Bill as Introduced

HB 201 – AS INTRODUCED

2003 SESSION

03-0155
10/01

HOUSE BILL ***201***

AN ACT relative to the definition of the practice of dentistry.

SPONSORS: Rep. Langley, Rock 88

COMMITTEE: Executive Departments and Administration

ANALYSIS

This bill changes the definition of practice of dentistry in the regulation of dentists and dentistry. This bill is a request of the board of dental examiners.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 201 – AS INTRODUCED

03-0155
10/01

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Three

AN ACT relative to the definition of the practice of dentistry.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Practice of Dentistry. RSA 317-A:20 is repealed and reenacted to read as follows:

317-A:20 Practice of Dentistry.

I. The practice of dentistry shall mean the evaluation, diagnosis, prevention, or treatment by surgical, non-surgical or related procedures of diseases, disorders, or conditions of the oral cavity, maxillofacial area, or the adjacent and associated structures and their impact on the human body.

II. A person shall be regarded as practicing dentistry within the meaning of this chapter who:

(a) Uses or permits to be used, directly or indirectly, for profit or otherwise, for that person or for any other person, in connection with the person's name, the word "dentist", or "dental surgeon", or the title "D.D.S." or "D.M.D.", or any other words, letters, titles, or descriptive matter, personal or not, which directly or indirectly imply the practice of dentistry;

(b) Owns, leases, maintains, or operates a dental business in any office or other room or rooms where dental operations are performed, or directly or indirectly is manager, proprietor, or conductor of the same, unless the activity in no way controls, restricts, or otherwise affects the professional judgment of dentists;

(c) Supervises a dentist within the scope of the definition of the practice of dentistry;

(d) Directly or indirectly informs the public in any language, orally, in writing, or in printing, or by drawings, demonstrations, specimens, signs, or pictures that the person can perform or will attempt to perform dental operations of any kind;

(e) Undertakes, by any means or method, including by use of electronic media, gratuitously or for a salary, fee, money, or other reward paid or granted directly or indirectly to that person or to any other person, to evaluate, diagnose, prevent or treat, or profess to evaluate, diagnose, prevent, or treat diseases, disorders, or conditions of the oral cavity, maxillofacial area, or the adjacent and associated structures and their impact on the human body;

(f) Except on the written prescription of a duly licensed dentist and by the use of impressions or casts made by a duly licensed and practicing dentist, directly or indirectly by mail, carrier, personal agent, or by any other method, furnishes, supplies, constructs, reproduces, or repairs prosthetic dentures, bridges, appliances, or other structures to be used and worn as substitutes for natural teeth, or adjusts the same; or

(g) Administers dental anesthetics, either general or local.

III. No challenge of dental treatment or of a dental treatment plan by a third party analyst, who provides a diagnosis, treatment plan, prescription, or any combination of these, shall be made unless performed by a dentist who is a graduate of a school of dentistry accredited by the American Dental Association.

IV. Any dentist who wishes to administer general anesthesia, deep sedation, or conscious sedation shall apply to the board for the appropriate permit and pay an application fee set by the board in accordance with RSA 317-A:12, XII-a.

V. Nothing in this chapter shall prevent students from American Dental Association accredited schools from practicing in hospitals or other institutions under the direct or indirect supervision of a faculty member of an American Dental Association accredited school who is licensed by the board under this chapter.

VI. Such things as the board shall determine to be "dental hygiene" under RSA 317-A:12 or RSA 317-A:21-c shall not be deemed to be the practice of dentistry within the meaning of this section.

2 Effective Date. This act shall take effect 60 days after its passage.

Hearing Minutes

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

PUBLIC HEARING ON HB 201

BILL TITLE: relative to the definition of the practice of dentistry.

DATE: February 5, 2003

LOB ROOM: 100 SH **Time Public Hearing Called to Order:** 9:40 AM

Time Adjourned: 11:40 AM

(please circle if present)

Committee Members: Reps. O'Neil, Hamel, Langer, Goulet, Zolla, N. Allan, Dexter, Hall, G. Robertson, Bergin, LaFlamme, Milligan, W. Field, Fitzgerald, Maybeck, Clayton, Schulze, DeJoie, Irwin, Pilotte and F. Sullivan.

Bill Sponsors: Rep. Langley, Rock 88

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Langley, sponsor. Supports bill.
Dennis Pellegrino, DDS, 230 Tiogo Tr., Stoddard, 756-3440. Representing NHDS. Opposes bill. He is a practicing dentist. Other things should have been referenced but were not. The things addressed were practices that should not have been.
*Dr. Raymond J. Jarvis, 2 Industrial Pk Dr., Concord, 271-4561, Representing Board of Dental Examiners. Supports bill. He is a practicing dentist. Current RSA A20 should be updated and redefined. Walked through bill. Tells us what dentistry is. Responsibility to look for welfare of patient, not to whom makes profit.
Dr. Peter Forssell, 298 Old Greenfield Rd., Peterborough, 924-3397. President, representing NH Medical Society. Opposes bill. This bill seeks to expand the practice of dentistry.
*Richard J. Rosato, 54 Peterson Cr., Concord, 226-1993. NH Society of Oral Surgery. Supports bill. Talked about definition of dentistry on first page of written material. The issue is whether or not the definition is restrictive.
Dr. Warren Emley, 194 Pleasant St., Concord, 224-2353. Opposes bill. Redefines the scope of dentistry. Why is bill necessary? What will happen if this bill is passed? Push by colleagues to treat whole facial problems; it eliminates all physician review. No oversight.

Recessed at 10:30 Resumed at 11:00

*Carol L. O'Brien, 9700 W. Bryn Maur, Rosemont, Il. 60018. General Council, Representing American Association of Oral and Maxillofacial Surgeons. Supports bill. 7,000 surgeons Supports bill. The definition of dentistry that this bill would proudly present. This bill includes a definition very close to ADA definition. OMS usually 1st on call in NH and that oral and other dental specialists handle the facial injury problems and reconstructive surgery.
Mark Hochberg, DMD, 25 Bay St., Manchester, 622-9441. Representing Society of Oral & maxillofacial Surgeons. Supports bill. Society is made up of dentists and is a dentistry profession.

Rocco R. Addante, DMD, MD, Professor and Chairman, Oral and Maxillofacial Surgery, Dartmouth Hitchcock Medical Center, Lebanon. Supports bill. Especially supportive of definition. Does not see anything in current definition that would prevent him from what he is now doing.

Respectfully submitted,

Rep. Ray Langer, Clerk

Testimony

American Academy of Otolaryngology — Head and Neck Surgery, Inc.

DEDICATED TO CARE OF THE EARS, NOSE, THROAT, AND RELATED STRUCTURES OF THE HEAD AND NECK

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January 30, 2003

Honorable Michael O'Neil
Chair, Executive Departments and Administration Committee
P.O. Box 818
Hampton, NH 03842-0818

RE: HB 201 (Langley)

Dear Representative O'Neil:

On behalf of the American Academy of Otolaryngology — Head and Neck Surgery (AAO-HNS), I strongly urge you to oppose House Bill 201. We believe the bill would negatively affect the quality of health care for citizens of New Hampshire.

AAO-HNS represents more than 10,000 physicians in the United States, including the State of New Hampshire, who diagnose, manage, and treat patients with disorders of the ears, nose, throat (ENT), and related structures of the face, head, and neck. The medical disorders treated by this specialty are among the most common that afflict all Americans. They include sinusitis, snoring and sleep apnea, swallowing disorders, facial and cranial nerve disorders, and head and neck cancer.

House Bill 201 broadly expands the scope of practice of dentistry to include evaluation, diagnosis, prevention, and treatment of the "oral cavity, maxillofacial area, or the adjacent and associated structures and their impact on the human body." This is simply not an update of the definition of the dentistry scope of practice; this is an expansion beyond the limited surgical training of dentists, specifically oral and maxillofacial surgeons. There is a clear distinction between physicians who receive extensive training in the surgical complexities of the head and neck region and dentists who receive training in surgery of the oral and maxillofacial region. This legislation goes further to eliminate existing provisions that differentiate medicine and dentistry. The bill seeks to remove current language clarifying that physicians freely engage in the practice of medicine apart from this licensure. Ultimately, the bill appears to be an effort to circumvent fundamental training and education requirements paramount to patient safety and quality care.

If this revision to New Hampshire law is approved, the public will be placed at serious risk as oral and maxillofacial surgeons will be allowed to perform a variety of soft tissue surgical procedures of the head and neck where medical education and training is essential.

The Academy and its New Hampshire membership have been vocal advocates for patient safety on this issue. Although dentists, including oral and maxillofacial surgeons, are valued members of the health profession, they simply do not have the proper experience, training, and qualifications to perform complex cosmetic surgery and other specialized medical procedures of the facial area, such as sinus surgery, face lifts, and eye lid procedures.

We encourage you to oppose this measure in order to protect patients in your State from this dangerous proposition. If this measure is enacted, it will deteriorate the quality of health care for citizens in New Hampshire and subject patients to undue risk and potential physical harm. Faced with a similar proposal last year, the State of New York, in recognition of the serious risk to patient care, limited oral and maxillofacial dentists' surgical treatment to procedures related to "restoring and maintaining dental health."

The Academy opposes HB 201 in its current form and urges you to carefully reconsider the language used in this measure. We would be happy to answer any questions you may have or provide additional information that may be helpful to your committee. We are also willing to assist in redrafting the bill or offering alternate language. Please feel free to contact me at 703-684-1558 or Khatereh Calleja at 703-684-4290.

Thank you for your consideration.

Sincerely,

David R. Nielsen MD

David R. Nielsen, MD, FACS
Executive Vice President

Cc: Rep. Albert Hamel, Vice Chair, Executive Departments and Administration; Rep. Ray Langer, Clerk, Executive Departments and Administration; Rep. Nelson Allan; Rep. Peter Bergin; Rep. William Clayton; Rep. John DeJoie; Rep. Judson Dexter; Rep. William Field; Rep. James Fitzgerald; Rep. Maurice Goulet; Rep. Charles Hall; Rep. Anne-Marie Irwin; Rep. Paul LaFlamme; Rep. Margie Maybeck; Rep. Robert Milligan; Rep. Maurice Pilotte; Rep. Carl Robertson; Rep. Joan Schulze; Rep. Francis Sullivan; Rep. William Zolla; Mark Kelly, MD, President, New Hampshire Society of Otolaryngology-Head and Neck Surgery; Christopher Daniell, MD, New Hampshire Society of Otolaryngology-Head and Neck Surgery; Khatereh Calleja, AAO-HNS; Palmer Jones, Executive Vice President, New Hampshire Medical Society; Janet Monahan, Deputy Executive Vice President, New Hampshire Medical Society;

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Section of Plastic Surgery

January 28, 2003

Representative Michael O'Neil, Chair
Executive Departments and Administration Committee
PO Box 818
Hampton, NH 03842-0818

Dear Representative O'Neil:

I urge you to vote "NO" on House Bill 201, legislation that would revise the state's definition of dentistry and expand the professional scope of dentistry to include authorization to perform surgical procedures, such as face lift, nose reshaping, eyelid surgery, ear surgery and liposuction.

House Bill 201 poses a true threat to patients seeking surgery of the head and neck. The broad, ambiguous language proposed in the legislation would leave the door open for your neighborhood dentist to gain approval to turn his/her practice into an aesthetic surgery center.

Please consider the following points when you determine your vote on H.B. 201:

M.D. TRAINING IS MORE EXTENSIVE THAN D.D.S. or D.M.D. TRAINING
While single-degreed dentists and oral surgeons (DDS or DMD) have extensive training in the area of oral health, their formal training does not include the level of education or clinical training plastic surgeons receive in medical school and surgical residency related to treatment of surgical patients. A medical student's education includes 24 months of clinical rotations during the final two years of the four-year curriculum, giving the medical school graduate the clinical foundation and training necessary to provide patients with quality medical care. Dental school students receive far less education regarding clinical patient care during related to oral health their third and fourth years of schooling.

WEEKEND SEMINAR CERTIFICATE IS NO SUBSTITUTE FOR BOARD CERTIFICATION
Non-physician practitioners often enroll in short continuing education courses that focus on cosmetic surgery. But unfortunately, these practitioners may not have adequate residency training to support the clinical material covered in these courses. Dentists "certified" in these types of seminars may give patients the impression that their training is equal to that of physicians with medical degrees. These types of classes are NO substitute for the residency training required for board certification by the American Board of Plastic Surgery.

PATIENT SAFETY IS A CONSTITUENT ISSUE
Patients seeking cosmetic surgery should be assured that the surgical care they receive is from a licensed physician and board certified plastic surgeon. Many health care providers are looking for shortcuts to providing increasingly popular elective surgical services, but these shortcuts expose patients to unnecessary risk and potentially hazardous outcomes. Don't fail your constituents by allowing legislation to be a substitute for medical education.

H.B. 201 compromises the quality of care patients deserve and expect in New Hampshire. Vote "NO" on H.B. 201.

Sincerely,

Christopher P. Demas, M.D.

CC: House Executive Departments and Administration Committee

Members
AMERICAN SOCIETY OF PLASTIC SURGEONS
Board Certified
American Board of Plastic Surgery

ENT ASSOCIATES OF NEW HAMPSHIRE, P.A.
JAMES P. STARK, M.D., F.A.C.S.
JOSEPH N. SIDARI, M.D.
MARK F. KELLY, M.D., F.A.C.S.

MEDICAL CENTER
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PHONE (603) 524-7402
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FAX (603) 524-0945

February 3, 2003

Dear Representative O'Neill,

As the president of the New Hampshire Otolaryngology Society, I have been made aware of a piece of legislation which if passed, will adversely affect the health of New Hampshire residents.

I am asking that you oppose HB 201. This legislation expands the scope of practice of dentistry to include evaluation, diagnosis, prevention, and treatment of the oral cavity, maxillofacial area, and all adjacent and associated structures and their impact on the human body. Moreover, it blurs fundamental distinctions between medicine and dentistry by removing existing provisions that differentiate these professions and bar any application to licensed physicians or surgeons. The legislation raises serious public health concerns as it allows dentists to perform limitless soft tissue surgical procedures of the head and neck that only physicians are qualified and trained to perform. Patients will be placed at serious risk of physical harm as dentists will be permitted to engage in myriad of complex medical procedures, such as nasal surgery and face lifts.

