A UCLA study released March 4th finds that Californians have not prepared for the next big earthquake, which most experts regard as inevitable. Commissioned by the California Emergency Management Agency (CEMA) and conducted by the UCLA School of Public Health, the study reported that less than 35% of Californians know how to make their home structure safer and safeguard their finances, less than 20% have structurally reinforced their home, less than 20% have purchased earthquake insurance, only 40% have a family disaster plan, and 40% keep the recommended 3 gallons of water per person stored in their home. Among its other findings, the study concluded that Californians in high risk areas have not prepared adequately for the greater risk they face, “few households have acted to mitigate losses and reduce injury,” and members of the Hispanic population were the least likely to have made preparations.

The study points out the gap between the risk of damage a future earthquake could cause in California and preparations taken to mitigate the damage. Rather than simply sound the alarm, the study also makes several recommendations. Most involve the dissemination of information, better messaging, and community education-related activities that would presumably fall upon local government agencies, non-profits, and community groups to implement. Many of these entities face similar challenges to individuals when trying to figure out how much time and how many resources they want to devote to disaster preparedness.

Thinking about catastrophic risk and its relation to practical preparedness measures is more complex than one might expect. In Richard A. Posner’s article “Thinking About Catastrophe,” which appears in a book called Blindside: How to Anticipate Forcing Events and Wild Cards
We hate lawsuits. We loathe litigation. We help doctors head off claims at the pass. We track new treatments and analyze medical advances. We are the eyes in the back of your head. We make CME easy, free, and online. We do extra homework. We protect good medicine. We are your guardian angels. We are The Doctors Company.

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What does it mean to be a member of a profession? from the Latin word “professio,” which means a public declaration with the force of a promise. Professions are groups which declare in a public way that their members promise to perform in certain ways, and that the group and the society may discipline those who fail to do so. The profession presents itself to society as a social benefit, and society accepts the profession, expecting it to serve some important social goal. The profession usually issues a code of ethics stating the standards by which its members can be judged. Traditionally, professions have most notably included medicine, dentistry, law, education, and clergy.

The marks of a profession are:

- competence in a specialized body of knowledge and skill;
- an acknowledgment of specific duties and responsibilities toward the individuals it serves and toward society;
- the right to train, admit, discipline, and dismiss its members for failure to sustain competence or observe the duties and responsibilities.

What is the difference between a profession and a business?

The line between a business and a profession is not entirely clear, since professionals may engage in business and make a living by it. However, one crucial difference distinguishes them: professionals have a fiduciary duty toward those they serve. This means that professionals have a particularly stringent duty to assure that their decisions and actions serve the welfare of their patients or clients, even at some cost to themselves. Professions have codes of ethics which specify the obligations arising from this fiduciary duty. Ethical problems often occur when there appears to be a conflict between these obligations or between fiduciary duties and personal goals.

Professionals responsible for the health and welfare of society, whose actions can literally save or take a life, should appropriately be held to higher ethical standards.

What are the recognized obligations and values of a professional dental specialist?

Professionalism requires that the practitioner strive for excellence in the following areas which should be modeled by mentors and teachers and become part of the attitudes, behaviors, and skills integral to patient care:

- Altruism: OMSs are obligated to attend to the best interests of patients, rather than self-interest.
- Excellence: OMSs are obligated to make a commitment to lifelong learning.
- Duty: An OMS should be available and responsive when “on call,” accepting a commitment to service within the profession and the community.
- Honor and integrity: OMSs should be committed to being fair, truthful, and straightforward in their interactions with patients and the profession.
- Respect for others: An OMS should demonstrate respect for patients and their families, other physicians and team members, dental students, and residents.

These values should provide guidance for promoting professional behavior and for making difficult ethical decisions.

Ethical behavior is defined in terms of morality and is recognized as the mark of a good and decent person and, likewise, of a trustworthy organization. Although we value it in all aspects of life and have been dismayed by its flagrant absence in some modern examples in the business world and in government, it is, of course, most critical for those individuals and organizations whose actions touch our very lives.

