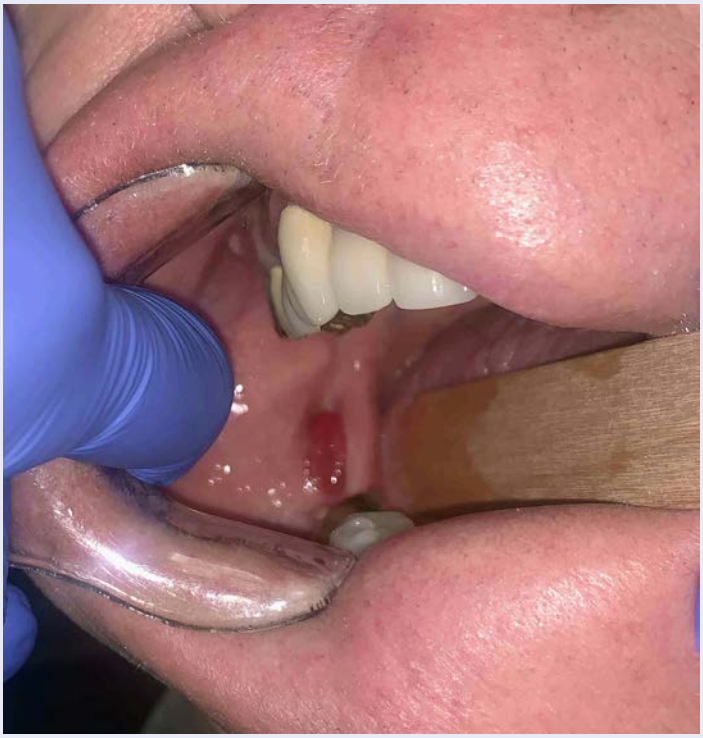

Figure 1. Well-demarcated, raised red lesion of right retromolar pad.

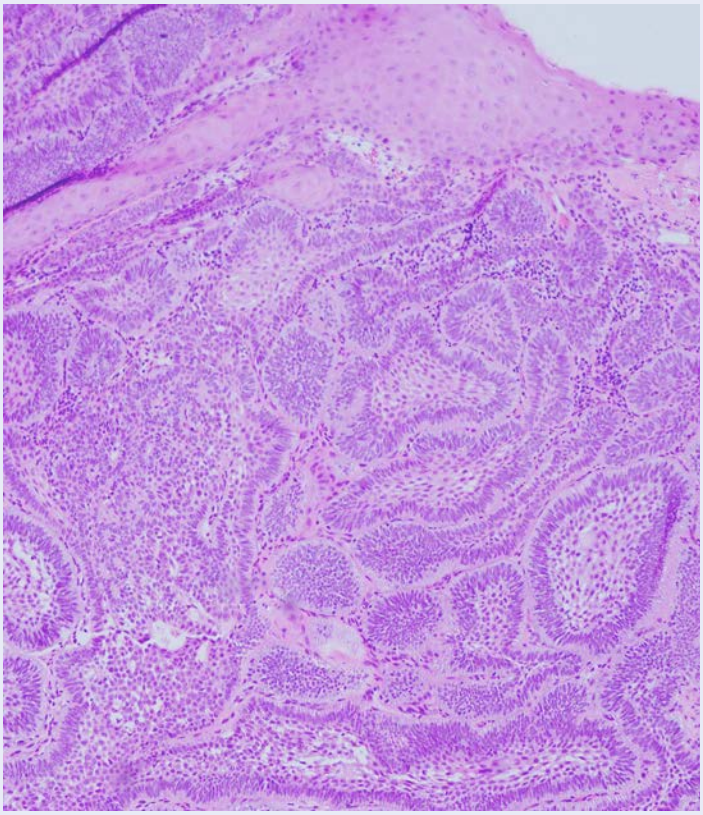

Figure 2. Underneath surface epithelium, lesion consists of abundant islands and cords of odontogenic epithelium. Peripheral cells of these islands are tall and columnar, with reversely polarized nuclei (100x, hematoxylin-eosin).

while the cores of the islands consist of loose angular cells resembling stellate reticulum (classic cellular morphology), or large polygonal squamous cells with abundant eosinophilic cytoplasm (acanthomatous cellular morphology).[3]

The second most common plexiform pattern of ameloblastoma is characterized by interlacing and anastomosing strands of epithelial cells with similar palisading and nuclear polarization of basal cells. Fifty percent of peripheral ameloblastomas show continuity with the overlying epithelium.[8]

Peripheral ameloblastoma may raise histologic suspicion for intraoral basal cell carcinoma (IOBCC). Albeit extremely rare, IOBCC has been reported on the gingiva. Therefore, when diagnosing peripheral ameloblastoma, it is important to be aware of some histologic features that are specific to IOBCC, such as its origination from surface epithelium, presence of scattered mitotic figures and apoptotic cells, the presence of mucoid ground substance and infiltration of the tumor throughout the connective tissue.[10]

More recently, immunohistochemical examination has been used to aid in the diagnosis and to differentiate between peripheral ameloblastoma and BCC, particularly the expression of BER-EP4 in BCC4. Peripheral ameloblastomas show positive reactivity to immunostaining of amelogenin, calretinin and cytokeratins 5, 14 and 19, with CK13 preferentially expressed in stellate reticulum-like cells, CK14 in peripheral cells and CK19 in all cells.[1]

The benign, slow-growing nature of peripheral ameloblastoma, coupled with a high recurrence rate, render the issue of preferred treatment controversial.[11] The current treatment of choice is conservative supraperiosteal surgical excision with disease-free margins.[6] The extent of the excision and decision to include healthy margins is dictated by histopathological features, tumor location, size and patient factors, such as age and one's individual anatomy.[5]

Surgery can be supplemented with curettage, cryotherapy, electrocautery or tissue fixation, which does not seem to play a role in potential recurrence.[12] Long-term follow-up of at least 10 years is necessary, given a relatively high recurrence rate of up to 19%, although the recurrence is mostly attributed to incomplete excision rather than disease behavior.[1]

Conclusion

The gingiva is a site that can be affected by a variety of oral pathologies, and chairside diagnosis presents a challenge

for the clinician. A biopsy is often necessary in rendering a definitive diagnosis for gingival lesions.

The authors of this paper report no conflicts of interest nor did their study receive commercial funding. Queries about this article can be sent to Ms. Cooper at Ac4746@cumc.columbia.edu.