I am a practicing physician in Laconia, New Hampshire specializing in Otolaryngology and a member of the American Academy of Otolaryngology-Head and Neck Surgery. The Academy represents more than 10,000 physicians in the United States who diagnose and treat disorders of the ears, nose, throat, and related structures of the head and neck. Otolaryngologists are also commonly referred to as ear, nose, throat specialists (ENTs). The medical disorders treated by this specialty are among the most common that afflict all Americans. They include chronic ear infection, sinusitis, snoring and sleep apnea, hearing loss, swallowing disorders, facial and cranial nerve disorders, and head and neck cancer.

Although dentists are valued members of the health profession, they are simply not trained and qualified to perform facial cosmetic surgery and other specialized medical procedures of the facial area.

I urge you to oppose this measure in order to protect patients in the state from this dangerous proposition. This measure will deteriorate the quality of health care for citizens of New Hampshire.

Sincerely,

Mark F. Kelly, M.D., F.A.C.S.

February 5, 2003

Executive Department of Administration Committee
New Hampshire House of Representatives

Testimony of Carol O'Brien, General Counsel and Associate Executive Director American Association of Oral and Maxillofacial Surgeons (AAOMS)

Members of the Committee, I am pleased to be here today as the General Counsel and Associate Executive Director of the American Association of Oral and Maxillofacial Surgeons (AAOMS), the national organization that represents more than 7,000 oral and maxillofacial surgeons. AAOMS is here today not only to represent the OMSs of New Hampshire, but also to represent our surgeons across the country, because we support HB 201, which would change the existing New Hampshire Definition of Dentistry to follow the national model American Dental Association (ADA) Definition of Dentistry. The formal ADA Definition of Dentistry has now been adopted in 13 states, and the majority of states now have language that contains critical terms in the ADA Definition.

We commend the New Hampshire Dental Board for following the example of the majority of dental boards across the country, with the support of the ADA and the American Association of Dental Board Examiners (AADE), to bring definitions of dentistry into the 21st century. HB 201 reflects the contemporary trend in the majority of states to enact new legislation, dental board rules or state policy to support the contemporary definition of dentistry adopted and promulgated by the ADA in 1997. At that time, the ADA published Report 13 on the Definition of Dentistry, which announced its intent as the leading national association for dentistry and its specialties to "develop a definition that ... allows for the evolution of the profession of dentistry." (See attached

ADA Report 13 on the Definition of Dentistry.) The ADA has since encouraged all 50 states to adopt this uniform, national definition. The AAOMS also supports this definition as supportive of the continually evolving specialty of oral and maxillofacial surgery, a specialty of dentistry which combines surgical, medical and dental training to ensure that OMSs achieve the high quality of education, training and technical expertise to treat complex facial injuries due to auto accidents, gunshot wounds and other trauma, as well as congenital and acquired defects of the face and jaws.

Most citizens, including possibly members of the Committee, may not realize that OMSs are usually the specialists first on call in New Hampshire and most states when a patient is rushed to the hospital at 3 a.m. with a major facial trauma caused by an auto accident, gunshot wound or other catastrophic event. Similarly, many patients do not realize that oral and maxillofacial surgeons – and other dental specialists including oral and maxillofacial radiologists and oral and maxillofacial prosthodontists – perform procedures involving the associated structures of the oral cavity and maxillofacial area, including procedures involving the eye orbits, eyelids, foreheads, cheeks, noses and nasal cavities, palates and jaws.

In advancing the legislation, the Committee will help provide clear direction to the dental and other health related boards who must increasingly work together to define the scope of practice of various practitioners, based on objective and supportable credentialing standards of education, training, experience and demonstrated competence.

Today New Hampshire follows the trend of several of neighboring New England states, including Rhode Island, Maine and Massachusetts. Rhode Island has adopted the ADA Definition of Dentistry, with the addition of the term "cranio-maxillofacial" area to

reflect the contemporary scope of oral and maxillofacial surgeons' treatment of trauma patients and complex facial anomalies such as cleft lip and palate and hemifacial microsomia. Maine has adopted a dental board policy to recognize the ADA Definition in considering scope of practice issues, and Massachusetts has incorporated the term "associated structures" and supports the contemporary scope of OMS practice based on education, training and experience.

One key term in the ADA Definition not included in HB 201 is the clause – "within the scope of his/her education, training and experience." The AAOMS respectfully recommends that the Committee consider adding this additional clause to the definition of dentistry in HB 201. This term not only provides a reasonable and supportable credentialing standard for dental, medical and other health boards, but also is the credentialing standard supported by the Joint Commission on Accreditation of Hospital Organizations (JCAHO), which through its published hospital accreditation standards and survey procedures, strongly supports the appropriate delineation of clinical privileges for each medical staff member and qualified practitioner based on training, experience and demonstrated current competence.

The American Board of Medical Specialties (ABMS) also "encourages and supports these [JCAHO] efforts." The American Medical Association Council on Ethical and Judicial Affairs also supports this policy, stating: "Decisions regarding hospital privileges should be based on the training, experience and demonstrated competence of candidates, taking into consideration the availability of facilities and overall medical needs of the community, the hospital and especially patients."

AAOMS is pleased that New Hampshire, like the majority of states, including Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, New Jersey, North Dakota, Oregon, Ohio, Pennsylvania, Rhode Island, Virginia and West Virginia, is considering adopting either the ADA Definition or Dentistry or similar definitions that recognize that dentistry, like medicine and all healthcare disciplines, is constantly evolving, thanks to new innovations such as laser surgery and other technological breakthroughs that are now commonplace, but may not have been possible or available even 5 to 10 years ago.

In these states and others, the scope of practice of dentistry often has been further defined in more specific dental board rules. States like Virginia and Oregon have enacted rules to set credentialing standards based on education and training for OMSs who perform certain cosmetic procedures. Similarly, other states, like Texas and Oregon, have adopted legislation or regulation that recognizes that any procedure taught in an accredited OMS residency training program or contained in the most version of the *AAOMS Parameters of Care*, will be deemed to be within the scope of practice of dentistry.

Other states like Georgia, Maryland, New Jersey, North Dakota and Minnesota have specifically recognized that facial cosmetic and reconstructive procedures, including, but not limited to, blepharoplasties (eyelifts), rhinoplasties (reconstructive and cosmetic procedures of the nose) and ancillary procedures such as taking bone grafts from ribs and hips to rebuild bone for facial reconstruction, are procedures within the scope of OMS and dentistry – for these procedures are required to be taught in OMS

residency training programs, and must be included in the OMS training curriculum to maintain accreditation by the Commission on Dental Accreditation (CODA) and the U.S. Department of Education.

AAOMS, as the national standard bearer for our specialty, has worked diligently with the states and state dental boards to enact rules and policies, such as those considered today, to advance our primary mission as a specialty – ensuring the highest quality of care to our patients by supporting rigorous standards of training, education and continued competence.

To advance that goal, AAOMS recently adopted a national model definition of the term "associated structures" to help our state dental boards, legislatures and our specialty define more precisely how this statutory term applies to the anatomical and functional factors of the maxillofacial complex as it applies to the specialty practice of OMS.

The AAOMS definition of "associated structures," which we would be pleased to provide to the Committee today, was crafted to reference and support the procedures contained in our *AAOMS Parameters of Care*, which has been submitted to the Committee for your information and as part of the record of today's testimony.

Similarly, AAOMS has also adopted national credentialing standards to ensure that all OMSs meet the highest quality possible in the procedures within OMS education, training and scope of practice. These credentialing standards include, at a minimum, completion of an accredited OMS residency training program or a fellowship following completion of an accredited residency, and/or demonstrated competency by a showing of hospital privileges or privileges in a national or state recognized accredited facility.

Again, we thank the Committee for allowing us the opportunity to address HB 201. We are here today not to expand the scope of practice of oral and maxillofacial surgery or dentistry beyond our current education, training and demonstrated competence, but to support the ability of our specialty to continue to perform the unique and essential face-saving treatments OMSs provide daily to patients in New Hampshire's trauma centers, hospitals, military facilities and OMS surgical centers and offices.

We are pleased that so many states have affirmatively taken action to advance legislation or other policy measures to protect and support the contemporary scope of OMS and dentistry. To date, no state court or legislature has taken an adverse action related to OMS scope of practice. Further, many State Attorneys General and dental boards have specifically recognized the critical role oral and maxillofacial surgeons provide for all patients in their states in serving as the trauma specialists first on call to treat complex facial injuries in Level 1 emergency trauma centers.

Oral and maxillofacial surgeons are required medical staff for Army and Navy medical military services, including aircraft carriers, and as many experts have noted, OMSs developed and pioneered many of the current trauma and facial reconstructive procedures in combat hospitals during World War II, Korea and Vietnam. OMSs pioneered cleft palate and other facial reconstructive procedures and were among the founders of the current medical specialty of plastic surgery, established in the late 1920s.

This history and AAOMS's continuous efforts to support and advance our quality of care and new treatment innovations is why AAOMS took a leadership role in 1986 in becoming one of the first dental or medical specialties to develop our comprehensive and acclaimed *Parameters of Care*. This is why AAOMS, together with the New Hampshire

Society of OMS, has continued to take a leadership role in developing model state anesthesia, office inspection protocols and scope of practice credentialing standards to ensure the advancement of the specialty and quality patient care. AAOMS will continue to promulgate standards of excellence through our American Board of Oral and Maxillofacial Surgery, a nearly 60-year-old board, which sets OMS board certification requirements through a rigorous oral and written examination process. Successful completion of board certification helps ensure continued competence in the specialty and earns OMSs who achieve the designation of AAOMS "fellow."

AAOMS will continue to advance OMS through education and training in OMS residency programs and through our Parameters of Care, which strongly tracks the requirements of all accredited training programs in areas of concentration, including patient assessment, trauma management and surgery, reconstructive surgery, cosmetic maxillofacial surgery, oral and craniomaxillofacial implant surgery, surgical correction of maxillofacial skeletal deformities, cleft and craniofacial surgery, temporomandibular joint surgery, diagnoses and management of pathologic conditions, dentoalveolar surgery and administration of anesthesia. Specific procedures and content of each of these areas is definitively described in our AAOMS *Parameters of Care*.

Our best testament to our specialty, our quality of care and the unique services oral and maxillofacial surgeons provide through our dual background in dentistry and medicine, is from our patients and colleagues in other specialties. While we understand that today we are not able to show the Committee our recently completed video – "Oral and Maxillofacial Surgeons – Saving Faces, Changing Lives" – which describes the unique skills of OMS based on real-life patient cases, we are pleased to present the

Committee with a copy for your record today and for you to view at an appropriate convenient time. The video has been well received by other state legislators and we hope it will provide helpful information about our specialty to the Committee. Thank you for your attention. I would welcome any questions.

Report 13

Definition of Dentistry

Background: At its December 1996 meeting, the Board reviewed a report from the Council on Dental Education that summarized issues relating to the scope of practice of dentistry. Included in these issues were two instances of state medical boards bringing suit against oral and maxillofacial surgeons. These suits alleged that the oral and maxillofacial surgeons were practicing beyond the scope of practice as defined by the state dental practice acts. The Council believed that a definition of dentistry could provide guidance to states in the development of dental practice acts in relation to scope of practice issues.

Following discussion of the Council's report, the Board adopted a resolution directing the development of a definition of dentistry. Further, the Board directed the appointment of a broadly representative Task Force to include one member each from the Board of Trustees, the Council on Dental Education (CDE), the Council on Dental Practice (CDP), the Council on Dental Benefit Programs (CDBP), the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) and the Council on Access, Prevention and Interprofessional Relations (CAPIR).

Task Force Development of a Definition of Dentistry: As directed by the Board's resolution, the President, with the concurrence of the Board of Trustees, appointed the Task Force to Develop a Definition of Dentistry. Members appointed to the Task Force include Dr. Myron L. Pudwill, Tenth District Trustee, chairman; Dr. Dennis J. Brandstetter, CDE; Dr. G. Lewis Mitchell, CEBJA; Dr. Theodore M. Roberson, CAPIR; Dr. Samuel E. Selcher, CDP; and Dr. James E. Spencer, CDBP. The Task Force met on April 25, 1997 in the Headquarters Building and by telephone conference call on August 15, 1997.

In addition to reviewing background information at its first meeting, the Task Force reviewed related Association policies and definitions, definitions of dentistry from several state dental practice acts, suggested definitions of dentistry from the Council on Dental Practice and the American Association of Oral and Maxillofacial Surgeons, and the ADA-approved definitions of each dental specialty. After careful consideration, the Task Force adopted a proposed draft definition of dentistry and forwarded it to the Board for review at its June 1997 meeting prior to circulating the definition to the communities of interest for comment.

June 1997 Board Action: At its June 1997 meeting, the Board adopted the proposed definition for circulation to the communities of interest. Further, the Board directed the Task Force to review all comments received and transmit a proposed definition to the Board for consideration at its August 1997 meeting and for transmittal to the 1997 House of Delegates.

Distribution of Definition to Communities of Interest and Review of Comments: As directed by the Board, in correspondence dated June 24, 1997, the following communities of interest were invited to comment on the proposed draft definition: constituent dental societies, state boards of dentistry, dental specialty organizations and certifying boards, Academy of General Dentistry, American Association of Dental Schools, American Association of Dental Examiners and the councils of the Association. A detailed rationale for the language contained in the definition was included in the correspondence. In addition, the July 3, 1997 edition of the *Executive Director's Update* included notification that the definition was being circulated for comment.

The Task Force reviewed all comments received in a telephone conference call on August 15, 1997. A total of 13 comments on the proposed definition were received and reviewed by the Task Force. Following careful consideration of all comments received, the Task Force recommended two editorial changes to the proposed draft definition as follows:

> **Resolved,** that dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical and surgical) of disease, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law.

Rationale for the Proposed Definition: It was the intent of the Task Force to develop a definition that is open-ended and allows for the evolution of the profession of dentistry. Additionally, in supporting the proposed language of the definition, it was the Task Force's intention that the proposed definition not conflict with any existing Association policies and/or related definitions, such as the Definition of Professional Dental Care (*Trans.*1996:688) and the approved definitions of the eight recognized dental specialties. The rationale for each phrase in the definition must be reviewed to fully understand the intended scope of the proposed definition.