Professionals responsible for the health and welfare of society, whose actions can literally save or take a life, should appropriately be held to higher ethical standards. Likewise, organizations such as ours, trusted to provide information to healthcare providers, the public, patients, and policy makers, and thus with the ability to have a profoundly beneficial impact on society, must similarly follow the highest ethical standards. The foundation of all we do is based on the public’s trust.
President’s Message

John L. Lytle, MD, DDS
President, CALAOMS

State of the Association

011 is off and running! All indications are that the economic environment is improving, and I look forward to a great year for our organization. Thank you for giving me the opportunity to lead our association. If you have any questions or concerns, please email me at John.Lytle@earthlink.net, or call me at 818-952-8183.

As oral and maxillofacial surgeons, we have developed and employed a unique and highly successful approach to the practice of dentistry. Nationally, it is known as the oral and maxillofacial surgery team concept of combined anesthesia and surgery (best known as the operator/anesthetist model). One surgeon and a highly-trained team provide all of the surgical and anesthesia care to the patient. We all know this to be a safe and successful approach. It has stood the test of time.

Unfortunately, our team model has come under attack once again. In October, 2010, the American Society of Anesthesiologists revealed their opposition to our approach. This opposition appears to be politically motivated and has no scientific basis. Our leaders at AAOMS have responded, and preparations are being made to put this issue to bed once and for all.

In April/May of this year, AAOMS will fund and begin a benchmark study. This randomized prospective study will be completed rapidly by a small subset of our national membership. Surgeons will be chosen randomly to participate. If chosen to participate, please take the time to assist in this most important study. The time spent will be appreciated by all of our members.

As a companion study, a registry will be set up by AAOMS to collect basic outcomes on a national level.

In October, 2010, the American Society of Anesthesiologists revealed their opposition to our approach (the operator/anesthetist model.)

All members will be asked to participate in this study which will generate large volumes of data very rapidly. Again, I implore all of you to participate. This data is crucial to protect and defend our specialty and our way of practice. Remember, anesthesia is what makes us unique, and nothing short of full participation will suffice.

CALAOMS has again taken the lead in advancing the OMS team concept by pioneering the Dental Sedation Assistant Permit. The statutes and regulations in place, and courses were started on a trial basis last year. We are close to obtaining the first permits from the Dental Board of California. Those who have permits will assess monitors, administer medication under the provider’s supervision, and remove I.V. catheters. The first permits should be mailed out in the next few weeks. This permit will further strengthen our team model, and I urge all providers to promote this in their offices in the coming year. If you have any questions, please feel free to contact the CALAOMS office.

CALAOMS and the Board of Directors wish you a healthy and prosperous new year.

The Anesthesia Examiner

The long-proven practice of oral and maxillofacial surgeons (OMSs) providing general anesthesia and sedation has come under scrutiny from many different outsiders. Their questions range from, “Should we, as OMSs, be administering general anesthesia?” to “Are OMSs qualified or adequately trained to provide such?”

A permit to administer general anesthesia is issued by the Dental Board of California provided that the candidate meets the criteria established and delineated in the California Code of Regulations. The permit holder is also required to undergo periodic in-office general anesthesia evaluations. This periodic on-site office inspection and evaluation of the surgery-anesthesia team consists of:

- Evaluation of the office facilities and equipment
- Treatment records (including the anesthesia record and informed consent)
- Required drugs for emergencies
- Demonstration of a general anesthetic
- Demonstration of competency in 12 simulated office anesthesia emergencies

While the Dental Board of California oversees the process, the evaluation is administered by two CALAOMS members—oral and maxillofacial surgeons—who are, themselves, holders of general anesthesia permits. Scheduling of the evaluation is coordinated through the office of Ms. Jessica Olney (at the Dental Board).