REFERENCES

1. Vezhavendhan N, Vidyalakshmi S, Muthukumaran R, Santhadevy A, Sivaramakrishnan M, Gayathri C. Peripheral ameloblastoma of the gingiva. Autopsy and Case Reports 2020;10(1). https://doi.org/10.4322/acr.2019.127.
2. Vered M, Wright JM. Update from the 5th Edition of the World Health Organization Classification of Head and Neck Tumors: Odontogenic and Maxillofacial Bone Tumours. Head and Neck Pathol 2022;16:63–75. https://doi.org/10.1007/s12105-021-01404-7.
3. Assis EM, Gomes HE, Sousa FE, Brener S, Leal RM, Alencar Souza PE, Rebello Horta MC. Recurrent peripheral ameloblastoma in an elderly patient: A case report. Gerodontology 2019;36(1):78–81. https://doi.org/10.1111/ger.12377.
4. Kaneko T, Nakamura S, Kawano R, Horie N, Shimoyama T. Peripheral ameloblastoma of the mandible: A case report. Journal of Oral and Maxillofacial Surgery, Medicine, and Patholog 2016;28(6):565–568. https://doi.org/10.1016/j.ajoms.2016.01.008.
5. Anpalagan A, Tzortzis A, Twigg J, Wotherspoon R, Chengot P, Kanatas A. Current practice in the management of peripheral ameloblastoma: a structured review. The British Journal Oral & Maxillofacial Surgery 2021;59(1): e1–e8. https://doi.org/10.1016/j.bjoms.2020.08.084.
6. Beena VT, Choudhary K, Heera R, Rajeev R, Sivakumar R, Vidhyadharan K. Peripheral ameloblastoma: A case report and review of literature. Case reports in dentistry 2012. https://doi.org/10.1155/2012/571509.
7. Guimarães LM, Coura BP, Gomez RS, Gomes CC. The molecular pathology of odontogenic tumors: Expanding the spectrum of MAPK pathway driven tumors. Frontiers in Oral Health, 2 2021, https://doi.org/10.3389/froh.2021.740788.
8. Philipsen HP, Reichart PA, Nikai H, Takata T, Kudo Y. Peripheral ameloblastoma: biological profile based on 160 cases from the literature. Oral Oncology 2001;37(1):17–27. https://doi.org/10.1016/s1368-8375(00)00064-6.
9. Hertog D, Bloemena E, Aartman IH, van-der-Waal I. Histopathology of ameloblastoma of the jaws; some critical observations based on a 40-year single institution experience. Medicina Oral, Patologia Oral y Cirugia Bucal 2012;17(1): e76–e82. https://doi.org/10.4317/medoral.18006.
10. Woods TR, Cohen DM, Islam MN, Kratochvil FJ, Stewart J C, Reeder SL, Bhattacharyya I. Intraoral basal cell carcinoma, a rare neoplasm: report of three new cases with literature review. Head and Neck Pathology 2014;8(3):339–348. https://doi.org/10.1007/s12105-013-0505-5.
11. Cadavid AM, Araujo JP, Coutinho-Camillo CM, Bologna S, Junior CA, Lourenço SV. Ameloblastomas: Current aspects of the new WHO classification in an analysis of 136 cases. Surgical and Experimental Pathology 2019;2(17). https://doi.org/10.1186/s42047-019-0041-z.
12. Borrello R, Bettio E, Bacci C, Valente M, Sivolella S, Mazzoleni S, Berengo M. (2016). A conservative approach to a peripheral ameloblastoma. Case Reports in Dentistry 2016, 8254571. https://doi.org/10.1155/2016/8254571.

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Low-Cost Liquid Tames Tooth Decay

Silver diamine fluoride prevents cavities and keeps existing ones from worsening in school-based program.

AN INEXPENSIVE, cavity-fighting liquid called silver diamine fluoride (SDF) works as well as dental sealants to keep tooth decay at bay in a school cavity prevention and treatment program, according to a new study by researchers at NYU College of Dentistry.

The study, which followed more than 4,000 elementary school students for four years and is published in JAMA Pediatrics, shows that SDF is an effective alternative to sealants, and can increase access to dental care while reducing costs.

To prevent cavities, especially among children less likely to see a dentist, the Centers for Disease Control and Prevention (CDC) supports the use of school sealant programs. In sealant programs, dental professionals visit schools to apply a thin, protective coating to the surface of teeth that hardens and safeguards against decay.

SDF has emerged as another promising treatment for fighting cavities. Originally approved by the FDA for treating tooth sensitivity, the solution is brushed onto the surface of teeth, killing decay-causing bacteria and remineralizing teeth to prevent further decay.

"A growing body of research shows that SDF—which is quicker to apply and less expensive than sealants—can prevent and arrest cavities, reducing the need for drilling and filling," said Richard Niederman, D.M.D., professor of epidemiology and health promotion at NYU College of Dentistry and the study's senior author.

Researchers at the College of Dentistry led Caried*Away*, the nation's largest school-based cavity prevention study, to compare the use of SDF and traditional sealants. The study included approximately 4,100 children in New York City elementary schools; more than a quarter of kids had untreated cavities at the start of the study.

At each school visit, a team of health professionals examined children's teeth and applied either sealants or SDF, followed by fluoride varnish, depending on which treatment the school was randomly assigned to receive. Sealants were administered by dental hygienists, while SDF was applied by either dental hygienists or registered nurses, all under the supervision of a dentist. Starting in 2018, the team visited each school twice a year, although the COVID-19 pandemic and school closures led to missed visits.

The researchers reported last year in the journal JAMA Network Open that a single treatment of either SDF or sealants prevented 80% of cavities and kept 50% of existing cavities from worsening two years later. The team continued their study for another two years, and in their study published in JAMA Pediatrics, found that SDF and sealants prevented roughly the same number of cavities after children were followed for a total of four years. Moreover, both sealants and SDF reduced the risk of decay at each follow-up visit.

The NYU researchers additionally found that children who had SDF applied by dental hygienists and registered nurses had similar outcomes, suggesting that nurses—including school nurses—could play a crucial role in cavity prevention programs.

This research was funded by the Patient-Centered Outcomes Research Institute (PCS-160936724). Also contributing to the study were Ryan Richard Ruff, Ph.D., M.P.H., associate professor of epidemiology and health promotion, the study's first author, and Tamarinda Barry Godin, D.D.S., M.P.H., associate program director and supervising dentist for Caried*Away*, the study's coauthor.

IT'S AN HONOR

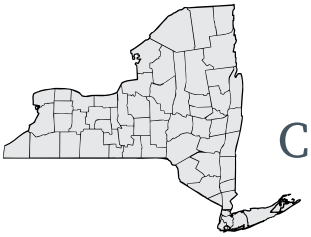
Dr. Bruce H. Seidberg of Jamesville, Fifth District, was honored with a Lifetime Service Award, presented by American College of Legal Medicine for his leadership, dedication and service to ACLM. Presenting Dr. Seidberg with his award during organization's annual meeting in San Diego is Dr. Jennifer Unis-Sullivan, general dentist from Pittsburgh, PA, and ACLM President-Elect. Dr. Seidberg was the first dentist president of ACLM, whose members are dual-degree physicians, dentists and attorneys.

Dental School Receives National Institutes of Health Diversity Award

THE UNIVERSITY AT BUFFALO SCHOOL OF DENTAL MEDICINE has received the Institutional Excellence in Diversity, Equity, Inclusion and Accessibility (DEIA) in Biomedical and Behavioral Research Prize from the National Institutes of Health.