The phrase "evaluation, diagnosis, prevention and/or treatment (nonsurgical or surgical)" (lines 1-2) is intended to include treatment planning and all other components of oral health care and the dental specialties. In line 2, the phrase "disease, disorders and/or conditions," "conditions" is intended to encompass the full scope including dysfunction, injuries, esthetics and deformities. The phrase is also intended to embody any real or perceived abnormalities related to form and/or function. In the phrase "oral cavity, maxillofacial area and/or adjacent and associated structures and their impact on the body (line 3-4), "oral cavity and maxillofacial area" are viewed as the

traditional beginning points for the scope of practice of dentistry. "Adjacent" is intended to imply structures or tissues physically and anatomically related to the resultant treatment area; "associated" is intended to imply structures that are functionally related to the resultant treatment area; and "their impact on the human body" is used to be consistent with the Association's definition of professional dental care. In the phrase "provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law" (line 4-6), "education, training and experience" are intended to be considered inclusively, not separately, while "in accordance with the ethics of the profession and applicable law" is intended to include issues of quality of care. In each instance of the use of "and/or," each individual item in a series is intended either separately or in combination with one or more of the other items in the series.

Relationship of the Proposed Definition to the ADA-Approved Definition of the Recognized Dental Specialties: The Task Force believes that the proposed definition is consistent with and complements existing Association policies and related definitions. The Association publishes a list of specialty definitions. The Task Force recommends that the approved definition of dentistry be incorporated into the published list of ADA-approved definitions of the dental specialties with the definition of dentistry appearing at the beginning of the list and the dental specialty definitions following in alphabetical order. The Task Force further recommends that the House-approved definition of dentistry along with the Association's definitions of the recognized dental specialties be disseminated to the communities of interest.

Periodic Review of Definition Adopted by the House of Delegates: The Task Force believes that the Association's definition of dentistry should be periodically reviewed to ensure that it continues to appropriately define the profession. The Task Force noted that the Council on Dental Education has responsibility for the development and periodic revision of definitions of the recognized dental specialties. For this reason, the Task Force suggests that initial responsibility for review and revision of the definition of dentistry be assigned to the Council on Dental Education. The Council has established procedures for revising specialty definitions that include circulation of a proposed revised definition to the communities of interest. The Task Force urges that this same procedure be followed for future revisions of the definition of dentistry. Final actions to revise the definition of dentistry should be made by the House of Delegates.

Summary: This report summarizes the activities of the Board-appointed Task Force to Develop a Definition of Dentistry. The report includes a resolution calling for adoption of a definition of dentistry and the report details the rationale for the proposed definition. Additionally, resolutions calling for distribution of the adopted definition to the communities of interest and for the periodic review and revision of the definition of dentistry by the Council on Dental Education are presented for consideration.

Board Recommendations: The Board concurs with the recommendations of the Task Force regarding the adoption of a definition of dentistry. Therefore, the Board recommends adoption of the following resolution.

Resolution

33. Resolved, that dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical and surgical) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law, and be it further

Resolved, that the approved definition of dentistry, adopted by the 1997 House of Delegates, be incorporated into the beginning of the Association's published list with the definitions of dental specialties following in alphabetical order and distributed to the communities of interest, and be it further

Resolved, that the Council on Dental Education have responsibility for the periodic review and revision of the definition of dentistry, in a manner consistent with its established procedures for revision of a dental specialty definition.

Rocco R. Addante, DMD, MD
Professor and Chairman
Oral and Maxillofacial Surgery
Dartmouth Hitchcock Medical Center
Lebanon, New Hampshire 03756

February 3, 2003

My name is Rocco Addante and I joined the surgical staff at the Dartmouth Hitchcock Medical Center in 1980 as their first full time oral and maxillofacial surgeon. I became a member of the section of section of plastic surgery and since my practice was essentially 100% hospital based, I saw a wide variety of complex clinical problems involving the head and neck. In time we became an integral part of the educational system designed to train medical students, general surgery residents and later plastic surgery residents and otolaryngology residents. We hold regular conferences with the plastic surgery residents and the otolaryngology residents and play an active role in their educational process. This involves not only the discussion of patients and disease entities but also hands on guidance in the operating room.

Indeed we are fortunate at DHMC as oral and maxillofacial surgeons to work collaboratively on many fronts. We are represented on the trauma team, cosmetic surgery team, head and neck cancer center and craniofacial anomalies clinic working with patients who have severe cleft deformities. We give lectures frequently to affiliated services such as dermatology, anesthesiology and medicine and hold weekly meetings with radiology and pathology providing educational discourse for students and faculty. Since Dartmouth does not have a dental school, we are often their sole exposure to the diagnosis and treatment of oral diseases.

Although somewhat geographically isolated, our network of outreach clinics brings us a wide variety of trauma throughout the year, be it from motor vehicle injuries, moose impacts, skiers, snowmobilers, snowboarders, our Dartmouth sports teams or our helicopter with far reaches into the mountainous areas of northern New Hampshire. We feel that we have provided an expertise that these victims would otherwise not have received. Access to health care is not easy but we at DHMC have worked hard to provide care to everyone that needs it.

I have served as an examiner for the Board of Oral and Maxillofacial Surgery for seven years and am familiar with the extensive training that

candidates must possess and the expertise that they must demonstrate in order to become certified in our specialty. Limitations to our practice will make it impossible for our students to gain the experience that they need to continue to provide the quality of care that has been characteristic of our discipline for decades.

Since 1980, there have been six oral and maxillofacial surgeons on the staff at DHMC. Some have had extended training in cosmetic surgery, others in head and neck cancer surgery and others in craniofacial surgery. We are thankful to our patients for the opportunity to serve them. We are also thankful to the residents of various surgical specialties with whom we interact who constantly challenge us and we are thankful to those who volunteer their time to oversee the accreditation of these services so that those in our specialty can continue to meet the needs of our patients, serve our communities and medical centers and maintain our commitment to the health care educational system.

NEW HAMPSHIRE MEDICAL SOCIETY

For the betterment of public health since 1791

7 North State Street
Concord, New Hampshire 03301
(603) 224-1909
Toll Free (800) 564-1909
FAX (603) 226-2432
E-mail: nhmsppj@aol.com
EXECUTIVE VICE PRESIDENT
Palmer P. Jones

February 5, 2003

HB 201, relative to the definition of the practice of dentistry.

The NH Medical Society is opposed to HB 201 because it expands the definition of dentistry well beyond the oral cavity and the bill eliminates the current exemption for physicians.

The definition being proposed in section I. of the bill puts no limits on the practice of dentistry and mimics what has been proposed in other states. The purpose of the broad definition is to allow dentists to expand their practices to include nose jobs, face lifts, wrinkle removal, eye lid procedures, sinus surgery, liposuction, chemical face peels and parotid surgery with facial nerve dissection. This list is not far-fetched, because in California, such procedures were being performed by dentists and oral surgeons until restrictions were enacted, only after patients were harmed.

Dentists (DDS) and oral surgeons (DMD) are very well trained in all aspects of oral health and dental surgery; however, they are not physicians. This is not a turf issue, but a patient safety issue. The NH Legislature is not in a position to grant medical privileges. All physicians who seek surgical privileges must not only complete years of rigorous education and training programs; they must demonstrate clinical competence. A well-respected surgical specialist, practicing 10 years at Massachusetts General Hospital, has to demonstrate clinical competence before being allowed to operate alone in another state. What that means is that each physician applying for new hospital privileges has to perform a set amount of surgical procedures with a credentialed surgeon to prove his or her clinical competence. Physicians do not seek to expand their range of procedures through legislation.

The other concern we have with HB 201 is the elimination of the current exemption for physicians. RSA 317-A:20, III. states:

"III. Nothing in this section shall prevent:

(a) Regularly licensed physicians or surgeons from:

(1) Treating or prescribing for lesions, diseases, disorders, or deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures;

(2) Extracting human teeth or administering anesthetics;

(3) Using or prescribing drugs or other remedies."

This omission would prohibit emergency physicians, otolaryngologists (ENTs) and plastic surgeons from treating trauma patients in the emergency room who have sustained injuries to their jaw and oral cavity. This omission makes HB 201 the most far-reaching *dentistry definition* bill that has been introduced around the country.

The Medical Society would like to encourage you to keep the current physician exemption in RSA 317-A and to utilize a definition that appropriately and safely describes the practice of dentists and oral surgeons:

"I. The practice of dentistry shall mean the evaluation, diagnosis, prevention, or treatment by surgical, non-surgical or related procedures of diseases, disorders, or conditions of the oral cavity, **or** maxillofacial area, ~~or the adjacent and associated structures and their impact on the human body~~ **related to restoring and maintaining dental health.**"

Thank you.

NEW HAMPSHIRE BOARD OF DENTAL EXAMINERS

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Tel. (603) 271-4561
In State Toll Free Telephone Number 1-800-852-3345, Ext. 4561
FAX #: (603) 271-6702
www.state.nh.us/dental
TDD Access: Relay NH 1-800-735-2964
Email: dentalboard@nhsa.state.nh.us

Raymond J. Jarvis, DMD
Executive Secretary

February 5, 2003

The Board of Dental Examiners' Position

House Bill 201

Pursuant to RSA 317-A, (Dental Practice Act) the Board of Dental Examiners is responsible for regulating the practice of dentistry in a manner that protects the public. To that end, the Board asked representative Jane Langley to sponsor a bill which proposes changes in RSA 317-A:20 Practice of Dentistry. These changes address the definition of the word "dentistry", ownership of dental practices, supervision of dentists, third party analysts, and dental students, as well as the deletion of several unnecessary or inaccurate subparagraphs. The reasons for the proposed changes are as follows:

RSA 317-A:20 I

The Board believes the word "dentistry" should be defined in paragraph I before addressing the practice of dentistry in paragraphs II through VI. Paragraph I defines dentistry in a manner similar to the American Dental Association definition and which reflects the education and daily practice of dentists.

RSA 317-A:20 II(b)

The phrase "unless said activity in no way controls, restricts or otherwise affects the professional judgment of dentists" would allow for the ownership of dental practices by non-dentists. Some states allow such ownership, others do not. This subparagraph protects the public while recognizing new forms of ownership and management of dental practices.

RSA 317-A:20 II (c)

This subparagraph is intended to protect the public by preventing interference with the professional judgment of dentists.

RSA 317-A:20 II (e)

This subparagraph uses the definition of the word "dentistry" found in paragraph RSA 317-A:20 I above. It also addresses the use of electronic media to practice dentistry.

RSA 317-A:20 III

This paragraph requires a third party analyst to be a dentist if he or she practices dentistry by providing a diagnosis, treatment plan or prescription for a dental patient.

RSA 317-A:20 V

This paragraph specifies the conditions under which dental students can treat patients in New Hampshire. It assures that they practice in an academic environment under appropriate supervision.

The Board is seeking deletion of the following subparagraphs:

RSA 317-A:20 I (e) "Extracts human teeth or corrects malpositions thereof or of the jaws;" This statement is superfluous because these procedures are included in the definition of the practice of dentistry.

RSA 317-A:20 I (h) "Engages in any of the practices included in the curricula of recognized dental colleges." This statement is inaccurate because some subjects taught in dental schools are performed by dental auxiliaries, such as dental assistants doing sealants or performing dental radiography.

RSA 317-A:20 III (a) "Nothing in this chapter shall prevent: (a) Regularly licensed physicians or surgeons from: (1) Treating or prescribing for lesions, diseases, disorders, or deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures; (2) Extracting human teeth or administering anesthetics; (3) Using or prescribing drugs or other remedies." This statement seems to be superfluous because RSA 329, the Medical Practice Act, defines the foregoing as the practice of medicine.

DARTMOUTH-HITCHCOCK MEDICAL CENTER

One Medical Center Drive
Lebanon, NH 03756-0001

Phone: (603) 650-5148
Fax: (603) 650-5809
e-mail: plastic-surgery@mailbox1.hitchcock.org

Section of Plastic Surgery

February 3, 2003

To Whom It May Concern:

This is to confirm that our Oral and Maxillofacial Surgeons play an active role in the education of residents in our Plastic Surgery Residency Program. They provide emergency coverage for facial trauma approximately 1 in 4 in our institution, as well as diagnosing and treating oral and maxillofacial pathology.

Should you have specific questions I can help you with please do not hesitate to contact me directly.

Sincerely,

Carolyn L. Kerrigan, MD
Section Chief & Program Director

Members
AMERICAN SOCIETY OF PLASTIC SURGEONS
Board Certified American Board of Plastic Surgery

Dartmouth-Hitchcock Medical Center

One Medical Center Drive
Lebanon, New Hampshire 03756-0001
603-650-8124

Section of Otolaryngology and Audiology
Glenn D. Johnson, M.D./F.A.C.S.
Otology and Neurotology
Skull Base Surgery

An oral surgeon is an essential member of the medical staff of a major medical center to give appropriate care of a large number of medical problems, some emergent, some elective. These include, but are not limited to, infections of the facial spaces of the face and neck resulting from dental infections, trauma of the head and neck, head and neck tumor management including exterpative and reconstructive surgery, rehabilitation of post-surgical defects of the head and face, as well as the management of dental diseases that require extraction or other surgical procedures. Oral surgeons are also necessary for the education of medical students and graduate residents in the diagnosis and treatment of diseases of the head, mouth, and neck. DHMC would be severely limited in its service to the residents of New Hampshire and Vermont if it did not have the expertise of the oral surgical staff.

Sincerely,

Glenn D. Johnson, MD, FACS

DARTMOUTH-HITCHCOCK MEDICAL CENTER

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Section of Plastic Surgery

February 7, 2003

Representative Michael O'Neil
Chairman, Executive Departments and Administration Committee
New Hampshire House of Representatives
P.O. Box 818
Hampton, NH 03842-0818

RE: House Bill 201

Dear Representative O'Neil:

I urge you to vote "NO" on House Bill 201, legislation that would revise the state's definition of dentistry and expand the professional scope of dentistry to include authorization to perform surgical procedures, such as face lift, nose reshaping, eyelid surgery, ear surgery and liposuction. House Bill 201 poses a true threat to patients seeking surgery of the head and neck. The broad, ambiguous language proposed in the legislation would leave the door open for your neighborhood dentist to gain approval to turn his/her practice into an aesthetic surgery center.