As evaluators, we are charged by the state to provide a thorough and unbiased evaluation of the candidate. Evaluators are mindful that they are acting as agents of the state of California on behalf of the public. Adherence to the evaluation criteria set forth in the Code of Regulations demonstrates our commitment to quality service and patient care that the public expects from a well-respected profession such as ours.

The Dental Board of California presents a periodic ‘calibration course’ for experienced and prospective evaluators. Included in the course is a review of existing and new regulations, as well as recommendations for the type of evaluation the Dental Board would like to see conducted.

Not only can we as evaluators strive to keep the standards very high for our specialty in providing anesthesia services to our patients, but we are given the opportunity to observe anesthesia being delivered in perhaps a different, but equally effective, manner as administered by our peers.

Current evaluators and any interested OMSs were encouraged to attend the calibration courses, given free of charge, in both northern and southern California in March of this year.
Greetings to all my friends in California.
It was a pleasure to see many of you at the recent CALAOMS meeting in Monterey. The venue was striking in its natural beauty, and the continuing education program was excellent.

AAOMS initiates anesthesia benchmark study

As the first quarter of 2011 winds down, activity at the AAOMS headquarters office is revving up for what promises to be a very eventful year. Of primary importance to the specialty is the prospective, statistically valid study for office-based anesthesia practice, benchmarks and outcomes, which the association will conduct over the next 12 months with OUTCOME™, the group that has been our technical partner in the successful anesthesia outcomes study.

Working with the AAOMS Committee on Anesthesia and the Special Committee on Outcomes Assessment, the association’s Board of Trustees recognized that despite an impressive record of patient safety and satisfaction, the current political and economic healthcare environment is prompting challenges to our oral and maxillofacial surgery anesthesia team model from our dental and medical colleagues.

In order to defend our specialty’s safe and effective method for the delivery and monitoring of office-based anesthesia, AAOMS will soon contact a randomly selected group of 300 actively practicing fellows and members, and ask that they participate in the new benchmark study. Participants will each be assigned a month during which they will enter patient data using a secure, state-of-the-art, HIPAA compliant, online data collection system for those patients who meet the study criteria.

In addition to providing the specialty with concrete data that unequivocally support the OMS anesthesia team model, the study offers unexpected benefits. It will, for example, provide a risk management tool that reflects the intent of AAOMS to adopt quality improvement strategies, and it will provide researchers with a valuable data set that will meet the criteria of journal reviewers.

If you are among the OMSs contacted to participate in this landmark study, please offer your assistance. This is a critical project for oral and maxillofacial surgeons and their ability to practice the full scope of the specialty.

Once the benchmark study is underway, AAOMS will also launch an anesthesia registry, which will capture a broader range of data from the entire membership. Additional information about the registry will be available within the next few months.

While it is true that winter on the east coast can be cold and snowy, it is also true that September in Philadelphia is glorious with colorful fall foliage and warm temperatures. Add to this idyllic scene the largest and best continuing education program offered anywhere to OMSs and their staff, and you will want to join AAOMS in Philly this September 12-17, 2011 for the 93rd Annual Meeting, Scientific Sessions and Exhibition. This year’s meeting will be held in conjunction with the Scandinavian Association of Oral and Maxillofacial Surgeons. AAOMS’ hotel reservation system opened March 7, and registration for the annual meeting opens in early April.

I look forward to seeing all the California and District VI fellows and members in Philadelphia this fall.

Warm Regards,
Larry J. Moore, DDS, MS
The precision of these connections is amazing and whole new selection of possibilities for milled custom I am sure most of us do. Looking at the cases, I am ultimately, each case has to be individually planned and executed, hence, at this time, no one single solution will fit all the cases. Understanding the benefits of restorations was not part of that early equation. But the restorations required servicing or screw retightening. However, the ability to cement implant-supported restorations more risky and often problematic when the restorations required servicing or screw retightening. However, the ability to cement implant-supported restorations uses techniques similar to conventional fixed prostheses overwhelmingly simplifies treatment planning and execution of the restoration of implants for novice practitioners.