UB is one of 10 universities that received the inaugural $100,000 prize for demonstrating exceptional dedication and innovation in fostering DEIA within research environments. UB's dental school was recognized specifically for its pathway programs, Destination Dental School and Native American Pre-Dental Gateway Program, and its mentoring program, Support, Training, Early-Career Enhancement and Retention (STEER).

The dental school's focus on celebrating diversity in the dental profession has also led to the creation of a required online, interactive pre-orientation to equity, diversity and inclusion for incoming first-year dental students and a course focused on the social determinants of health.



Component NEWS

EIGHTH DISTRICT

CE Advocate Honored

Kevin J. Hanley, D.D.S.

On Friday, March 22, the Eighth District held its spring lectures "Diamonds and Pearls are a Practice's Best Friend" and "Embrace the Change," both presented by Dr. Timothy Bizga at Salvatore's Italian Gardens in Depew. This was also the inaugural Dr. Marshall Fagin Spring Lecture, honoring Dr. Marshall Fagin, a longtime supporter of continuing education in the Eighth District.

Dr. Fagin started the Metropolitan Dental Study Club in 1974 to aid local dentists in treatment planning cases and continuing education. The study club grew over the years, offering evening CE lectures on multiple topics, including a once-a-year full-day program in combination with the University at Buffalo School of Dental Medicine and Alpha Omega Dental's Sugarman Program. COVID brought the MDSC to an end, and its Board of Directors donated its proceeds to the Eighth District in honor of Dr. Fagin to support CE in the district.

The "Diamonds and Pearls" portion of the day provided a bevy of "diamonds" on clinical techniques and treatment planning and "pearls" essential to seeing long-term success and financial growth. From understanding patient decision-making to tools and tips for getting patients to be "WOWed" with the overall experience, the course gave practical "soup-to-nuts" approaches to the latest clinical research and approaches to human behavior, with special emphasis on team communication.

The "Embrace the Change" portion of the day reviewed key concepts and provided clinical pearls for dental professionals who provide esthetic implant and complex restorative procedures to patients. The course helped troubleshoot familiar challenges faced when executing these procedures.

Those in attendance left with practical knowledge they could incorporate into their practices, as well as 7 MCE credits.

Managing Risk

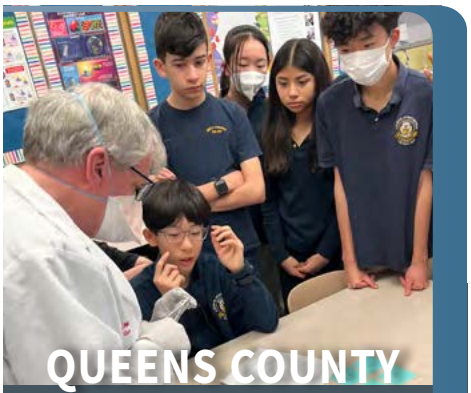
On Thursday, March 28, the Eighth District, along with Fortress Insurance Co., held "Reducing Dental Practice Risk" at the district office. Dr. Michael R. Ragan, D.M.D., J.D., LL.M., discussed strategies and resources to enhance patient safety and reduce risk in everyday dental practice. Closed claim topics included ethnic restorations, wisdom tooth extractions, oral cancer, endodontic treatment and implants. Risk management topics included documentation, communication, informed consent, ethnology, patient selection, referrals, prescription practices, patient noncompliance and ethics.

Attendees earned 3 CE hours and a 10% discount on their malpractice insurance premiums for three years.

Keeping Offices Safe

On Thursday, April 11, the Eighth District presented "Infection Control in Dentistry: A Practical" at district headquarters. Dr. Alyssa Tzetzo, D.D.S., M.P.H., discussed the latest developments in infection control in the dental practice.

Dental office infection control has evolved since the OSHA Bloodborne Pathogens Standard and the NYS training



QUEENS COUNTY

Choose Dentistry—Queens County past president Alan N. Queen traveled to BELL Academy (MS294 Queens) in Bayside for the school's annual Career Day in March. Dr. Queen spoke with about 50 middle school students about health professions and dentistry as a career. He also gave a demonstration of suturing techniques using a stuffed animal named "Mrs. Jones." (Photo by Danielle Queen)

FOURTH DISTRICT

Cancer Warriors—It was "Stick it to Cancer Night" when the Adirondack Thunder hockey team took to the ice on Mar. 29. And the Fourth District was there, to provide free oral cancer screenings. The event was arranged by the New York State Dental Foundation and the CR Wood Cancer Center at Saratoga Hospital. Volunteer screeners saw close to 50 fans that night. They included, from left, Drs. John Mitza, Joseph Potvin and Tim Adams. They are joined by Foundation Executive Director Stacy McIlduff. Also volunteering was Dr. Jamie Cohn.

requirement were introduced in 1992. Practices have continued to incorporate advisories from federal, state and local agencies. The latest challenge to dentistry is, unquestionably, the COVID-19 pandemic. Every dental office needs to be familiar with current guidance to provide a safe environment for patients and staff. Updates from OSHA, NIOSH, CDC, FDA, EPA and ADA must be incorporated into our daily routines. Dr. Tzetzo's course examined conventional and emerging aspects of infection control.

Attendees received 3 MCE hours and satisfied the four-year license renewal requirement for infection-control education.

Be Retirement-Ready

The Eighth District will hold its annual Medicaid seminar on Monday, April 22, at the district office. This seminar will cover all the ins and outs of Medicare for members approaching their 65th birthdays. Those who have already reached this milestone know there are annual and trending changes to Medicare program plans. The seminar will not replace the annual enrollment meeting held in October, but will allow our soon-to-be-retiring members to get a leg up on their future retirement planning with answers to their Medicare questions. Representatives from both HIGHMARK Medicare and Walsh Duffield Healthcare Insurance will present a variety of service plans and options to the members.

Evening CE

The Erie County Dental Society will hold an evening continuing education course on Tuesday, April 23, at Santora's on Transit Road in Williamsville. Dr. Samil Nigalye will present "Rehabilitation of the Severely Atrophic Maxilla." Dr. Nigalye's discussion will include the epidemiology of the condition, pertinent anatomy and options for treatment, anatomical and restorative considerations, surgical techniques, and restorative and surgical complications involved in the various methods of rehabilitation.

Participants will earn 1.5 hours of MCE.

Read, Learn and Earn

Readers of *The New York State Dental Journal* are invited to earn two (2) home study credits, approved by the New York State Dental Foundation, by properly answering 20 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.

Guiding our Implants—Page 20-23

1. Dynamic surgical guidance (DSG) is a recent advancement in implant dentistry, used to maximize the efficiency and predictability of implant dentistry.
   ☐ T or ☐ F

Visit our online portal for more....