Please consider the following points when you determine your vote on H.B. 201:

M.D. TRAINING IS MORE EXTENSIVE THAN D.D.S. or D.M.D. TRAINING

While single-degreed dentists and oral surgeons (DDS or DMD) have extensive training in the area of oral health, their formal training does not include the level of education or clinical training plastic surgeons receive in medical school and surgical residency related to treatment of surgical patients. A medical student's education includes 24 months of clinical rotations during the final two years of the four-year curriculum, giving the medical school graduate the clinical foundation and training necessary to provide patients with quality medical care. Dental school students receive far less education regarding clinical patient care during related to oral health their third and fourth years of schooling.

WEEKEND SEMINAR CERTIFICATE IS NO SUBSTITUTE FOR BOARD CERTIFICATION

Non-physician practitioners often enroll in short continuing education courses that focus on cosmetic surgery. But unfortunately, these practitioners may not have adequate residency training to support the clinical material covered in these courses. Dentists "certified" in these types of seminars may give patients the impression that their training is equal to that of physicians with medical degrees. These types of classes are NO substitute for the residency training required for board certification by the American Board of Plastic Surgery.

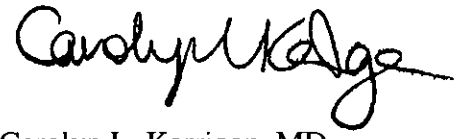
Members
AMERICAN SOCIETY OF PLASTIC SURGEONS
Board Certified
American Board of Plastic Surgery

PATIENT SAFETY IS A CONSTITUENT ISSUE

Patients seeking cosmetic surgery should be assured that the surgical care they receive is from a licensed physician and board certified plastic surgeon. Many health care providers are looking for shortcuts to providing increasingly popular elective surgical services, but these shortcuts expose patients to unnecessary risk and potentially hazardous outcomes. Don't fail your constituents by allowing legislation to be a substitute for medical education.

H.B. 201 compromises the quality of care patients deserve and expect in New Hampshire. Vote "NO" on H.B. 201.

Sincerely,



Carolyn L. Kerrigan, MD
Section Chief, Plastic Surgery
Program Director, Plastic Surgery Residency Program

cc: House Executive Departments and Administration Committee Members

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Section of Plastic Surgery

January 30, 2003

Representative Michael O'Neil, Chair
Executive Departments and Administration Committee
PO Box 818
Hampton, NH 03842-0818

Dear Representative O'Neil:

I urge you to vote "NO" on House Bill 201, legislation that would revise the state's definition of dentistry and expand the professional scope of dentistry to include authorization to perform surgical procedures, such as face lift, nose reshaping, eyelid surgery, ear surgery and liposuction.

House Bill 201 poses a true threat to patients seeking surgery of the head and neck. The broad, ambiguous language proposed in the legislation would leave the door open for your neighborhood dentist to gain approval to turn his/her practice into an aesthetic surgery center.

Please consider the following points when you determine your vote on H.B. 201:

M.D. TRAINING IS MORE EXTENSIVE THAN D.D.S. or D.M.D. TRAINING

While single-degreed dentists and oral surgeons (DDS or DMD) have extensive training in the area of oral health, their formal training does not include the level of education or clinical training plastic surgeons receive in medical school and surgical residency related to treatment of surgical patients. A medical student's education includes 24 months of clinical rotations during the final two years of the four-year curriculum, giving the medical school graduate the clinical foundation and training necessary to provide patients with quality medical care. Dental school students receive far less education regarding clinical patient care during related to oral health their third and fourth years of schooling.

WEEKEND SEMINAR CERTIFICATE IS NO SUBSTITUTE FOR BOARD CERTIFICATION

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Members
AMERICAN SOCIETY OF PLASTIC SURGEONS
Board Certified American Board of Plastic Surgery

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e-mail: plastic-surgery@mailbox1.hitchcock.org

Section of Plastic Surgery

PATIENT SAFETY IS A CONSTITUENT ISSUE

Patients seeking cosmetic surgery should be assured that the surgical care they receive is from a licensed physician and board certified plastic surgeon. Many health care providers are looking for shortcuts to providing increasingly popular elective surgical services, but these shortcuts expose patients to unnecessary risk and potentially hazardous outcomes. Don't fail your constituents by allowing legislation to be a substitute for medical education.

H.B. 201 compromises the quality of care patients deserve and expect in New Hampshire. Vote "NO" on H.B. 201.

Sincerely,

E. Dale Collins, M. D.
Associate Professor of Surgery and
Director, Comprehensive Breast Program

Members
AMERICAN SOCIETY OF PLASTIC SURGEONS
Board Certified
American Board of Plastic Surgery

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Section of Plastic Surgery

PATIENT SAFETY IS A CONSTITUENT ISSUE

Patients seeking cosmetic surgery should be assured that the surgical care they receive is from a licensed physician and board certified plastic surgeon. Many health care providers are looking for shortcuts to providing increasingly popular elective surgical services, but these shortcuts expose patients to unnecessary risk and potentially hazardous outcomes. Don't fail your constituents by allowing legislation to be a substitute for medical education.

H.B. 201 compromises the quality of care patients deserve and expect in New Hampshire. Vote "NO" on H.B. 201.

Sincerely,

Mitch Stotland, MD
Depts. of Surgery (Plastic) and Pediatrics
Director, Craniofacial Anomalies Clinic
Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, New Hampshire 03756
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One Medical Center Drive
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FAX 603-650-7898

4 Feb
2003

To Whom It May Concern,

As a previous section chairman of Otolaryngology, I would like to support and document the collaborative role of the Section of Oral Surgery at Dartmouth Hitchcock Medical Center. Dr. Addante, Section Chairman of Oral Surgery, has played a significant role in the diagnosis And management of head and neck diseases and has been instrumental in the collaboration and reconstructive surgery of the head and neck.
Oral surgery at Dartmouth Hitchcock Medical Center contributes to our weekly conferences in both participation and presentation of cases. They are readily available for consultation.

Sincerely,

NAG/vml

Otolaryngology/Head & Neck Surgery

J. Oliver Donegan, M.D./ F.A.C.S.
Section Chairman
603-650-8123

Dudley J. Weider, M.D./ F.A.C.S. 603-650-8122
Nathan A. Geurkink, M.D./ F.A.C.S. 603-650-8130
Peter Dixon, PAC
608-650-8130

Glenn D. Johnson, M.D./ F.A.C.S. 603-650-8124
Benoit J. Gosselin, M.D./ F.A.C.S. 603-650-8112

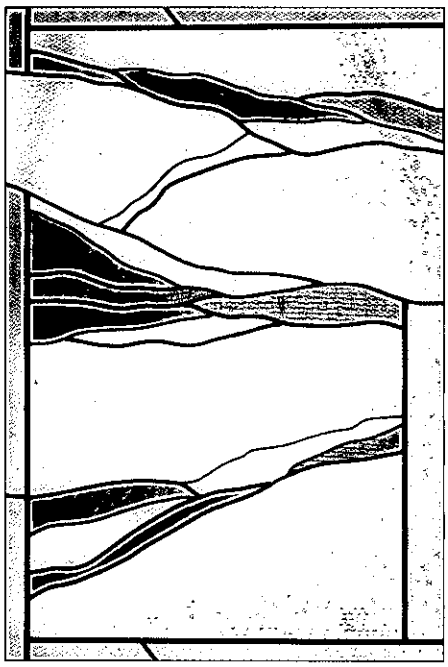
Audiology

Frank E. Musiek, Ph.D.
Director
603-650-8125

Karen S. Kibbe, M.A./CCC-A
Suzanne B. Lenz, M.A./CCC-A
Audra D. Smith, M.A./CCC-A
Leah Schoenberg, M.Ed./CCC-A

HEAD AND NECK CANCER

Norris Cotton Cancer Center



Information for our patients

DARTMOUTH-HITCHCOCK
MEDICAL CENTER

Comfort, Care, Cure: A Team A to Cancers of the Head and

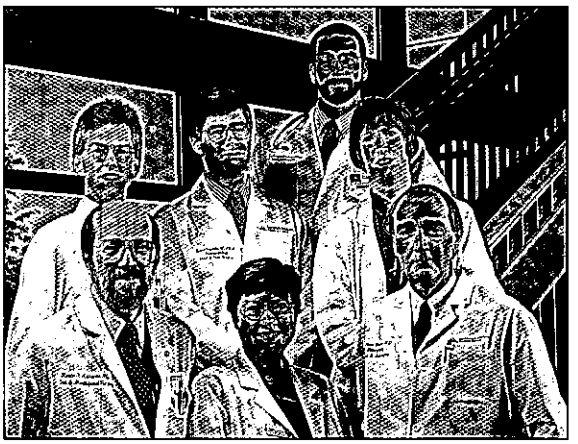
At Norris Cotton Cancer Center...

you will benefit from comprehensive resources for diagnosing and treating cancers of the head and neck, and a supportive environment for your care and recovery. Our Head and Neck Cancer team specializes in tumors of the oral cavity, pharynx, larynx, lips, nose, sinuses, salivary glands, neck, ears and temporal bones, and skull-based tumors. We work closely with you, your family, and your own physician to determine the treatment strategy best for you. We combine personal attention, compassionate care, and innovative therapies to make your diagnosis and treatment for head and neck cancer as comfortable and effective as possible. We emphasize attention to quality of life issues, including appearance, speech, and swallowing.

Your care and treatment will be managed by a team...

of experienced cancer physicians, advanced practice nurses, research coordinators, and other healthcare professionals who specialize in treating people with cancers of the head and neck. Your team will coordinate your care and do its best to help you arrange appointments at convenient times.

Our team approach begins with the establishment of a diagnosis following physical examination, MRI and CT radiology imaging, endoscopy, and biopsy as needed. We will then work with you and your referring physician to create an individualized treatment plan that may include surgery, radiation therapy, and/or chemotherapy. Surgery and radiation therapy are used to treat localized tumors, and may be combined with chemotherapy to treat more advanced tumors and to inhibit the spread of cancer cells throughout the body. Chemotherapy and radiation therapy are generally given as outpatient services; hospital facilities are available at DHMC for surgery and



The Head and Neck Cancer Team

other procedures as needed. We offer technically advanced treatments including hyperfractionated radiation therapy with concurrent chemotherapy, brachytherapy (seed implants), advanced reconstructive surgery to repair bone and soft tissue deficits, voice restoration following laryngectomy, and rehabilitation of swallowing disorders.

The Head and Neck Cancer team meets regularly to discuss test results, plan treatment, and ensure smooth coordination of care. Through the course of your diagnosis and treatment, these professionals may be involved in your care:

- Head and neck surgeon (otolaryngologist)
- Diagnostic radiologist
- Radiation oncologist
- Medical oncologist
- Oral and maxillofacial surgeon
- Oncology nurse practitioner
- Pathologist
- Speech therapist
- Nutritionist
- Physical therapist

For advanced tumors encroaching into the chest and cranial cavity, the patient may also see a cardiothoracic surgeon or neurosurgeon.

PPROACH NECK

You and your family members will be supported...

because our goal is to cure cancer and/or extend life, while helping patients look their best, achieve optimum function, and feel as well as possible. We strive to provide effective pain relief, reduce side effects of therapy, give emotional support, and help solve the challenges of living with cancer, including practical problems like insurance and transportation. When your treatment ends, we'll help guide you through recovery and rehabilitation. Supportive services include smoking cessation programs, rehabilitative assistance for swallowing problems and speech, and management of fatigue and other symptoms. A support group for adults with cancer meets once a week, and information resources about head and neck cancer are available through clinicians and our patient and family library.

You'll have access to the latest research and clinical trials...

because NCCC is one of the leading cancer research institutions in the United States. Newly developed therapies are brought to patients as quickly and safely as possible through research studies called clinical trials. These studies may offer hope for cure, a longer life, or a way to feel better during cancer treatment. They are developed at NCCC, and through the national research organizations in which our investigators actively participate, including the Radiation Therapy Oncology Group. A current research study developed by NCCC focuses on newer techniques of delivering radiation therapy combined with chemotherapy with a view to preserving organs such as the larynx, pharynx, and tongue. We will be happy to discuss appropriate trials with you and your primary care physician.

A Center of Excellence

Norris Cotton Cancer Center is a premier cancer treatment and research facility. It is one of only 37 institutions nationwide to receive the National Cancer Institute's designation as a comprehensive cancer center. NCCC gives residents of northern New England access to cancer resources typically associated with more urban areas.

Working through our outreach clinics and with primary care physicians throughout the region, Norris Cotton Cancer Center strives to bring advanced cancer treatments to patients at locations comfortably close to home. Research programs in basic sciences and therapeutics bring new cancer treatments to our patients, often directly from laboratory to bedside through clinical trials.

Patients with all forms of cancer are treated here, and all care is provided by clinicians who specialize in cancer. Each patient is treated as an individual and receives the focused attention of a team of physicians, oncology nurses, and other professionals who are expert in serving the broad needs of cancer patients. Personal attention and a supportive environment are hallmarks of care at Norris Cotton Cancer Center.

CONTACT:
For further information about our Head and Neck Cancer Program, or to make an appointment, please call (603) 650-8123.

Or consult the NCCC website:
http://nccc.hitchcock.org

Cover photo: Stained glass window in the NCCC Infusion Center.

NCI CCC

A Comprehensive Cancer Center Designated by the National Cancer Institute

Directions to Norris Cotton Cancer Center

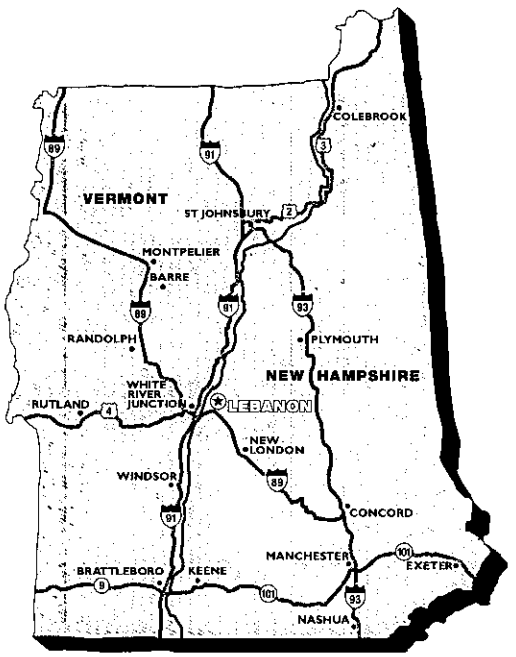
From the North: I-91 south to Exit 10S (Airport-New Hampshire). Merge onto I-89 south and follow to Exit 18. Turn left at the end of the ramp onto Rte. 120 and follow the blue and white signs approximately three miles to DHMC.