Screw retained restorations are on the comeback…again.

I often receive inquiries from my referring doctors asking for some guidance in matters related to choice and application of restorative components. I am sure most of us do. Looking at the cases, I am still very much involved in final abutment and prosthetic appliance selection in over 75% of cases, as all of my referrals, with the exception of two prosthodontists, are generalists. In the past two years, we have started employing a larger number of milled restorative connections, which has exposed me to a whole new selection of possibilities for milled custom cementable and screw-retained restorative options. The precision of these connections is amazing and holds great promise for reducing all of the past con- nection problems faced in implant restorations. This article will briefly review the connection options and benefits, as well as the disadvantages of each option. Ultimately, each case has to be individually planned and executed, hence, at this time, no one single solution will fit all the cases. Understanding the benefits of each option can guide the practitioner to make the best selection and optimally complete these cases.

As we have recently progressed into the third-generation of abutment connections in implant prosthetics recognizing that most abutment systems are now internally based with some aspect of platform switching as part of their design, the old controversy of whether to use a screw-retained or a cemented restoration still exists. The new platform switching design (figure 1) allows for better retention of crestal bone, and, as such, supports the interproximal soft tissues better. The new abutment design locates the abutment connection internally; however, the design has not affected issues of subgingival cement retention at the restoration-abutment interface. The North American market is largely based on cementable restorations for most single- and short-span fixed partial denture (FPD) restorations. As we follow these cases for extended periods of time, the incidence of peri-implantitis secondary to cement retention (figure 2) is increasing and will continue to do so as more fixtures are being placed and followed.

In Europe, the screw-retained concept has been popular for many years. Initially, that was the core concept of the Branemark design, and the cementation of restorations was not part of that early equation. But due to off-label, experimental, and (sometimes) salvaging restorative techniques in anterior esthetic cases, the cemented restoration became popular. After initial success, the relatively high rates of screw and abutment connection instability noted with first-generation connections and screws have made the use of cementable restorations more risky and often problematic when the cement margin is level vertically and equal circumferentially (figure 2) is increasing and will continue to do so as more fixtures are being placed and followed.

The key disadvantage of cementing implant-supported restorations, as noted, was the potential difficulty in retrieving the restoration. Should an abutment loosen, or any repair of the restoration become necessary, the restoration may be destroyed during the removal procedure if the cement seal cannot be easily broken. Furthermore, and more importantly, any force applied to a restoration on a loosened abutment has the potential to damage the internal threads of the implant.

There is an overriding biomechanical issue that needs to first be addressed in any discussion of this issue, the stability of the abutment-to-implant screw joint. Long-term stability through reduced micro-motion is the single most important requirement for cemented restorations. The same abutment-to-implant stability is essential for screw-retained restorations, as well. Today’s manufacturers have developed adequate materials, implant sizes, and manufacturing protocols to resolve this issue. Implant diameters have been increased, and in conjunction with increased implant platform size, this has resulted in greater overall implant strength and resistance to tilting forces. Improved abutment-to-implant connections, particularly at the internal interface, using interference-type machining, likewise, has dramatically improved abutment stability. Finally, improvement of the abutment screws through design changes, refinement of materials, surface coating, and exact torque protocols now produce higher mating forces to the joint and improved the initial preloads.

With the improved connections and screw retention, the cement-retained concept had gained greater acceptance, especially out of practical need to empower even the entry-level skilled dental operators to restore more dental implants. In the last decade, large numbers of new implant care practitioners have presented to the market. The cement technique has allowed for the most parallel process to the standard “tried, tested, and true” crown and bridge therapy taught in most dental schools in North America. Also, with cementation, it has become easier to overcome structural integrity and coupling discrepancies which often exist in some of the less-than-accurately manufactured prostheses. Implant companies realize this and heavily marketed the simplicity of this technique with product names that highlighted the ease and simplicity of the restorative process.