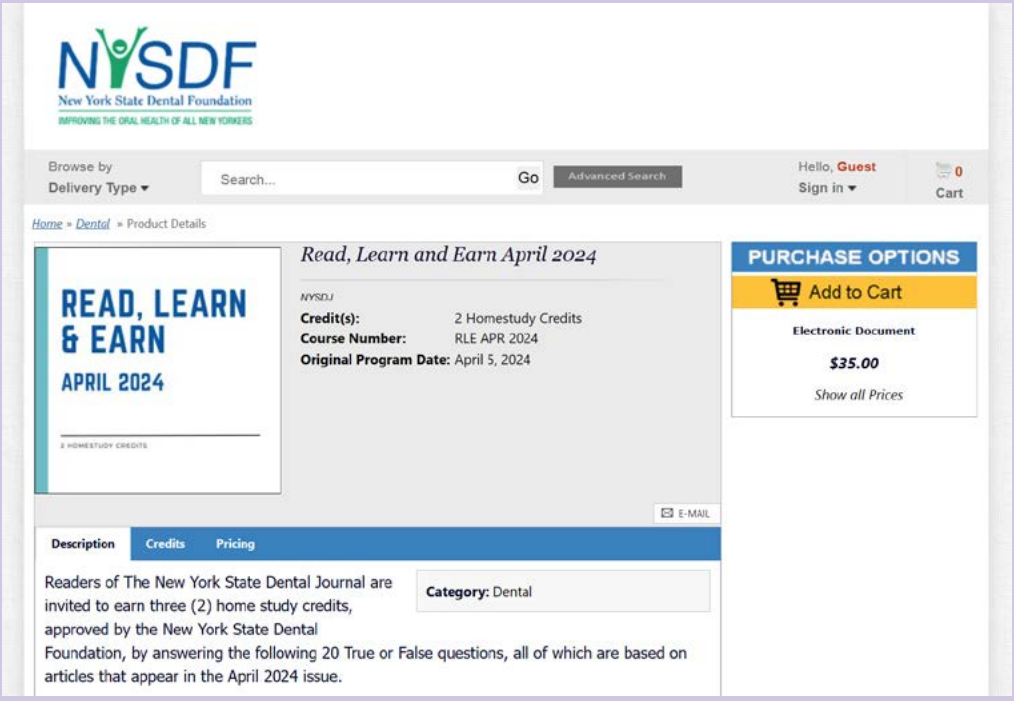
Peripheral Ameloblastoma—Page 24-26

1. Peripheral ameloblastomas (PA) are usually fast growing and painful.
   ☐ T or ☐ F

Visit our online portal for more....

Click below

ONLINE CE QUIZ



CLASSIFIED
INFORMATION

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FOR SALE

NEW YORK METRO AREA: Well-established practice in prime NYC area. Beautiful office and great lease available in Woodside, Queens. Very negotiable. Current dentist unwell and looking to retire. Will stay on for short transition period if needed. Please contact to discuss. Email: hjameradds@gmail.com; or call (347) 453-9581.

SARATOGA SPRINGS: Excellent turnkey, state-of-the art dental office available. Bright and immaculate 1,800-square-foot suite. Highly desirable location. Digital X-rays, CS 3800 scanner and fully computerized. Three well-equipped operatories with state-of-the-art technology. Well-trained team available for transition if desired. Excellent opportunity for startup or satellite office. Photos available. Priced to move with favorable terms. Contact: dr.benjamin@benjaminsmile.com.

LOWER WESTCHESTER: 2-office general practice for sale. Larchmont and Bronxville; will separate. Total gross between $400K - $450K for last 3 years on 30-hour workweek with 12 weeks vacation. Mostly implant restoration, hygiene and C&B. All endo, perio, ortho and surgery referred. Mostly PPO and private; no HMO or Medicaid. Each office has about 1,000 active patients and can easily be expanded with full-time schedule. Contact to discuss. Email: esr77@optonline.net.

FOREST HILLS: General dental practice and real estate for sale. Beautiful and recently renovated dental office with 4 ops, reception area, waiting room and restroom, private office, private lab with restroom, CBCT/Pan machine. Plumbed to add 5th op. Fully digital with Dentrix and Dexis. Located in heart of Forest Hills, just off Queens Blvd and convenient to all subways. Located in residential building on ground floor with separate entrance and signage. Strong patient base with mix of PPO and FFS. Grossing $850K, plus fair market pricing for real estate. Package deal. Contact by email do discuss. Email: chauncyang24@gmail.com.

GREATER ALBANY AREA: General dental practice for sale. Premier dental practice serving greater Albany community for nearly 20 years with focus on exceptional patient care and staff satisfaction. Located in modern, newly constructed medical office. Boasts five state-of-the-art operatories; expandable to seven. Poised for growth with 2,200 active patients and 10-15 new patients monthly. 100% FFS with collections of $1.5M and EBITDA of $360K. Excellent opportunity for expansion by extending operating hours beyond current four-day week. Real estate available. Albany's blend of urban and natural settings, along with rich cultural scene and affordability, makes this ideal location for both professional and personal fulfillment. For more information, contact Professional Transition Strategies by email: bailey@professionaltransition.com or call: (719) 694-8320. Reference #NY22124.

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.

NYC METRO AREA: Endo practice. Located in Northern New Jersey near New York City, an esteemed endodontic practice now available for acquisition, offering blend of suburban appeal and urban accessibility. Reputable practice, established for decades, known for strong patient relationships and excellence in care. Four fully equipped operatories and impressive performance, with 735 cases in past year and attracting 65-70 new patients monthly through word-of-mouth. Highlights: annual collections of $1.8M and EBITDA $340K. Current doctor-owner open to various transition options, including collaboration for smooth transfer of ownership. Interested parties invited to contact Bailey Jones at Professional Transition Strategies for more details and to review the prospectus. Contact: Bailey Jones by email: bailey@professionaltransition.com; or call (719) 694.8320. #NJ122023.

ALBANY: Nestled in Albany, renowned for its rich history, cultural vibrancy and top-tier educational institutions is thriving general dental practice. Situated along scenic Hudson River, well-established practice holds strong patient base with 1,560 active members. Six (6) state-of-the-art operatories, supporting both principal doctor and associate. Open four days/week and offers room for growth. Generating impressive EBITDA of $530K. Real estate can be acquired at time of sale, presenting outstanding investment opportunity. Current owner keen on ensuring seamless transition, prioritizing practice's ongoing success. Interested parties invited to discover this golden opportunity further by contacting Professional Transition Strategies: Email Bailey Jones at bailey@professionaltransition.com; or call: (719) 694- 8320, referencing #NY83023.

BRONX: Long-established general dental practice for sale in Kingsbridge area of Bronx. Located in high-visibility building with significant foot traffic. Medicaid/Insurance /Private. 100% digital and paperless office with digital X-rays and practice software. 2-op practice with 1,100 square feet at $1,500/month. Parking available for dentist. Open Monday-Thursday from 10 a.m. to 4 p.m., creating lots of potential to grow practice. 2022 gross collections $399K. Asking $350K. Contact to discuss: Victor Henriquez at (347) 749-2049; or email: eribaez@hotmail.com.