From the South: I-91 north to Exit 10S (Airport-New Hampshire). Merge onto I-89 south and follow to Exit 18. Turn left at the end of the ramp onto Rte. 120 and follow the blue and white signs approximately three miles to DHMC.

From the Southwest: Route 4 to White River Junction, take I-89 south to Exit 18. Turn left at the end of the ramp onto Rte. 120 and follow the blue and white signs approximately three miles to DHMC.

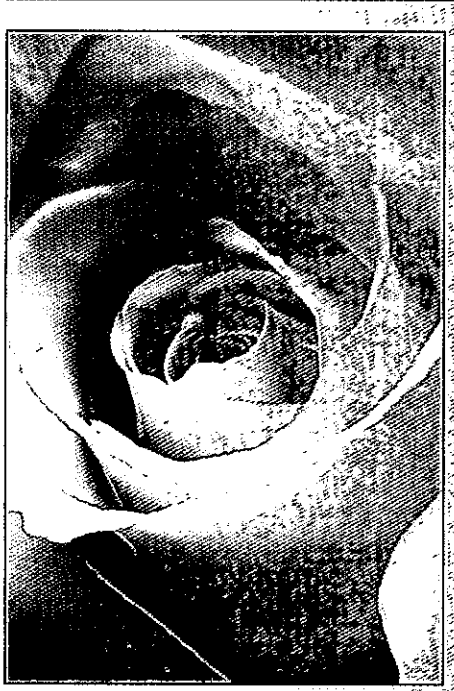
From the Southeast: I-89 north to Exit 18. Turn right at the end of the ramp onto Rte. 120 and follow the blue and white signs approximately three miles to DHMC.

At DHMC, the main entrance to Norris Cotton Cancer Center can be reached by taking the East Entrance (Emergency, Cancer Center) off the DHMC Loop Road. Bear left off the East Entrance road into the NCCC parking lot.



NORRIS COTTON CANCER CENTER
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Lebanon, NH 03756

COSMETIC SURGERY



A multidisciplinary approach for patients.

DARTMOUTH-HITCHCOCK
MEDICAL CENTER

Our Approach



Dr. Christopher Demas, MD, and Dr. Carolyn Kerrigan, MD, are active members of the American Society of Plastic and Reconstructive Surgeons.

The decision to have cosmetic surgery can be a difficult one to make. The Cosmetic Surgery Center at Dartmouth-Hitchcock allows you to make your decision with full confidence that you'll have a positive experience. The Cosmetic Surgery Center gives patients access to the expertise and knowledge that they would expect from one of the nation's leading teaching hospitals by bringing together all of the related medical disciplines available on the Medical Center's campus.

This multidisciplinary approach to treatment draws upon the skills of physicians and staff from the sections of Plastic and Reconstructive Surgery, Dermatology, Otolaryngology, Ophthalmology, Maxillofacial Surgery and Vascular Surgery. By working collaboratively, patients are provided with the appropriate specialized treatments in a cost-effective manner.

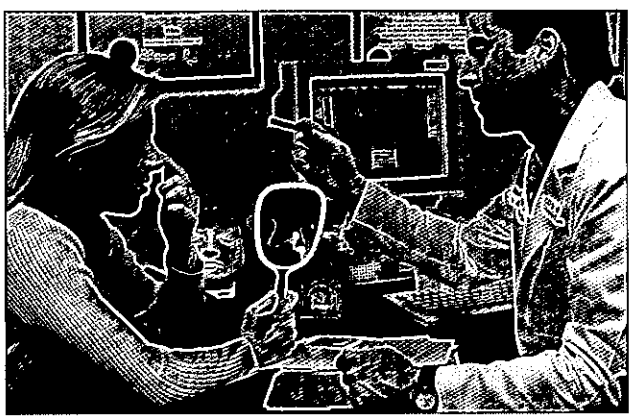
The Center realizes that, in addition to providing comprehensive evaluation and treatment, patient comfort and personal attention is also a priority. This attention to "customer service" is the shared goal of every member of the Cosmetic Surgery Center team.

Services Offered

All physicians providing services at the Cosmetic Surgery Center at Dartmouth-Hitchcock are Board certified or eligible and are trained in the latest techniques of cosmetic and reconstructive procedures. Cosmetic surgery involves procedures that reshape facial and bodily features, and is designed to improve a person's appearance and self-confidence.

The cosmetic procedures that we provide are:

- laser surgery (wrinkle removal)
- rhinoplasty (nose surgery)
- liposuction
- breast augmentation (enlargement)
- breast-lift
- botox injections
- eyelid surgery
- face-lift
- ear surgery
- abdominoplasty (tummy tuck)
- scar revision
- blemish removal
- vein surgery
- brow lift



Dr. Mitchell Stotland discusses the various cosmetic surgery options and benefits available to patients.

Physicians:

ROCCO R. ADDANTE, MD, DMD
Board Certified: Maxillofacial Surgery
Special Interest: Surgical correction of upper and lower jaw deformities and dental implants

M. SHANE CHAPMAN, MD
Board Certified: Dermatology
Special Interest: Cosmetic laser surgery and botox injections

DANIEL COLLISON, MD, Section Chief, Dermatology
Board Certified: Dermatology
Special Interest: Removal of benign skin growths, and lasers. Additional interest and expertise in diseases of the nails, prevention and treatment of skin cancer, and sclerotherapy of spider veins

CHRISTOPHER DEMAS, MD
Board Certified: Plastic Surgery
Special Interest: Facial cosmetic surgery, body contouring, head and neck reconstruction, microvascular limb surgery and breast surgery

BENOIT J. GOSSELIN, MD, FRCSC
Board Certified: Otolaryngology
Special Interest: Cosmetic facial surgery including scar revisions, facelifts, laser resurfacing, eyelid rejuvenation, facial implants, botox injections, and reconstruction of post-oncologic craniofacial and congenital deformities

CAROLYN L. KERRIGAN, MD, FRCSC,
Section Chief, Plastic Surgery
Board Certified: Plastic Surgery
Special Interest: Breast surgeries, abdominoplasty, and liposuction

RICHARD J. POWELL, MD
Board Certified: Vascular Surgery
Special Interest: Endovascular and minimally invasive vascular surgery, and peripheral arterial disease

JOSEPH M. ROSEN, MD
Board Certified: Plastic Surgery
Special Interest: Rhinoplasty, scar revisions, liposuction, breast surgeries, abdominoplasty, and facelifts

WILLIAM J. ROSEN, MD
Board Certified: Ophthalmology
Special Interest: Eyelid surgical procedures, including reconstruction after tumor removal, correction of eyelid misdirection, and cosmetic eyelid surgery

STEVEN K. SPENCER, MD
Board Certified: Dermatology
Special Interest: Melanoma, dermatopathology, MOH's microscopically controlled excision of skin cancer

MITCHELL STOTLAND, MD, FRCSC
Board Certified: Plastic Surgery
Special Interest: Rhinoplasty, facelifts, laser resurfacing, scar revisions, liposuction, reconstruction of congenital, post-traumatic, and post-oncologic craniofacial deformities

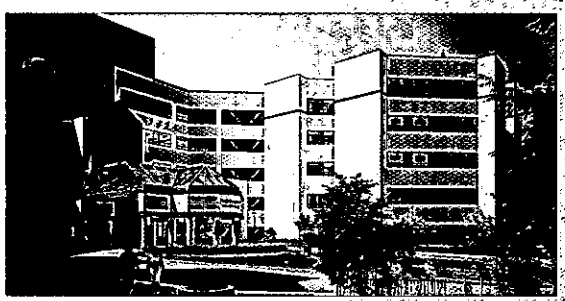
DANIEL B. WALSH, MD
Board Certified: Vascular Surgery
Special Interest: Arterial and venous disease

Is Cosmetic Surgery Right for You?

There are many things to think about when considering cosmetic surgery. How experienced are the surgeons? Are they trained in the latest procedures? Will the surgery be painful? When can I return to work?

Dartmouth-Hitchcock recently expanded its Cosmetic Surgery Center in response to increasing interest in these procedures from area residents concerned about improving their appearance and enhancing self-esteem.

As one of the country's leading teaching hospitals, Dartmouth-Hitchcock provides northern New England residents with extensive resources and medical specialists—so you don't need to leave the area to take advantage of these helpful treatments.



How to Contact Us

To schedule an appointment for your initial consultation and evaluation, and to learn about our payment policies, please call (603)650-0600. Our offices are open from 8:00AM to 5:00PM, Monday through Friday. Please feel free to contact our staff with any questions, concerns or suggestions which will enable us to improve the care we provide.

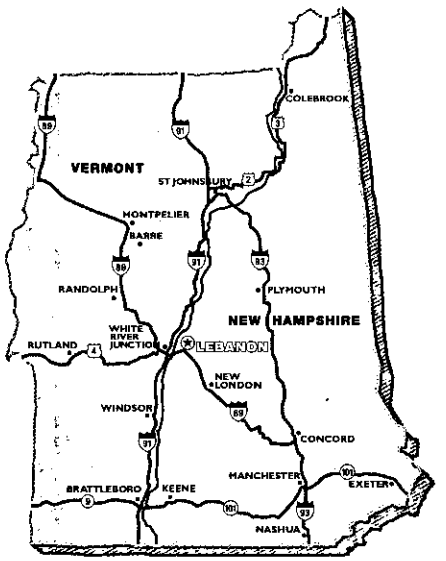
Directions to Dartmouth-Hitchcock Medical Center, Lebanon

From the North: I-91 south to Exit 10S (Airport-New Hampshire). Merge onto I-89 south and follow to Exit 18. Turn left at the end of the ramp onto Rte. 120 and follow the blue and white signs approximately three miles to DHMC.

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From the West: Route 4 to White River Junction, take I-89 south to Exit 18. Turn left at the end of the ramp onto Rte. 120 and follow the blue and white signs approximately three miles to DHMC.

From the Southeast: I-89 north to Exit 18. Turn right at the end of the ramp onto Rte. 120 and follow the blue and white signs approximately three miles to DHMC.



CONTACT: For information or consultation, call (603)650-0600.

COSMETIC SURGERY CENTER
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A word to the wise on
WISDOM TEETH

Your teen's mouth may seem big. But when wisdom teeth — technically known as third molars — begin to appear, there generally won't be enough room for them in the jaw. As soon as it's clear that third molars will not grow in normally they should be removed, the latest research recommends. Early extraction lessens the risk that your teen will experience impaction or partial eruption — and the complications that often result.

An impacted tooth remains below the gum, often completely surrounded by bone. If left in place, the tissue sac around it can fill with fluid, becoming a cyst. Such cysts can hollow out the jaw, resulting in permanent damage to other teeth, the jawbone and even the nerves of the face and lips. Worse yet, tumors may develop that require complex surgery to remove.

Likewise, a partially erupted tooth — one that only comes in part way — stands a much greater chance of infection than a tooth that comes in completely. Partially erupted third molars threaten the health of adjacent teeth and can push an entire row of teeth out of line as they grow in.

Did you know?
Complication rates are much higher for wisdom teeth removed from older adults.

Keep an eye on third molars

So how likely is it that there won't be enough room for third molars in your child's mouth?

"It varies by population, but in areas where the water is fluoridated and there is good preventive dental care available, 80% or more of wisdom teeth will have to be removed," says Louis K. Rafetto, DMD, an oral and maxillofacial surgeon, or OMS, based in Wilmington, Del. Dr. Rafetto is a member of the American Association of Oral and Maxillofacial Surgeons' Third Molar Task Force, which has developed detailed recommendations to help your dentist and surgeon determine when wisdom teeth should be removed.

These recommendations call for monitoring development of the four third molars from the early teens to early adulthood. Using x-rays and physical examinations, your dentist and an oral and maxillofacial surgeon can usually spot problems before painful complications arise.

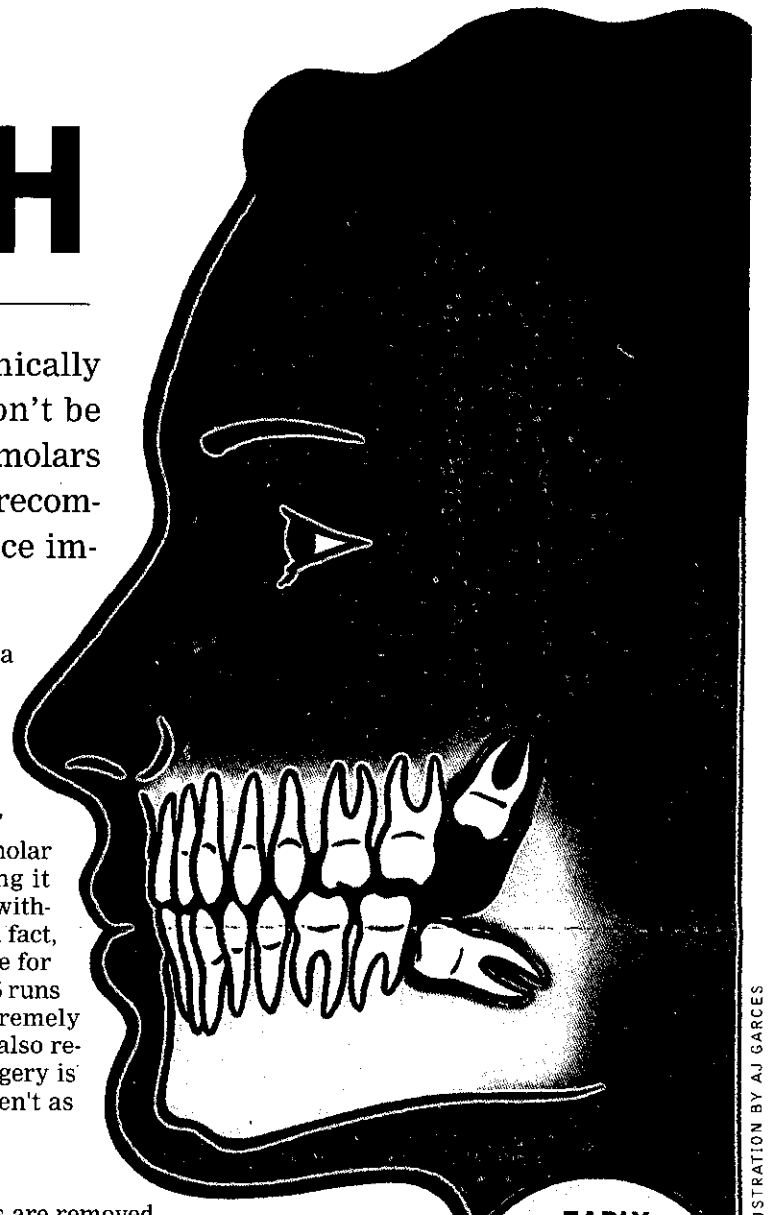
Should these exams suggest wisdom teeth be removed, it's best to do it as early as possible, says Robert T. Lindner, DDS, a Greensburg, Pa.-based oral and maxillofacial surgeon who is also a member of the AAOMS Third Molar Task Force. "There's less chance of complications with a younger patient."