When cemented abutments are utilized, it is paramount that the cement margin is shaped to maintain a relationship with the scalloped gingival margin. With many prefabricated stock abutments, the cement margin is level vertically and equal circumferentially (figure 3), which can lead to deeply localized cement margins. Cement removal becomes difficult, if not impossible, with connections Continued on page 14
Continued on page 13

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"Screw Retained Restorations" Continued from page 11

being made 1mm or more below soft tissue margins. It can lead to soft tissue irritation initially, and after the final restorations are in place, you will see an increasing number of cases presenting with severe localized peri-implantitis with resultant fixture, esthetic, and functional failures. Deeply placed connection margins that cannot be corrected by abutment selection are, therefore, a contraindication for stock abutment-based cement retention. Milled abutments offer the option of differential margin location and correct the emergence profile for maximum restoration balance and soft tissue health (figure 4).

In addition to using scalloped margins, other techniques to reduce subgingival cement retention have been suggested. These include seating of the luted restoration on an abutment model or replica once prior to seating on the actual abutment in the mouth. Such pre-seating allows for expression of excess cement from the crown prior to final seating, and hence, less likelihood of expression of that excess cement below the gingival contour. Crowns have also been constructed with a small relief hole on the lingual aspect to allow for a controlled avenue for cement expression that is away from the actual subgingival margin. Yet another popular strategy has been utilizing more biocompatible cements of dissolvable luting agents, such as TempBond or eugenol-based cements. These are also being made 1mm or more below soft tissue margins. It can lead to soft tissue irritation initially, and after the final restorations are in place, you will see an increasing number of cases presenting with severe localized peri-implantitis with resultant fixture, esthetic, and functional failures. Deeply placed connection margins that cannot be corrected by abutment selection are, therefore, a contraindication for stock abutment-based cement retention. Milled abutments offer the option of differential margin location and correct the emergence profile for maximum restoration balance and soft tissue health (figure 4).

The Compass - Spring 2011

Figure 4.

The Compass - Spring 2011

Figure 5.

In addition to using scalloped margins, other techniques to reduce subgingival cement retention have been suggested. These include seating of the luted restoration on an abutment model or replica once prior to seating on the actual abutment in the mouth. Such pre-seating allows for expression of excess cement from the crown prior to final seating, and hence, less likelihood of expression of that excess cement below the gingival contour. Crowns have also been constructed with a small relief hole on the lingual aspect to allow for a controlled avenue for cement expression that is away from the actual subgingival margin. Yet another popular strategy has been utilizing more biocompatible cements of dissolvable luting agents, such as TempBond or eugenol-based cements. These are believed to more readily dissolve, and hence, have lesser chance of staying at the marginal junction over time.

The other absolute contraindication to cement-retained implant restorations is the clinical situation where there is extremely limited interocclusal space present which limits the vertical wall heights on abutments. Also, any abutment misalignment that allows access holes for the cement to be located in a position where a displacing screw to be located in a position where a displacing screw access channel, particularly if the channel is cast in metal. Second, if the metal is cut back to hide the nonaesthetic metal, porcelain fracture around the screw access channel can occur. Third, screw-retained prostheses generally require both the abutment screws and bridge screws to be tightened using a torque driver to effect preload of the screws. This torquing appears to have lowered, but not eliminated, the incidence of screw loosening. Finally, the cast conventional screw-retained systems generally leave a microgap beneath the gingival crest, resulting in some chronic gingival inflammation. This will be less of an issue with increased use of milled connections based on virtual impressions, but microgaps will always exist.

The pendulum seems to swing back with new fabrication and milling technology becoming readily available. Implant companies are shifting their marketing efforts to the screw-retained restorations. The ceramic and silica-based abutments can be shaded and direct placed. Also, obviating the need for porcelain or high index composite enveloped. Access holes can now be readily located on the facial as closure functional failures. Deeply placed connection margins that cannot be corrected by abutment selection are, therefore, a contraindication for stock abutment-based cement retention. Milled abutments offer the option of differential margin location and correct the emergence profile for maximum restoration balance and soft tissue health (figure 4).