BRONX: 3-op office designed for comfortable working conditions available for sale. Includes lab and sterilization area. Very heavily populated area. Owner retiring for medical reasons. Call to discuss: (347) 831-3742 or (718) 379-4800.

QUEENS: Astoria practice for sale. 3-op practice with X-ray room and located on busy Steinway Street. 25-year-old practice is gold mine for young dentist seeking to productively start career. Mostly Fidelis Care and DentaQuest insurance, along with some PPOs. Contact Dr. Samarneh to discuss at (914) 714-3770.

BUFFALO: General dental practice for sale. Located in culturally rich and architecturally significant city of Buffalo. Opportunity includes two strategically situated practices, each with four operatories, totaling eight. Practice boasts over 2,000 active patients, with an influx of 32 new patients monthly, reflecting its strong community trust and reputation. Key financial highlights include collections of $1.9 million and EBITDA of $430K. Operational model accommodates both an owner-doctor and associate, fostering collaborative environment. Seeking partnership with either individual dentist or dental group that shares patient-first philosophy. Buffalo offers vibrant lifestyle with its cultural scenes, educational institutions and outdoor attractions. For more information and to review prospectus, contact Professional Transition Strategies. Email Bailey Jones at bailey@professionaltrasition.com; or call (719) 694-8320. Reference #NY122023.

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 Michael Damon at (315) 430-9224; or email: mike.damon@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 completely paperless. Revenue over $700K. One FT and one PT Hygienist. Real estate also. 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 Michael Damon by email: mike.damon@henryschein.com; or call (315) 430-9224. #NY3071.

ORANGE COUNTY: Family-oriented practice in desirable location experiencing explosive retail and residential growth, with completion and early success of Legoland. Well-established practice has served dental needs of area for past 30 years. Housed in 1,500-square-foot building with mixed tenants. Four fully equipped treatment rooms featuring contemporary up-to-date equipment, including intraoral camera, imaging scanner, Picasso laser unit and utilizes Dentrix and Dexis. Diagnostic, preventive and restorative-driven practice, with strong hygiene program. For details contact Dental Practice Transitions Consultant Chris Regnier at (631)766-4501; or email: chris.regnier@henryschein.com. #NY3257.

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.

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 seller and for sale with practice. Contact Dental Practice Transitions Consultant Brian Whalen at (716) 913-2632; or email: brian.whalen@henryschein.com. #NY1648.

JEFFERSON COUNTY: Great opportunity. Long-established, profitable practice is 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/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.

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 impression systems added in recent years. 3,500 active patients and combination of insurance and FFS. Strong hygiene program. Well-trained team available for transition. Contact Dental Practice Transitions Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3395.

EASTERN LONG ISLAND: Well-established PPO/FFS dental practice/charts sale. In practice for 17 years with over 779 active patients and averages 10-15 new patients monthly. For details contact Transition Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3437.

BINGHAMTON AREA: Reduced price with motivated seller. Highly profitable $600K-revenue, modern, attractive practice 20 minutes from downtown. Great location, with beautiful views from 2 of 4 well-equipped treatment rooms. Approximately 1,000-square-foot space. Standalone building, available for sale with practice purchase, has apartment to rent upstairs. Practice utilizes Eaglesoft PM with digital sensors and digital scanner. Refers out most specialties. Strong new patient flow with 1,100 active patients. Practice open 34 hours/week. FFS/PPO. Doctor willing to stay on with transition. Contact Transition Sales Consultant Mike Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3444.

SUFFOLK COUNTY: Well-established general practice located in professional building that overlooks beautiful park and plenty of parking. Three fully equipped treatment rooms and open 4.5 days/week. Highly profitable with collections over $570k. Collections based on 50% FFS and 50% PPO insurance. Seller open to transition options. For details contact Transition Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3470.

UPSTATE NY: Long-established practice in diverse community halfway between Binghamton and Syracuse; situated just minutes from area hospital and college on busy 2-lane road with excellent street visibility. Three operatories in 3,000 square feet and room to expand. Real estate also available. Building includes 2,000-square-foot rental apartment upstairs for great passive income. Three full-time employees, including one full-time Hygienist. 75% FFS and 25% PPO. Refers out all endo, ortho and oral surgery, offering great upside for new owner. 2022 gross collections $358K. Highly motivated seller. Contact Transition Sales Consultant Mike Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3488.

STATEN ISLAND: State-of-the-art general practice in highly desirable area. Doctor will provide 100% seller financing. 1,500-square-feet in beautiful free-standing building with 5 fully equipped treatment rooms. Open Dental software, digital X-rays and paperless. 80% FFS and 20% PPO, with collections $624K in only 2.5 days/week. For more information contact Transition Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3562.

ONEIDA COUNTY: Bright, immaculate, all-digital, 100% FFS practice, with great curb appeal. Highly desirable location, with convenient access to highways. $900K+ revenue on 4-day workweek. Seller in practice for 30 years and committed to aiding in very successful transition. Four well-equipped operatories and Dentrix, all in efficiently designed 1,100-square-foot space. Thriving general practice averages 30+ new patients per month. Excellent turnkey opportunity. Contact Transitions Sale Consultant Mike Damon at (315) 430-9224 or email: mike.damon@henryschein.com. #NY3513.

ROCKLAND COUNTY: Beautifully appointed, very welcoming practice with collections just under $445K sits in front entrance of multi-tenant office building, with street-front visibility and free parking. 3 ops within 1,325 square feet. Seller will provide doctor-friendly lease, with option to purchase. 60% PPO and 40% FFS. Office has hygienist and refers endo, ortho, pedo, oral surgery and implant placement. Seller available to stay during transition period. Strong upside to grow revenues with added procedures and hours. Contact Transition Sales Consultant Donna Costa by phone (609) 304-0652; or email: donnacosta@henryschein.com. #NY3563.

SENECA COUNTY: Charming practice in heart of Finger Lakes region; 45-minute drive to both Rochester and Syracuse city centers. Digital practice offering 3 equipped ops, with 2022 revenue of $653K on 3 clinical days/week. Softdent, 2D pano and diode laser. 1,700-square-foot practice offers comprehensive dental care in welcoming environment. Full-time Hygienist and full administrative

staff, all with excellent systems and training in place. 50% FFS. Refers out specialties. Real estate also available. Schedule to see this wonderful opportunity today. Contact Transition Sales Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3572.

MANHATTAN: Great opportunity to own private, well-established practice in elegant boutique residential apartment building with commercial street-front-level entrance in desirable area, close to Lexington Ave. 2 treatment rooms in 600 square feet, including intraoral camera, scanner, laser and digital X-ray in nicely renovated modern office. Collections in 2022 were $409K, driven by 60% PPO, 40% FFS and active patient base, with strong new patients per month. Great startup for younger doctor looking for successful Manhattan focal point. Contact Transition Sales Consultant Rikesh Patel by phone: (845) 551-0731; or email: rikesh.patel@henryschein.com. #NY3596.