That's partly because third molar roots continue to grow, making it more difficult to remove them without disturbing other tissues. In fact, the incidence of nerve damage for third molar removal after age 35 runs as high as 10%, while it is extremely rare for teenagers. Teenagers also recover a lot quicker and the surgery is easier because their bones aren't as dense, Dr. Rafetto explains.

What to expect

Generally, all four third molars are removed at once. The procedure is usually done in an office setting under sedation and local anesthesia, Dr. Lindner says. After surgery, patients recover for about an hour and then go home. "There's usually swelling and moderate discomfort for a few days afterward, but pain medication takes care of it."

Removal of wisdom teeth by oral and maxillofacial surgeons has become so common that it's practically a right of passage for teenagers in the United States. "A lot of my friends have had it done," says 16-year-old Kayla Wittich of Wausau, Wis., who recently had her wisdom teeth removed. "It wasn't nearly as bad as I thought it might be. My doctor was very nice and with the medicine I didn't feel or remember a thing. It was awesome."



EARLY REMOVAL of impacted wisdom teeth can prevent pain, crowding of existing teeth, infection and even tumors.

ILLUSTRATION BY AJ GARCES



PAGE 5

Also inside

WATCH YOUR MOUTH FOR CANCER
Self-exam guide.
Page 4

NEW FACE, NEW YOU
Corrective jaw surgery can offer a new lease on life.
Page 5

IN SPORTS
Joe Garagiola chews out spit tobacco.
Back page

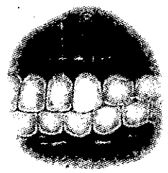
So long, dentures and bridges

Dental implants are here to stay

Not many years ago, when you lost permanent teeth you had two replacement choices: dentures or bridges. But dentures can fit poorly, causing pain and difficulty chewing and speaking. And there's nothing like waking up to your teeth in a glass of water to make you feel old.

While bridges reside in your mouth 24/7, they can create other problems. Installing bridges usually requires grinding down and capping adjacent teeth. That exposes otherwise healthy teeth to decay and gum disease — not to mention the extra stress of supporting a replacement tooth. And bridges typically last no more than seven to 15 years.

Dental implant



A more "natural" alternative

Today there's a better choice — dental implants.

Because they replace the tooth's root as well as its visible crown, implant-mounted replacement teeth are far stronger, more comfortable and usually much longer-lasting than dentures, bridges or single crowns.

"Implants directly stimulate the jaw bone. Implants help prevent the loss of bone, chronic denture sores and additional tooth loss often associated with dentures," explains Michael S. Block, DMD, an oral and maxillofacial surgeon at the Louisiana State University School of Dentistry who has also organized several AAOMS seminars on dental implants.

In most cases, placing dental implants is a two-part process.

During the first phase, an oral and maxillofacial surgeon places a titanium implant about the size of a natural tooth root directly in the jawbone. The implant is then covered with gum tissue and allowed to bond with the bone for three to six months. A temporary removable tooth or denture is usually fitted to fill the space.

Once the implant has securely bonded to the bone the second phase begins. The implant is uncovered and a post is attached that protrudes through the gum, much as natural teeth do. A restorative dentist caps it all off with a permanent crown.

The result is a replacement tooth that looks and acts just like the original. You care for it the same way too: regular brushing, flossing and professional cleaning are all that's needed.

Implants can also be used to anchor partial bridges or removable dentures, offering better fit and stability than dentures supported by natural tissue alone.

More than
90%
of dental implants remain in place for 20 years or more.

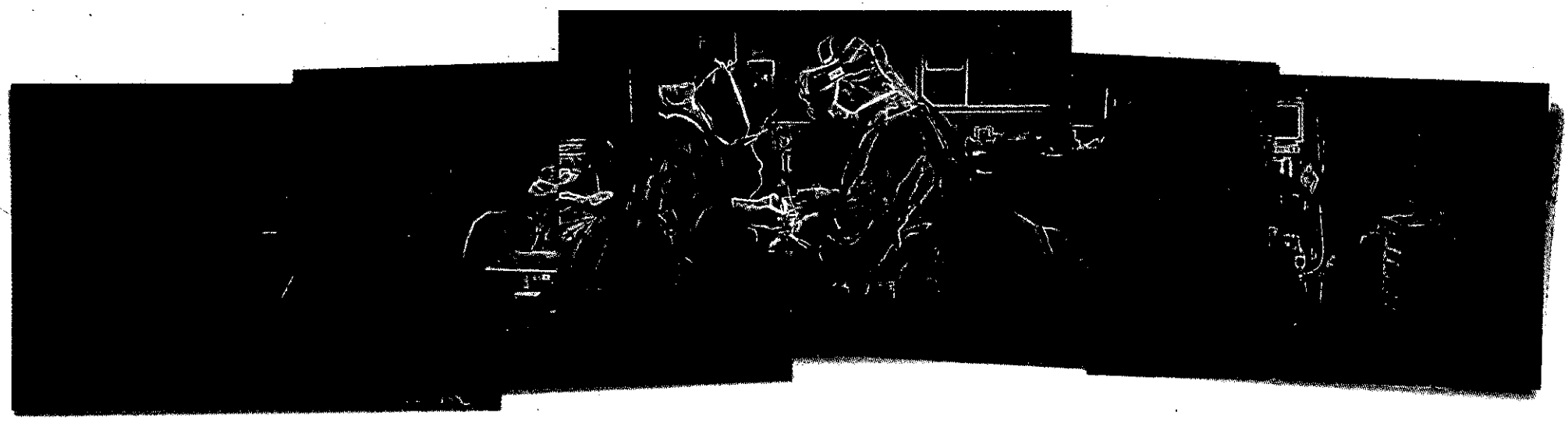
Implants have successfully been placed in people ranging from age 15 to over 100.

But does it hurt?

Getting an implant is generally less painful than having a tooth pulled, says Gilbert R. Triplett, DDS, PhD, an oral and maxillofacial surgeon at the Baylor College of Dentistry in Dallas. "My patients often tell me 'you gave me pain medicine but I didn't need it.'" Swelling, bruising and moderate discomfort are the most common post-implant problems. They generally clear up within a few days.

Overall, dental implants have a spectacular success rate. More than 90% of implants placed 20 years ago or more are still in place. "If the surrounding tissues remain healthy, implants have a potentially unlimited life span," Dr. Triplett says.

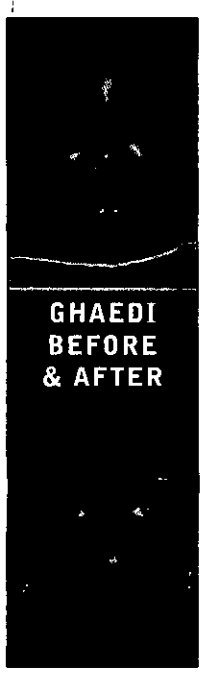
Dr. Block expects implants will continue to grow in popularity. "For most people they are a superior tooth replacement option."



IT'S ALL IN A DAY'S WORK FOR ORAL AND MAXILLOFACIAL SURGEONS

Saving faces

The last thing Golpar Ghaedi remembers about her accident is trying to hang onto the hood of her careening SUV. Struck from behind, she had been thrown through the windshield of her truck as it rolled down an embankment and onto a Chicago expressway. But memory is merciful. What Ghaedi doesn't recall is hitting the pavement face first, breaking virtually every bone in her face.



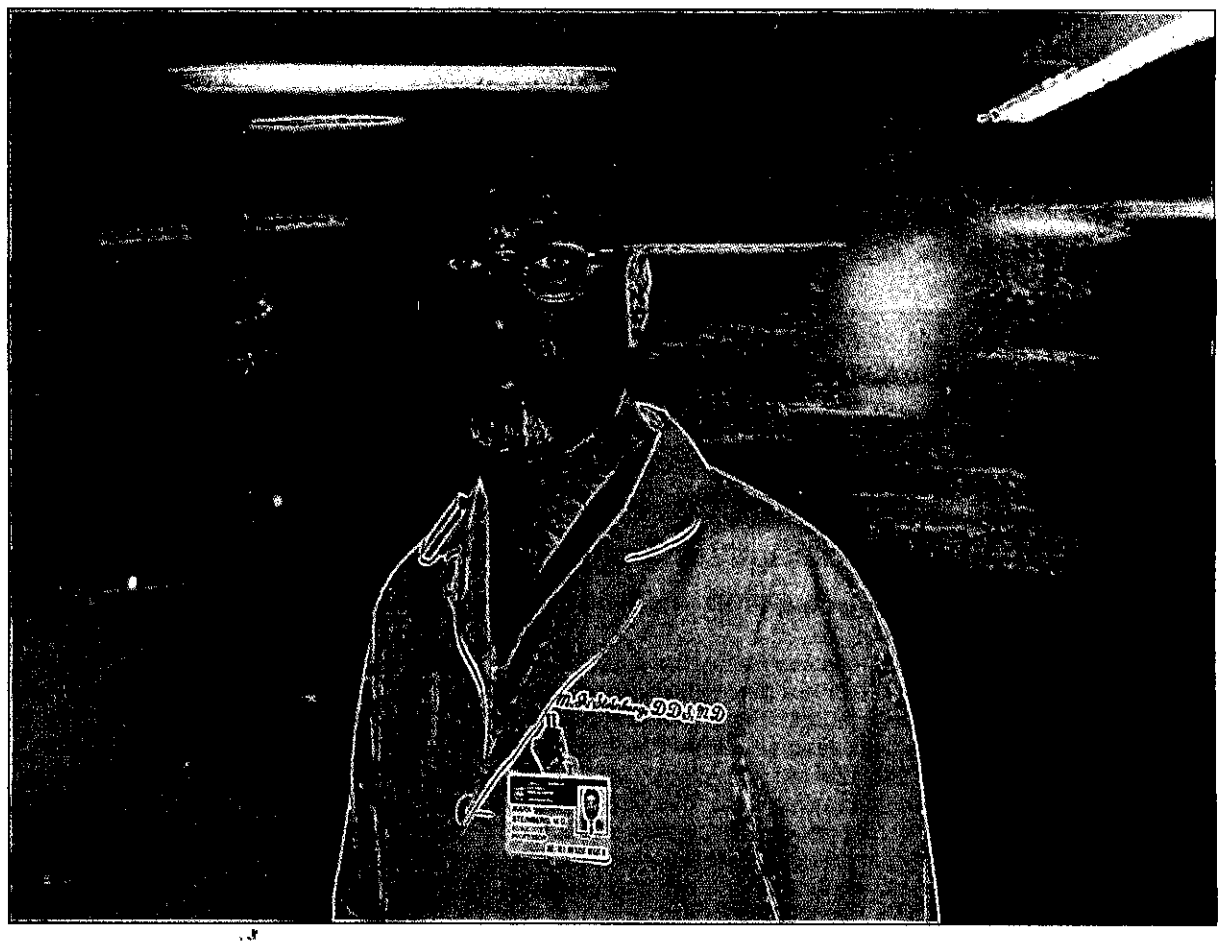
GHAEDI BEFORE & AFTER

"My mother tried to keep me away from mirrors in the hospital," Ghaedi says. But as she awaited surgery last November, the 23-year-old caught a glimpse of herself in a glass door. "I was afraid I would never look the same."

Enter oral and maxillofacial surgeon, or OMS, Mark J. Steinberg, DDS, MD, of Chicago's Loyola University Medical Center. In a single 15-hour operation, he reconstructeded Ghaedi's skull, cheekbones and jaw, repaired a shattered eye socket with an implant, and, with assistance from a neurosurgeon, examined bone fragments that had penetrated Ghaedi's brain. With no evidence of brain damage, they left the shards in place rather than risk disturbing delicate brain tissue to remove them.

The surgery was a success. Not only has Ghaedi recovered full use of her jaws and facial muscles, she also regained her good looks. "I thought I would have huge scars on my face, but there are only a few small ones you can barely see," she says. "I am very pleased with the results."

She was surprised to learn of Dr. Steinberg's specialty. "I thought a plastic surgeon would be working on my face. I didn't realize he had a dental background until after the surgery. I didn't know oral surgeons did this."



PHOTOS BY RUSSELL McGONAGLE

The real ER

Injure your face and chances are an oral and maxillofacial surgeon, like Dr. Mark J. Steinberg will do the repairs. He heads the OMS training program at Chicago's Loyola University Medical Center.

nal medicine, general surgery, plastic surgery, neurosurgery, and ear, nose and throat surgery. Some complete an additional two years of training in which they receive a medical degree, though most enter practice following residency training. "What matters isn't the degree, it's the surgical training," Dr. Steinberg says.

In addition to trauma, OMSes routinely remove complex tumors and repair congenital deformities, such as cleft palates. These surgeries require extensive reconstructive techniques, including bone grafts and implants.