These restorative solutions are gaining popularity and are all screw-retained and based on angled multi-unit connections with possible multi-planar angulation corrections of up to 30 degrees. These prostheses now utilize more composite-based denture teeth, which is much easier to camouflage the access hole.

Contemporary screw-retained dental implant restorations have a key advantage of relative ease of retrievability. This enduring design attribute permits necessary servicing of the implant superstructure as needed, and is particularly valuable in multiple-unit, full-arch, or cantilever prostheses, where some maintenance of restorative materials, structures, components, or implants will be necessary during the lifetime of that prosthesis. In traditional cast restorations, however, this design still demands precise placement of the implant fixture for lingual-to-incisal location of the screw access hole. Buccal-to-incisal direction of placement can lead to an unaesthetic restoration if screw retention is to be used. The issue is quite common in maxillary anterior fixture cases. To eliminate the presence of the screw access hole in esthetically-demanding areas, other methods have been used to connect implant restorations to abutments or implants.

These include the use of pre-angled abutments, which allow for screw-retained restorations, and the previously mentioned cemented implant restorations to angled or custom abutments. Stock pre-angled abutments can reduce misalignment in which axial wall reduction becomes so extreme that in attempting to achieve parallelism, individual abutment retention is lost.

The disadvantages of a screw-retained implant system are numerous. First, there is the previously mentioned problem of a lack of esthetics at the screw access channel, particularly if the channel is cast in metal. Second, if the metal is cut back to hide the nonaesthetic metal, porcelain fracture around the screw access channel can occur. Third, screw-retained prostheses generally require both the abutment screws and bridge screws to be tightened using a torque driver to effect preload of the screws. This torquing appears to have lowered, but not eliminated, the incidence of screw loosening. Finally, the cast conventional screw-retained systems generally leave a microgap beneath the gingival crest, resulting in some chronic gingival inflammation. This will be less of an issue with increased use of milled connections based on virtual impressions, but microgaps will always exist.

Finally, the idea that somehow the screw chambers, with their resultant composite fillings, disrupt the occlusal design has been postulated by many. It was felt that the access hole reduces the ability to develop ideal occlusal design and forces the restorative occlusal scheme to contact on inclines of cusps which are not directly over the implant base, and, therefore, cause greater off-axis loading. But, it may not be a concept that is clinically relevant. We place occlusal access holes routinely for endodontic purposes. Also, a well-diagnosed implant treatment would have only 4 to 6 chambers in most routine full-arch situations, and

Continued on page 16
If a patient presents with an ulcerative nodule of the tongue dorsum (Figure 1), then the surgeon might consider several possibilities in the clinical differential diagnosis: traumatic ulcer, traumatic ulcerative granuloma, infection (mycobacterial, deep fungal infection [histoplasmosis]), pyogenic granuloma, and malignant neoplasia. Squamous cell carcinoma is the commonest oral malignancy, but it rarely occurs on the tongue dorsum; so the second most frequent oral malignancy, lymphoma, could be included among the diagnostic considerations. An incisional biopsy revealed an atypical lymphoid proliferation worrisome for malignant lymphoma (Figure 2). However, the lesion spontaneously regressed following biopsy, and it completely resolved by the 5-week post-op appointment (Figure 3).

This case exemplifies the problem of atypical lymphoproliferative disorders (pseudolymphomas or prelymphomas). The term “pseudolymphoma” is appropriate because standard pathology methods (histologic evaluation, immunohistochemistry for lymphoid markers, clonality gene rearrangement studies) result in a malignant diagnosis (lymphoma or “worrisome for lymphoma”) but clinical work-up and follow up reveal its true benign nature. Oral pseudolymphomas go by several names: lymphomatoid papulosis,4,20,24

Screw Retained Restorations” Continued from page 15

Cemented and screw-retained implant prostheses present their own distinct advantages and limitations. The major difference between the 2 strategies is that a screw-retained prosthesis can be removed and replaced by the clinician, while a cemented restoration is not intended to be retrieved. Each can be the best option, depending on the objectives of the prosthesis, patient factors, the attributes of the implant system, and the philosophy of the practitioner.