ST. LAWRENCE COUNTY: Highly profitable, $550K+ revenue, all digital practice on just 3 day/week schedule. Located in scenic St. Lawrence County, along Canadian border. 5 well-equipped treatment rooms. Approximately 2,500-square-foot practice space with building available for sale. Large property with ability to expand footprint. Eaglesoft PM and iCat 3D. Refers out all Endo and Ortho. 1,200 active patients, with strong new patient flow. FFS practice with 1 in-network insurance. Doctor willing to stay on for 12 months to assist with transition. Priced to move. For more information, contact Transition Sales Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3632.

WESTCHESTER: Holistic general dental practice for sale. 4 ops in spacious 1,800-square-foot suite in medical building. FFS office on pace to gross over $1.7M in 2023. Cone beam CT, Dentrix software, Trios scanner, as well as digital X-rays, computers, TVs in every operatory. Open only 4 days/week. Amazing opportunity to purchase profitable practice with huge growth potential in wonderful community. For details contact Transitions Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3641.

NASSAU COUNTY: FFS practice for sale. Consistently grosses over $1.3M and highly profitable. Selling dentist has owned practice for 39 years. 4 treatment rooms in approximately 1,100 square feet. Dentrix software, digital X-rays and open 4.5 days/week. For more information contact Transition Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3650.

SOUTHERN ERIE COUNTY: Fantastic opportunity to grow in 3-op digital practice treating 1,100 active patients 3.5 days/week. Well-established patient base of mixed PPO and FFS. Real estate with apartment also available. Plenty of off-street parking. Low overhead and skilled team make great opportunity for profit and lifestyle. Contact Transition Sales Consultant Brian Whalen at (716) 913-2632; or email: Brian.Whalen@henryschein.com. #NY3661.

WESTERN NEW YORK: 5-op practice with 4,700 active patients and averaging 40 new patients per month. Well-established growing practice with loyal patient base. 86% insurance and 14% FFS. Fully digital pan, sensors, intraoral cameras and paperless charting, all integrated with Eaglesoft software. Building with off-street parking and additional rental units also for sale or lease. Outstanding staff and established patient base make this wonderful opportunity. Contact Transition Sales Consultant Brian Whalen at (716) 913-2632; or email: Brian.Whalen@henryschein.com. #NY3665.

SOUTHERN TIER: Long-established, stable, 8-op FFS practice. No in-network insurance. Located on main road, this standalone building offers great visibility and curb appeal. 2,620-square-foot, 100% digital practice utilizes computers throughout with Softdent, Carestream sensors and CS8100 panoramic X-ray. Well-trained, experienced team of professionals, including 4 full-time hygienists expected to transition with practice. Open 5 days per week with 4,100 active patients and healthy new patient flow. Doctor willing to stay on for up to 12 months to assist with transition. Priced to move. Contact Transition Sales Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3679.

CAPITAL REGION: Attractive 2,100-square-foot practice in professional building on busy main road. 5 well-equipped treatment rooms and 6th plumbed in long-established practice. Located in desirable, affluent community, with one of area's top school districts. Affordable rent with assignable lease. 100% digital, paperless and utilizes Eaglesoft. Doctor refers out all endo, implants, perio, ortho, and some extractions. Primarily PPO. Schedule showing today, as seller looking to sell and transition quickly. Contact Transition Sales Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3691.

WESTERN NEW YORK: Fantastic opportunity to own well-established, thriving general practice in beautiful area. 5-ops, fully digital, paperless, supported by Eaglesoft software, with room to expand if desired. Strong hygiene team treats patients with care and has excellent recall. Sensors, scanner, laser, air, electric handpieces, CAD/CAM technology, Carivue detection and more. 60% PPO, 40% FFS, with 2,300 active patients. Real estate available. Turnkey opportunity. Contact Transition Sales Consultant Brian Whalen at (716) 913-2632; or email: Brian.Whalen@henryschein.com. #NY3695.

NASSAU COUNTY: 4-treatment-room practice based on 60% PPO insurance and 40% FFS. 1,100-square-foot office available for rent or purchase. Tremendous room for growth as doctor refers out endo, ortho, implants and oral surgery cases. Contact Transition Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3698.

JEFFERSON COUNTY: Well-established, spacious, 3,500-square-foot practice in beautiful, historic building housing 7 equipped treatment rooms, with 8th plumbed. Practice utilizes Dentrix PM software. FFS/PPO; only in-network with 2 insurances. Strong hygiene program, with dedicated team ready to stay on. All specialties referred out. Revenue $837K and positioned for continued growth. Stunning property also for sale includes 4 fully occupied residential apartment units. Doctor looking to stay on for extended period. Contact Transition Sales Consultant Michael Damon at (315) 430-9224; or email: mike.damon@henryschein.com. #NY3719.

NEW YORK CITY: High-tech dental practice with CBCT, two scanners, two lasers and A-Dec dental chairs. Three equipped treatment rooms and 4th plumbed. Located in co-op that is also available for purchase. Collections consistently over $1.1M. Open 5 days/week. Contact Transition Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3722.

SUFFOLK COUNTY: Well-established, 1,500-square-foot practice averaging 45 new patients monthly. Three ops with one additional plumbed needing only dental chair/unit. Dentrix, Dexis, and digital Pan. On heavily trafficked main road, with great visibility in standalone building shared with medical urgent care. Medicaid/PPO and FFS patients. Nicely appointed and excellent opportunity for growth. A must-see opportunity. Contact Transition Sales Consultant Chris Regnier at (631) 766-4501; or email: chris.regnier@henryschein.com. #NY3746.

INDEX TO ADVERTISERS

MANHATTAN: Upper East Side. State-of-the-art dental practice just a stone's throw away from iconic Central Park. Situated in one of most desirable neighborhoods in NYC. Grossing $1.8M in collections with seven meticulously designed operatories. Cutting-edge technology, including 3D imaging and Dentrix PMS. Mostly FFS, with some PPO insurance accepted. Open 4 days/week. 3,920-square-foot office located in professional building, with plenty of room for growth. Contact Transition Sales Consultant Rikesh Patel at (845) 551-0731; or email: rikesh.patel@henryschein.com. #NY3759.

UPPER WEST SIDE: General dental practice for sale. 40-year practice in excellent location with 2 ops. All FFS; no insurance contracts. Referring out all endo, most perio and surgery. Low overhead. 2023 gross $290K. Priced to sell at $100K. Flexible terms. Seller can stay one year to work for new buyer. Excellent potential for the right person. Text: (917) 612-0042; or email: exceldent5@verizon.net.