LESS PAIN, MORE GAIN THROUGH RESEARCH

Four years of hospital training

Dr. Steinberg's role in trauma surgery is not unusual. "Trauma management is involved in 35% to 40% of our training," notes Douglas P. Sinn, DDS, chair of the division of oral and maxillofacial surgery at the University of Texas Southwestern Medical Center in Dallas. In fact, Level I Trauma Centers are required to have oral and maxillofacial surgeons on call. Dr. Sinn has repaired facial injuries caused by everything from gunshots to being gored by bulls. "I'm from Texas and there are a lot of rodeo injuries here."

In many parts of the country, these specialists do the lion's share of surgery for head and face injuries. "We are required to be able to treat the whole facial skeleton and soft tissues," says Mark R. Stevens, DMD, a Miami-based OMS whose group takes trauma call at Jackson Memorial Hospital, one of the nation's premier trauma centers.

Oral and maxillofacial surgeons gain their surgical skills through a four-year hospital residency. They train alongside medical doctors in disciplines including interdisciplinary trauma surgery, plastic surgery and otolaryngology (ear, nose and throat). They use cutting-edge technologies, such as cryosurgery in which a super-cooled probe is inserted after a tumor is removed, preventing the return of cancer by freezing any remaining cancer cells. They also reconstruct soft tissues and do elective cosmetic procedures on the face, including the nose, lips, palate and ears.

Dental training, which emphasizes jaw alignment and correcting the bite, is essential in doing complex reconstructions, Dr. Stevens says. "If you get the bite right, you have a big part of the puzzle solved. It helps you put the fractured bones back in the right place."

Dental training also emphasizes working inside the mouth. The more repair work that can be done from inside the mouth, rather than through external incisions, the fewer visible scars — a big plus for patients.

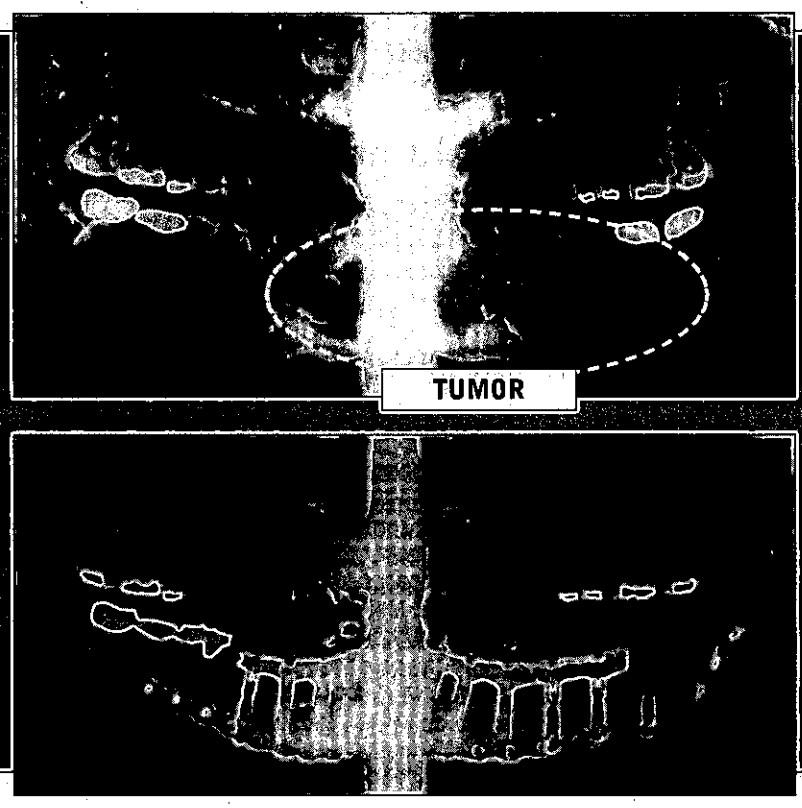
Many of these techniques are used in elective cosmetic surgery. Advances in technologies such as lasers make it possible to smooth the skin and minimize scarring.

"Function and cosmetics go together," Dr. Sinn points out. "The best outcome is to have both."

A NEW JAW

Ravaged by cancer, rebuilt by doctors

Extensive bone grafts and dental implants were used to rebuild this jaw after a large tumor was removed. The tumor is visible as a dark shadow on the top x-ray to the right, which was taken before surgery. The x-ray below it shows the metal plates used to hold in place the bone graft used to reconstruct the jaw. Implants that were used to replace lost teeth are also clearly visible.



Less pain. Quicker recovery. Smaller scars. Stronger bones. These are benefits patients enjoy from advances in oral and maxillofacial surgery over the last few years. Here are a few examples:

Promotion of tissue growth. Artificial bone proteins, as well as growth factors drawn from the patient's own blood, promote quicker bone growth and healing, making bone grafting a more reliable and flexible option in reconstructing faces. DNA transfer techniques aid wound repair and recovery. And new surgical appliances guide the natural growth process to lengthen bones that would have required extensive reconstruction and grafting just a few years ago.

New materials. OMSes have mostly eliminated the second surgery most children once underwent to remove screws and plates used in reconstructive surgery. Hardware is now made from advanced materials that are dissolved and absorbed by the body over time.

Minimally invasive surgery. New fiber optic instruments make it possible for OMSes to perform complex surgery through very small incisions from inside or outside the mouth. Quicker recovery, less pain and smaller, if any, visible scars are the result.

One-day implants. Rather than wait six months between receiving a dental implant and getting a replacement tooth, some patients can walk out with a new tooth the same day an implant is installed. Advances in implant design and new installation techniques make it possible.

Cosmetic surgery. Advances in computer graphics programs allow patients to see how they'll look after surgery. New laser techniques smooth skin and reduce scarring for a better aesthetic outcome.

ORAL & MAXILLOFACIAL SURGERY

Much more than extracting teeth

By Donald F. Booth, DMD, and Francis P. DiPlacido, DMD

As leaders of the American Association of Oral and Maxillofacial Surgeons, we're often asked just what exactly oral and maxillofacial surgeons do. Most people know us as the doctors who extract wisdom teeth. We do that and much more.

Reading this publication has probably given you a better idea of the broad scope of oral and maxillofacial surgeons, or OMS, activities and procedures. Now here's the official definition from the American Dental Association:

"Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial region."

In plain English, that means OMSes are trained to do just about any surgery or cosmetic procedure to correct just about any kind of problem with the mouth, jaws, facial structures and neck. We do everything from correcting cleft palates to rebuilding jaws, cheeks, noses, eye sockets and foreheads damaged in accidents. We remove complex tumors as well as impacted and nonrecoverable wisdom teeth. We also do other complex dental extractions. We do bone grafts and dental implants to restore jaws. Using the same implant technology, we place supports for prosthetic ears, noses and even eyes and eyebrows. Much of our work involves cosmetics. Whether it is following reconstructive surgery or as elective cosmetic procedures, we change the profiles of faces, reshape noses and remove extra facial tissue.

As with any surgical specialist, dental or medical, OMSes receive rigorous training. It starts with four years of dental school in which candidates learn general dentistry. Depending on the school, they earn a DDS (doctor of dental surgery) or DMD (doctor of dental medicine) degree.

What oral and maxillofacial surgeons do

- Provide safe and effective office anesthesia.
- Extract impacted and nonrestorable teeth (dentoalveolar surgery)
- Replace lost teeth (dental implants)
- Perform corrective jaw surgery (orthognathic surgery)
- Remove complex tumors (oncologic

SAFE AND EFFECTIVE, THE CORNERSTONE OF OUTPATIENT SURGERY

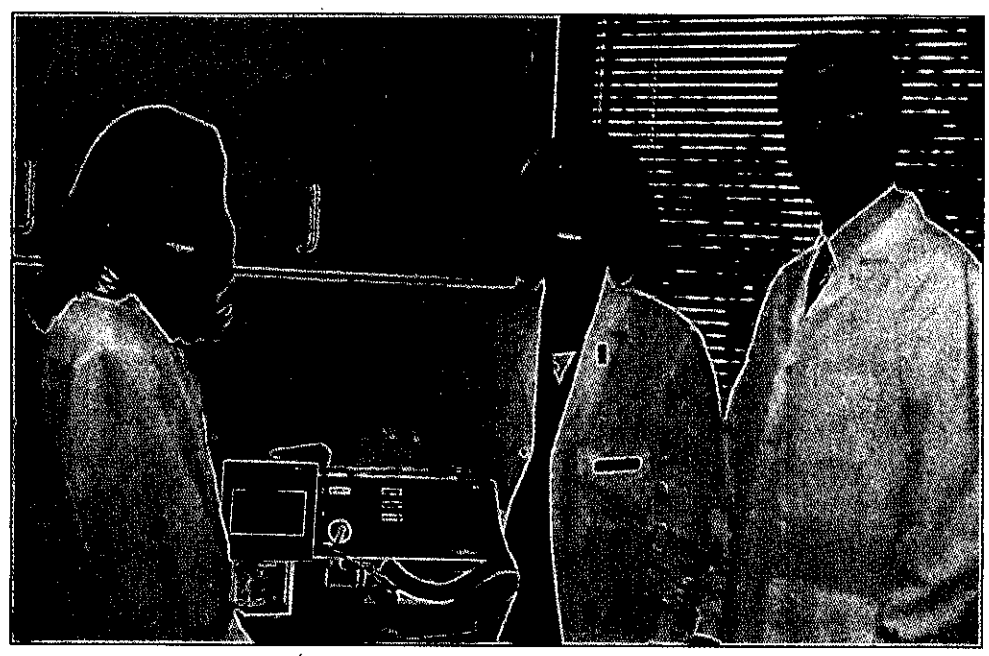
Office anesthesia

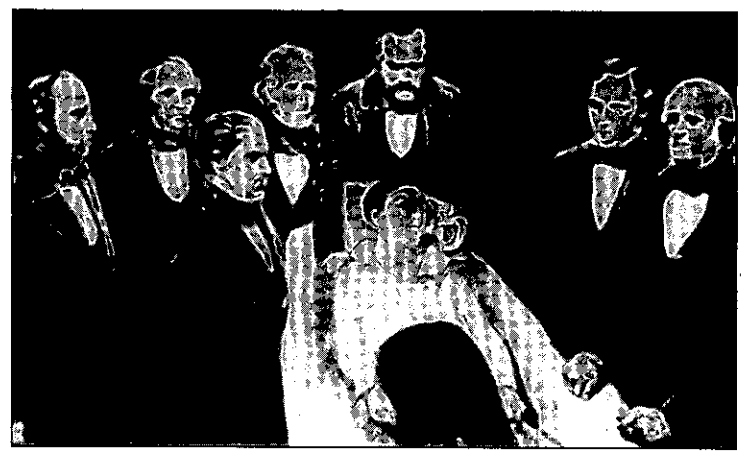
There was a time when a shot of whiskey and a bite on a bullet were the standard for surgical pain control. How much pain you could endure was often a determining factor in how extensive surgery could be or even whether you got it at all.

There's been a whole lot of progress since then.

Today, patients routinely undergo everything from tooth extractions to implant placement and even the occasional corrective jaw surgery — with no pain and no memory of the procedure — right in the oral and maxillofacial surgeon's office. Advanced office anesthesia techniques make it possible.

These techniques also make office anesthesia safe. While the extremely rare office surgery adverse outcome may grab the headlines, the real news is that office anesthesia is administered without incident thousands of times daily, and is at least as safe as anesthesia performed in a hospital setting.





Then and now

Oral surgeon William P. G. Morton demonstrates anesthesia for the first time in 1846. A modern anesthesia team (top) includes an oral and maxillofacial surgeon directing assistants trained in anesthesia and life support, using sophisticated monitoring equipment.

Preparation makes perfect

This remarkable safety record is no accident. It's the result of years of specialized training, state dental board regulation, office standards development, rigorous onsite inspection programs and a team approach to managing anesthesia, says Michael J. Stronczek, DDS, a Fort Wayne, Ind.-based OMS, who is the incoming chair of the American Association of Oral and Maxillofacial Surgeons' Committee on Anesthesia. "If you're going to do anesthesia in the office you have to be well-prepared."

That preparation starts with residency training. During the additional four-years of hospital training that dentists undergo to become oral and maxillofacial surgeons, four or more months are spent on the medical anesthesia service. No other medical specialists (except anesthesiologists) spend as much time training in anesthesiology. In addition, residents provide anesthesia services for adults and children throughout their four years of training.

Oral and maxillofacial surgeons also complete certification in advanced cardiac life support, so they are prepared to assist a patient in the rare case when an anesthesia problem does occur.

Once in practice, OMSes must comply with extensive office anesthesia standards developed and constantly reviewed and updated by the AAOMS and state dental boards. These standards include using anesthesia monitoring equipment, such as pulse oximeters to measure the amount of oxygen in the patient's blood, and cardiac life support equipment. The standards also require OMSes to have assistants specially trained in anesthesia and life support on the anesthesia team. The AAOMS offers anesthesia assistant training programs ensuring assistants are prepared to provide optimum care.

While local anesthesia is sufficient to block the pain of most oral and maxillofacial procedures, patients usually want something more, Dr. Stronczek says. "What I often hear from patients is 'I don't want to know what you're doing or remember what happened.' "

OMSes work with patients to ensure an appropriate level of sedation. Depending on the patient's health, level of anxiety and the procedure, choices range from mild sedation, in which the patient may still be aware of what is happening but doesn't care; to deep sedation, where the patient is responsive but doesn't remember what hap-

After earning a dental degree, prospective oral and maxillofacial surgeons move on to a hospital-based residency program that lasts at least four years. Competition is intense for these OMS training slots — only about 170 are available each year and most programs will only consider candidates in the top 10% of their dental school class.

During residency, OMSes train alongside future anesthesiologists, internists, general surgeons, plastic surgeons, ear, nose and throat surgeons, and emergency physicians. Some complete an extra two years of training in an integrated OMS/MD program to obtain a medical degree. Many take fellowships for extra training in advanced surgical techniques.

Upon completion of the minimum four years dental school and four years hospital training OMSes become full members of the health care team. Dentists and physicians alike refer patients to OMSes for diagnosis and treatment of oral and maxillofacial problems. And OMSes share call with medical and dental colleagues in trauma centers and local hospitals.

Most of all, OMSes are dedicated to patient welfare. Whether it's an injury, congenital defect or disease of the face, jaws or mouth, you can count on an OMS to provide a high standard of care.