Credits:
Figure 2. Courtesy of Steve Hurson, Chief Engineer, NobelBiocare
Figure 5. Courtesy of Randy Carlson, DDS, Bonsall, CA

Self-healing Ulcerative Pseudolymphoma

by Lee Slater, DDS, MS, Scripps Oral Pathology Service, San Diego, California; Lecturer, Department of Oral & Maxillofacial Surgery, Loma Linda University School of Dentistry

If a patient presents with an ulcerative nodule of the tongue dorsum (Figure 1), then the surgeon might consider several possibilities in the clinical differential diagnosis: traumatic ulcer, traumatic ulcerative granuloma, infection (mycobacterial, deep fungal infection [histoplasmosis]), pyogenic granuloma, and malignant neoplasia. Squamous cell carcinoma is the commonest oral malignancy, but it rarely occurs on the tongue dorsum; so the second most frequent oral malignancy, lymphoma, could be included among the diagnostic considerations. An incisional biopsy revealed an atypical lymphoid proliferation worrisome for malignant lymphoma (Figure 2). However, the lesion spontaneously regressed following biopsy, and it completely resolved by the 5-week post-op appointment (Figure 3).

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Continued on page 18
"Ulcerative Pseudolymphoma" Continued from page 17
traumatic ulcerative granuloma with stromal eosinophilia,23 CD30-positive T-cell lymphoproliferative disorder,1 and EBV-positive mucocutaneous ulcer.5

If a surgeon biopsies an ulcerated tongue or buccal mucosal lesion and receives a diagnosis of malignant lymphoma, the surgeon should probably query the pathologist as to whether the lesion could be a pseudolymphoma (atypical lymphoproliferative disorder), particularly if the elderly patient has been receiving immunosuppressive therapy (methotrexate) for rheumatoid arthritis.5,11 Epstein-Barr virus (EBV) infection contributes to inducing pseudolymphomatous “EBV-positive mucocutaneous ulcers.”5 Similarly, if a patient presents with an acute necrotizing ulcerative gingivitis-like (ANUG-like) gingival lesion (that is, a depressed ulcer showing evidence of neither a mass nor a radiolucent lesion) and the biopsy is diagnosed as lymphoma, then the surgeon should question the diagnosis: a lymphoma should present as a mass, not the absence of a mass. Pseudolymphoma would deserve serious consideration.

The prognosis of a pseudolymphoma is unclear. Some lesions regress when iatrogenic immunosuppression is decreased or discontinued.8,11,16,22 Some patients, after multiple “migratory” recurrences over years, never develop life-threatening lymphoma.24,27 (EBV) infection contributes to inducing pseudolymphomatous “EBV-positive mucocutaneous ulcers.”5 From the upcoming “big one,” it is important to follow the levels of preparedness and the threat of significant damage at some point in the future. Posner concludes by warning, “We simply cannot afford in this day and age not to think about catastrophic risks. But thinking about them is very difficult, doing something practical about them even more so. Society therefore faces a great challenge, to which it had better rise.” California had better rise quickly.

In order to close the gap between Californians’ current levels of preparedness and the threat of significant damage from the upcoming “big one,” it is important to follow the guidelines laid out by CEMA. As we have seen, though, getting people to do this poses as great a challenge as ever. Motivating people to prepare will become much easier if doing so could save the population a great deal of money in the future. Written by Brian St. Clair, and originally published by the San Diego Nonpartisan Examiner (March 6, 2011) and is reprinted with their permission. The editorial staff thought that in light of the tragic events that unfolded in Japan, we should all rethink our own disaster preparedness for both our homes and offices.