SOUTHERN TIER: General dental practice for sale. Located in picturesque Southern Tier region of New York State, well-established general dental practice boasting over thirty years of exceptional patient care and community service. 100% FFS. Excellent investment opportunity, featuring 7 operatories (one plumbed but unequipped), allowing for immediate expansion and customization. Strong patient base of 3,350 active individuals, with 20-25 new patients monthly. Four-day workweek presenting significant growth potential by extending hours or services. Strategically positioned near major cities like Rochester, Syracuse, and Scranton benefiting from low competition and proximity to vibrant community known for cultural richness and outdoor activities. Recent remodeling enhances real estate value, making an attractive purchase. Collections $1.6M and EBITDA nearly $300K. Prosperous venture for those aiming to continue legacy of success. For further details, contact Professional Transition Strategies by emailing Bailey Jones email: bailey@professionaltransition.com; or calling (719) 694-8320, referencing #NY21424. Unique chance to invest in thriving dental practice within community that offers affordable, quality lifestyle.

FOR RENT

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; karenjtj@aol.com.

MIDTOWN MANHATTAN: Dental op for rent all week, Monday-Friday. Located 2 blocks from Grand Central Station. Newly renovated office. Best rates in Midtown. Must see. Contact Yamile at (917) 972-8614.

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

MIDTOWN MANHATTAN: Space for rent in great location. 1-2 operatories available full time or part time. Renovated, sunny, windows, with private office in 24-hour doorman building. Reasonable. Call or email for details: (212) 581-5360; or email: kghalili@gmail.com.

MIDTOWN MANHATTAN: Madison Avenue. 3 to 4 operatories for rent full time. Renovated, large, bright and modern dental operatories available 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 Dr. Anthony Ceccacci at (646) 265-7949; or email: office@madisonavenuesmiles.com.

MANHATTAN: Two operatories for rent in the beautiful and iconic French Building. Fifth Avenue address and minutes from Grand Central, Bryant Park and Rockefeller Plaza. Please call or email for more information. Phone: (212) 764-0440 or email: drakhavan@drakhavandental.com.

MINEOLA: Dental office for rent. Great opportunity for specialist or startup. Modern, high-profile location. 3 operatories, handicap ramp, good parking. Multiple days available. Fixed or percentage; negotiable. Text (646) 526 -3631; or email: idealdentalimplants@aol.com.

MIDTOWN EAST: Op for rent. Beautiful operatory with windows and private office available for rent. Elegant, modern, street-level, best location. Please call or email for details. Contact: (917) 721 6825; or email: esenayny@gmail.com.

MANHATTAN: Great location next door to Grand Central Station. Two new dental treatment rooms and reception desk in large, elegantly renovated office. Nitrous and CDR panoramic. Optional Hygienist services available. Please email Dr. Robert Lichtenstein: rlddspc@gmail.com.

OPPORTUNITIES AVAILABLE

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.

BAY RIDGE, BROOKLYN: Seeking part-time general dentist associate with experience. Must possess excellent clinical plus communication skills. Proficiency in all aspects of general dentistry. Must be team player and self-starter. State-of-the-art facility. Must be able to work Saturdays and Thursdays. Please call (347) 487-4888; or email: Studiodntl@gmail.com.

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 and be able to perform high-quality dentistry. Please forward resume or contact to discuss. Email: karenron94@yahoo.com.

CATTARAUGUS COUNTY: Olean. Seeking general dentist to join Freedom Dental Partners team. Premier pathway to ownership and lucrative base salary plus equity-based compensation. Close to Buffalo, Olean serves as financial, business and entertainment center of Cattaraugus County. **We Offer:** Guaranteed daily rate or 32% of collections, whichever is greater; unlimited earning potential; opportunity for percentage of vested equity with no financial buy-in; $10K signing bonus; PTO; 401K; annual continuing education stipend; no weekends; office hours M-F 8-5; premium-level FDP office management services to handle daily practice operations. **What You Will Bring:** confidence & drive; friendliness & flexibility; responsibility & ambition; care & compassion. **Qualifications:** DDS/DMD; active and unrestricted license to practice in NY; 3+ years general dentistry experience; desire to continue growing and learning while superseding your patients' needs; entrepreneurial mindset. **Why You Will Love Working with Us:** We are empowering professionals to achieve ultimate financial lifestyle by utilizing the power of community to create transformational and multigenerational wealth. Freedom Dental Partners is cooperative of over 300 entrepreneurial dentists nationwide and fastest growing group in all of dentistry. We're disrupting dental industry to put power back in the hands of dentists. If you desire career autonomy, lifestyle freedom and wealth you deserve for your hard work, this is your opportunity. Contact Kennedy Wilhite at: recruiting@freedomdentalpartners.com or call: (551) 245-0203.

ELMIRA: Dr. Albert and team seek the right General Dentist to join growing practice as Associate/Junior Partner Dentist. Serving Elmira community over 20 years. Finger Lakes region is scenic escape full of culture and outdoor sporting activities. If you are general dentist (DDS/DMD), hard worker, ethical and talented, driven for success and focused on building relationships with patients and team—this opportunity will catapult your career. Qualified candidates must have active license in good standing and pass extensive criminal background check. Want to join privately owned dental practice with complete autonomy? Looking to reach highest earning potential? Excited to find modern office with digital radiography, implant placement equipment and scanners? **Benefits/Compensation:** $1,000/day minimum OR 32% collections (whichever is higher); $30K sign on bonus for FT candidate and $15K relocation bonus if applicable; up to $50K student loan reimbursement ($10K/year); $3K/year CE stipend. Consistent FT schedule and heavy new patient flow with busy hygiene schedule. The right fit will earn equity in practice, becoming junior partner without having to buy in. 3-4 days/week, with flexibility and no weekends. Strong, committed team ready to support you. **Candidates Must Be:** Friendly & flexible; responsible & ambitious; caring & compassionate. Dr. Albert and team have FFS practice, commitment to supporting each other and exceeding patient expectations. We schedule extra time to ensure each patient has great experience. As we invest in practice, your voice and opinion on technology and equipment will be heard and honored. To learn more, contact Kennedy Wilhite at (551) 245-0203; or email: recruiting@freedomdentalpartners.com.

ONEONTA: Seeking General Dentist at Bassett Healthcare Network. Progressive, academic health system in Central New York, major teaching affiliate of Columbia University, seeks Dentist to join our staff. Bassett Healthcare Network provides care and service to people living in eight-county region covering 5,600 square miles, including five corporately affiliated hospitals, as well as skilled nursing facilities, community and school-based health centers, and health partners in related fields. **Job Description:** Established group of general dentists, hygienists, oral surgeon and pediatric dentist; must possess outstanding communication and documentation skills, function independently and as part of team, be competent in all aspects of general dentistry, including behavior management for children and special needs patients; EPIC Wisdom-integrated medical-dental records, digital radiography; minimal evening and weekend phone call shared among network dentists. **Salary Range:** $174,736 - $189,785 represents Bassett Healthcare's good-faith belief of compensation range at time of posting. Salary based on factors, including, but not limited to, qualifications, experience, education, licenses, specialty, training, and fair market evaluation based on industry standards. Sign-On Bonus up to $100K, Group Employed Model. **Qualifications:** DMD/DDS; Board Eligible or Board Certified; NYS licensure. **Benefits:** Medical, dental and vision insurance; paid time off; life insurance and disability protection; paid malpractice; retirement plan; CME time and money; moving allowance. For confidential consideration, please contact Ashley Camarata, Medical Staff Recruitment, by phone: (607) 547-6975; or email: ashley.camarata@bassett.org. Visit us online at: www.experiencebassett.org.