Bibliography
Risk Management Corner

Risk Management Does Not Stand Alone

Risk management, which has been part of the health care lexicon for decades, has firmly established the concept of minimizing liability and improving patient outcomes. However, in the last 20 years, new concepts—such as quality of care, regulatory compliance, and patient safety—have prompted the question, “is risk management still relevant?”

Before answering this question, let’s explore these newer concepts.

One of the earliest areas of focus involved quality of care (quality control, quality assurance, quality improvement, process improvement, etc.). Many professionals announced that quality initiatives would take the place of risk management because improving quality was what health care was all about. What they failed to recognize was that the legal system would continue to require a definition of the standard of care.

The standard of care is the minimum legal standard and is defined by what a reasonably prudent health care professional would do. Failing to meet this minimum standard is defined as negligence. The health care community realized that quality initiatives were taking us in the right direction but were not getting us far enough, fast enough. Providing high-quality care was not enough when the systems for delivering that care were rife with opportunities to make errors and harm patients. Patient safety became the number one priority of health care: providing high-quality care that was delivered safely.

As a result of this classic study To Err is Human, all providers became aware of their fallibility as humans and the need to develop systems that would help avoid errors. Fatigue, overwork, stress, and over-reliance on memory can be the precursor of an error. Understanding the interplay between human beings and the systems in which they work reveals weaknesses that may be corrected.

The reality is that the oral and maxillofacial surgeon can greatly reduce exposure to malpractice claims in the support of patient safety initiatives by implementing and maintaining an effective office support system. The operational aspects of your office can have a big impact on avoiding claims. The Doctors Company now has available a system loss-prevention checkup tool, Interactive Guide for Dentists and Dental Specialists.

While we work to improve quality, comply with regulations, and adopt patient safety goals, we have come to the understanding that the standards against which health care is measured are constantly changing. We must not only adopt and implement patient safety goals, new regulations and quality measures, but we must also recognize that they are becoming the new minimum legal requirement. Failing to properly implement patient safety goals means that we risk being found negligent if our patients suffer as a result of our failure to meet these new standards and goals.

The purpose of risk management is to protect the assets of the organization. Assets are protected by:

- Meeting minimum professional standards of care (evidence of the standard of care is derived from professional societies, scientific studies, etc.)
- Adopting and implementing patient safety goals (“Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery”, etc.)
- Studies indicate that some of the most common bases for oral surgery lawsuits include:
  - Wisdom tooth extraction errors and injuries
  - Implant errors and injuries
  - Failure to diagnose and treat post-surgical infections
  - Improper administration of anesthesia
  - Wrongful tooth extractions

The application of some straightforward risk management strategies in conjunction with application of quality and patient safety principles can reduce the risk of complaints, claims, or even regulatory investigations. Effective communication skills deployed throughout the interaction with the patient, especially during the consent process, are a pre-requisite. An honest reflection by the practitioner on their competence to carry out a procedure, considering their skills, the equipment and support available, can result in fewer legal cases.

No one discipline alone has the capacity to address all of the requirements placed on health care providers today. By enhancing your awareness of the value of applying the concepts of quality care, compliance, and patient safety along with risk management tools and resources, all oral and maxillofacial surgeons will minimize their liability risk while, at the same time, provide quality care to their patients.
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**San Francisco East Bay Area** Board Certified/Board Eligible Oral Surgeon sought by UC Davis affiliated public hospital system in Contra Costa County. Located 30 miles east of San Francisco, with excellent weather, and close to outstanding cultural, recreational and natural attractions. One hour to the Napa Valley wine country or beach. 2 ½ hours to skiing. Martinez sits on San Francisco Bay, at the gateway to the Sacramento River Delta, for superb boating and fishing. New hospital & surgical facilities serve needs of ethnically and culturally diverse population, who have an fascinating variety of clinical problems. Excellent compensation package includes health care, vacation & sick leave, disability insurance, paid CME and defined benefit pension. Half-time Position available immediately.

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- **Medical Emergencies**
  - November 9, 2011

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  - August 27 - 28, 2011
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