ONEONTA: Service Line Chief of Dental Services. Bassett Healthcare Network, progressive, academic health system in Central New York, major teaching affiliate of Columbia University, seeks Service Line Chief of Dental Services to join our staff. Bassett Healthcare Network provides care and service to people living in eight-county region covering 5,600 square miles, including five corporately affiliated hospitals, as well as skilled nursing facilities, community and school-based health centers and health partners in related fields. Seeking dynamic individual to provide strategic leadership and direction for all aspects of Basset Healthcare Network service line. In addition to maintaining their own clinical practice, Chief will be expected to take active role in providing clinical and administrative leadership to practitioners in regional clinics. **Job Description:** Established group of operatory, general dentists, hygienists, oral surgeon; management and oversight of 21 school-based dental health sites and 3 dental clinics which include 5 general dentists and 1 oral surgeon; must possess outstanding communication and documentation skills, function independently and as part of team, be competent in all aspects of general dentistry, including behavior management for children and special needs patients; develops, implements and maintains 'patient focused service' focus pervasive throughout group practice operations with monitoring component to provide feedback for staff; monitors patient satisfaction with services rendered from group practice members; partners with SL director regarding budget, volumes, operational efficiencies, clinical performance and financial outcomes; establish and maintain effective working relationships with representatives of professional societies and healthcare agencies at local, state and federal level; EPIC Wisdom-integrated medical-dental records, digital radiography; minimal evening and weekend phone calls shared among network dentists. **Salary Range:** $206,046-$246,109 represents Bassett Healthcare's good-faith belief of compensation range at time of posting. Salary based on factors, including but not limited to, qualifications, experience, education, licenses, specialty, training, and fair market evaluation based on industry standards. Sign-On Bonus up to $100K, Group Employed Model. **Qualifications:** DMD/DDS; Board Eligible or Board Certified; NYS licensure; demonstrated experience in leadership roles preferred, minimum 5 years post-residency experience practicing dentistry required; prior healthcare leadership experience in large, complex system or academic medical center setting preferred; strong record of administration, including finance and strategic planning and track record of involvement working with communities to increase oral health care access. **Benefits:** Medical, dental and vision insurance; paid time off; life insurance and disability protection; paid malpractice; retirement plan; CME time and money; moving allowance. For confidential consideration, please contact Ashley Camarata, Medical Staff Recruitment, by phone: (607) 547-6975; or email: ashley.camarata@bassett.org. Visit us online at: www.experiencebassett.org.

TUORO COLLEGE OF DENTAL MEDICINE: Touro College of Dental Medicine invites applicants for paid part-time (1-2 days/week) Oral and Maxillofacial Surgery Clinical Faculty positions. Academic rank and salary commensurate with experience. Responsibilities include clinical teaching, supervision/provision of patient care and associated administrative responsibilities. Candidates required to have DDS or DMD from CODA-accredited dental school, certificate of training from CODA-accredited Oral and Maxillofacial Surgery program, ABOMS certification or eligibility and CPR/ACLS certification. **Maximum Salary:** $75K; **Minimum Salary:** $60K. For additional information and/or to apply: Oral Surgeon in Hawthorne, New York | Careers at Skyline (icims.com)

STONY BROOK: State University of New York at Stony Brook School of Dental Medicine is seeking part-time, non-tenure-track Clinical Assistant Professor in orthodontics. Job description and application can be found at https://apptrkr.com/5062177.

Panelists assembled for Black History Month event helped define strides made in promoting diversity in dental profession and what remains to be done.

NYSDA DEI Chair Ioanna Mentzelopoulou and President-Elect Prabha Krishnan, at left, with, from left in front, Dominque Marshall, Elizabeth Maas, Julian Boykins (speaker), Vaugh Arroyo. Behind them, Dr. Jerica Cook, Dr. Prince Morgan.

A Time to Celebrate and to Learn

New York County observance of Black History Month provides diverse perspectives and lasting impressions.

New York County Dental Society headquarters came alive Feb. 26, pulsing with the vibrant energy of celebration and enlightenment. Dentists and aspiring dental professionals had gathered to commemorate Black History Month with an enriching panel discussion titled "Diverse Perspectives and Lasting Impressions." Hosted by the New York State Dental Association's Diversity, Equity & Inclusion Task Force and moderated by Dr. Fabiola Milord, the event promised to deliver insight, inspiration and networking opportunities—and it did just that.

Assembled for the event were esteemed figures in the dental community, each sharing unique stories and experiences that shed light on their journeys within the profession. Dr. Milord, who served as moderator, is an advocate for diversity and inclusion within the dental profession. She set the stage for an engaging dialogue that would resonate with attendees long after the event concluded. As associate dental director for the general practice residency program at Northwell's Long Island Jewish Medical Center and a respected figure in private practice, her commitment to advancing the profession has long been evident.

Serving as panelists were four distinguished representatives of the profession. Dr. Tricia Quartey-Sagaille, president of the Second District Dental Society, shared her extensive experience and emphasized the evolution of dentistry, stressing the importance of representation within professional organizations. Dr. Frank Aguebor, a vocal advocate for diversity, provided highlights from his five years in private practice in Manhattan and spoke of his dedication to serving underserved communities through free dental screenings. Representing the future of dentistry was D4 student Julian Boykins, who emphasized the importance of nurturing diverse talent within educational institutions. Lastly, Dr. Lorna Flamer-Caldera, with over two decades of experience, focused her attention on the significance of mentorship and professional engagement as the national spokesperson for the Academy of General Dentistry.

Enriched by the diverse backgrounds and perspectives of the speakers, the panel discussion served as a reminder of the strides made in promoting diversity within the dental community, while also highlighting the work that remains to be done. Dr. Flamer-Caldera shared a striking statistic from an August 1991 Washington Post article, reporting that the percentage of Black dentists in the U.S. had remained at 2.6% for the prior 20 years. In the 33 years since the publication of that article, the percentage of Black dentists has increased to 3.8 %, according to information provided by the ADA Health Policy Institute.

As we reflect on Black History Month and its significance in celebrating the achievements and contributions of Black individuals throughout time, events like these serve as catalysts for meaningful dialogue and action. By amplifying diverse voices and experiences within the dental profession, we move closer to a future where equity and inclusion are the norm.

From the sharing of personal journeys to discussions on the future of the profession, the event left a lasting impression on all attendees.

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