Drs. Booth and DiPlacido have both served recently as presidents of the American Association of Oral and Maxillofacial Surgeons.

surgery)
- Rebuild faces damaged by injury or disease (reconstructive surgery)
- Relieve jaw pain (TMJ surgery)
- Perform cosmetic surgery of the face, jaws and neck

To ensure that OMSes keep their anesthesia skills up to date, office anesthesia is subject to strict oversite by state regulators. Most states require OMSes to obtain anesthesia permits and submit to periodic office inspections to retain their permits. These inspections include a review of compliance with office anesthesia standards, condition and calibration of monitoring equipment, and an assessment of the OMS' anesthesia skill.

In many states, the state inspectors are themselves practicing OMSes. "It's an opportunity for both the inspector and the inspectee to pick up tips on the latest techniques," says Paul G. Sims, DDS, a Butte, Mont.-based OMS who heads the AAOMS Committee on Anesthesia. The goal is to ensure that OMSes are providing the safest and most appropriate anesthesia for their patients.

pens, to general anesthesia, in which the patient is completely unconscious during the procedure. It's up to the doctor and the patient to decide the best course.

In any case, anesthesia in the OMS office is at least as safe as in a hospital. Using local anesthetics in conjunction with sedative agents reduces the total amount of anesthetic needed, reducing risk and speeding recovery. Patients recover quickly and go home in a short time following surgery.

As technology and insurance payment rules drive more and more surgery to an outpatient setting, many of the techniques OMSes have developed are being adopted by other specialties, including ear, nose and throat surgeons, plastic surgeons, and orthopedic surgeons. "We've been doing this for years," Dr. Sims notes. "The other specialties are just getting started."

KEY QUESTIONS

The American Association of Oral and Maxillofacial Surgeons recommends you ask the following questions before having a procedure done:

1. What are the doctor's credentials?
Make sure your surgeon is properly trained. Membership in the American Association of Oral and Maxillofacial Surgeons ensures your doctor has extensive training in surgery and anesthesia. To become an AAOMS fellow, surgeons must be board certified.

2. Is your doctor trained and experienced in the procedure you seek?
Your chances of a good surgical outcome are better with doctors experienced in the particular procedure you are undergoing. Oral and maxillofacial surgeons are uniquely qualified to perform routine and complex procedures. Ask your family dentist or physician for an appropriate referral.

3. Are there any patients with whom you can speak?
Firsthand references can help you assess how your surgeon's skills, follow-up and manner meet with your expectations.

4. Is the procedure covered by medical or dental insurance?
Many oral and maxillofacial procedures are covered by one or the other or both. Be sure to discuss this with your surgeon or office staff. It could affect your out-of-pocket expense. Some cosmetic and elective procedures are not covered.

5. What are the risks involved with the procedure?
Risk is inherent in all surgery. The AAOMS requires surgeons to discuss the risks and benefits of surgery and inform patients of treatment options before surgery.

6. How long is the recovery period?
Recovery periods vary greatly by procedure and the health of the patient. Be sure to discuss this with your surgeon.

7. Where will the procedure be performed?
Most procedures can be safely and comfortably done in an office setting. But sometimes a hospital is indicated.

American Association of Oral and Maxillofacial Surgeons

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Rosemont, IL 60018-5701
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1-(800)-IMPLANT (467-5268)
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AAOMS
the symbol of excellence

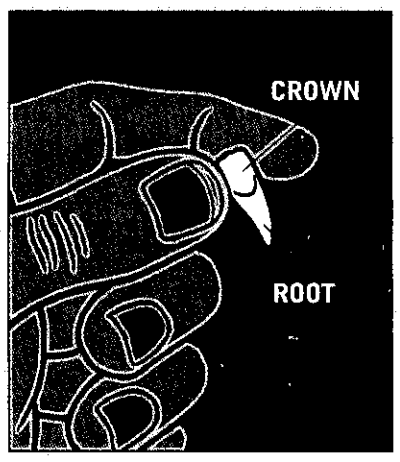
Looking for an oral and maxillofacial surgeon? The symbol of the American Association of Oral and Maxillofacial Surgeons is your assurance of excellence. While other doctors may perform some aspects of oral and maxillofacial surgery, only members or fellows in good standing with the AAOMS may display the AAOMS symbol. It ensures that the OMS you choose is fully trained and certified in oral and maxillofacial surgery. To become a fellow, OMSes must also be board certified by the American Board of Oral and Maxillofacial Surgery. The AAOMS symbol guarantees that your OMS complies with rigorous continuing education requirements and submits to periodic office inspections, ensuring that all procedures and office personnel meet national standards. The AAOMS symbol. Look for it.

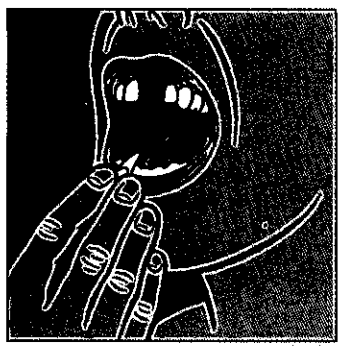
PULL-OUT SECTION

First Aid Tips

KNOCKED-OUT TEETH

● Seek immediate help from an oral and maxillofacial surgeon. Most knocked-out teeth can be saved if cared for properly and reimplanted within 40 to 60 minutes. Call your family dentist for an emergency referral or go to a hospital emergency department where the on-call OMS can assist you.
● Find tooth and hold by crown only.





● Rinse tooth; do not rub. Avoid contact with root.
● Replace tooth in socket, cover with gauze or tissue, and bite down to stabilize it. Or store tooth temporarily in cold milk or salt water, or between cheek and gum.
● Do not allow tooth to dry out.

BROKEN TOOTH

● Clean injured area; apply ice.
● Save tip of tooth. Contact your family dentist immediately. He or she may be able to reattach the broken part.

FACIAL CUTS

● Cover wound with a clean dressing. Apply pressure.
● Do not remove blood-soaked dressing.
● Add additional cloth and apply pressure.
● Go to a hospital emergency department, where the oral and maxillofacial surgeon on call can assist you. Often, broken jaws or other injuries inside the mouth must be repaired before facial cuts can be closed.

CUTS INSIDE THE MOUTH

● Gently rinse mouth with cold water.
● Bite on gauze, clean cloth or tissue and apply pressure to the wound.

JAW INJURY

The U-shaped lower jaw often suffers multiple breaks. An upper jaw fracture may cause visible distortion of the face.

If your teeth fit together normally when you close your mouth:
● Apply ice to control swelling.
● Take ibuprofen or similar pain medicine to control pain.
● Restrict diet to soft foods.
● If there is no improvement in 24 hours, call an oral and maxillofacial surgeon for an evaluation.

If your teeth do not fit together normally when you close your mouth:
● Consult an oral and maxillofacial surgeon immediately.
● Gently align the jaws.
● Immobilize the jaw by wrapping a cloth or gauze bandage under the chin and tying it securely over the head.
● Apply ice to control swelling.



BROKEN NOSE

● Gently pack nose with gauze or tissue.
● Apply ice. Do not blow nose.

HEAD AND NECK INJURY

● Do not move victim without professional assistance.
● Immobilize head by placing rolled towels on either side.



Under the weather?

MAYBE AN OMS CAN HELP

Your jaws, face and mouth are made up of countless bones, muscles and soft tissues. When they're all working together as they should, you feel good. But even a small problem in any one of them can cause pain, disturb your sleep, or even threaten your life. Below are symptoms that may indicate a problem your oral and maxillofacial surgeon can evaluate and treat.

Chronic facial pain or headache

Facial and head pain can result from several problems. Grinding your teeth is one. This often can be corrected with physical therapy and mouth splints. Misaligned jaws or displaced cartilage in the jaw joints are other possible causes. Either can place unusual stress on muscles, nerves and bones, leading to tension and pain. These problems can also be treated with physical therapy and medicine, though surgery may be necessary.

Snoring and sleep apnea

While there are many causes of snoring, problems with the soft tissues in the mouth and throat are often the culprits. This can be treated with oral appliances or surgical reduction of excess palate tissue. Snoring may also indicate sleep apnea, though sleep apnea may occur without snoring. Sleep apnea is a serious condition in which the airway is obstructed during sleep, leading to constant awakenings to clear the airway. If someone close to you has noticed you stop breathing during sleep or often wake up abruptly, gasping for air, consult your oral and maxillofacial surgeon for evaluation and treatment.

● Go to a hospital emergency department, where the oral and maxillofacial surgeon on call can assist you. Often, an OMS must address injuries inside the mouth before external injuries can be repaired.

ILLUSTRATIONS BY AJ GARCES

● Keep victim warm to reduce risk of shock.
● If unconscious, clear mouth. Hold tongue forward to maintain open airway.

Watch your mouth for cancer

While shaving on Thanksgiving in 1996, Louie F. Peede, DMD, noticed an unusual shadow under the right side of his jaw. The small lump he found there turned out to be cancer. Within a few weeks, the Denver oral and maxillofacial surgeon underwent surgery to remove his cancerous tonsils and 52 lymph nodes from his jaw and neck. Fortunately, the cancer had not spread beyond the one swollen lymph node. Dr. Peede underwent six weeks of radiation therapy, and the cancer has not reappeared.

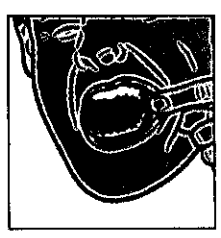
But due to the amount of muscle removed during surgery, Dr. Peede was off work for two years. He's not bitter, though. "It's lucky I had it checked within two weeks," he says. If he hadn't? "Ultimately I would have died."

Dr. Peede recommends thoroughly checking your mouth, jaws and neck at least once a month for signs of oral cancer. He also recommends a quick check every day when brushing your teeth. "What you're looking for is anything that wasn't there the day before," Dr. Peede says. Note any lumps, bumps, sores or discolored spots. And if you find something, have it checked immediately by an oral and maxillofacial surgeon.

Also, when visiting your family dentist ask for a cancer exam as part of your regular checkup. If your dentist finds anything suspicious ask for a referral for a comprehensive exam by an oral and maxillofacial surgeon.

How to conduct a self-exam for oral cancer





■ Remove any dental appliances.

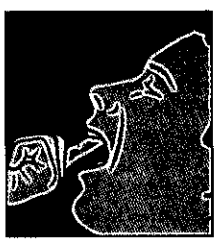
■ Look and feel inside your lips and the front of gums.

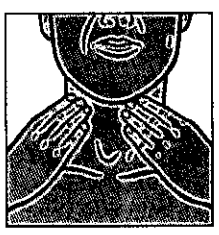
■ Tilt your head back to examine and feel the roof of your mouth.

■ Pull your cheek out to see the inside of it and the back gums.

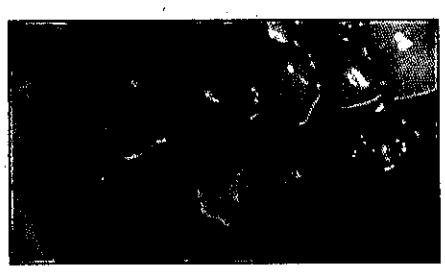
■ Stick out your tongue, look at all surfaces.

■ Feel for lumps or enlarged nodes (glands) in both sides of the neck and under the lower jaw.





WHAT IT LOOKS LIKE



Whitish spots on gums or lips. Have it checked.



Dark spot on lip. Could be a bruise or cancer. Have it checked.



Swelling of the lip. This salivary cyst is benign, but should be removed.



Whitish spot on tongue. Could be cancerous or precancerous. Check it.

Jaw pain and popping
Noise and pain in the jaws and limited jaw mobility while chewing and talking is often caused by internal damage to the joints connecting the jaw to the skull. Often the discs that cushion the temporomandibular joints slip out of place or wear over time. Treatment options range from medication to bite splints to physical therapy or surgery. Stress management counseling may also be helpful.

Overbite or underbite
Overbites and underbites are often caused by growth problems in the upper jaw, lower jaw, or both. Beyond their generally negative impact on appearance, misaligned bites can cause problems chewing and speaking, and can lead to premature tooth wear. Braces alone may be enough to alleviate the problem in many cases, but surgery is sometimes necessary.

Tooth pain
Tooth decay is the most common cause of tooth pain. But if your family dentist can find no obvious decay, pain could be due to other problems, including impacted teeth, tooth grinding or cysts. Ask your family dentist for an appropriate referral to an oral and maxillofacial surgeon, who can evaluate and treat these conditions.

Oral or facial swelling
Swelling in the mouth and face may be caused by many problems, including blocked salivary glands, erupting wisdom teeth, facial infections, cysts or even tumors. Using x-rays and an oral exam, an oral and maxillofacial surgeon can identify the cause and treat the problem.

Lumps, bumps or sores in mouth
Oral growths, sores, lumps or bumps could be signs of cancer and should be monitored closely. If they don't go away within two weeks, or if they go away and come back, or if they bleed, they should be examined by an oral and maxillofacial surgeon, and possibly sampled for laboratory analysis.

For more information
Call 1-(800)-IMPLANT *(467-5268)* or visit our Web site at *www.aaoms.org*

A Mission of MERCY

Word spreads quickly in rural Honduras when U.S. dental care volunteers arrive. People walk for hours or even days over gravel mountain trails — often barefoot — to reach the clinic during the two weeks it is open.





Now he can smile

Cleft palates are common in many parts of the world. Repairing them is a major emphasis of overseas missions by U.S. oral and maxillofacial surgeons.

"The average family income in the area we visit is $300 to $400 per year," explains J. Thomas Soliday, DDS, a Gaithersburg, Md.-based oral and maxillofacial surgeon who has led missions to remote regions of this Central American country every year for the last five years. "They can't afford shoes for their children until their feet stop growing, and sometimes not even then."

Dental care, even basics such as daily brushing and fluoridated water, is also largely unavailable or unaffordable for most residents. As a result, tooth decay is rampant. "Some of these people open their mouths and there is nothing left but roots," Dr. Soliday says. "The pain they go through has got to be excruciating."

Dr. Soliday's goal is not just to relieve that pain, but to prevent it. His team of general dentists and oral and maxillofacial surgeons perform hundreds of extractions, fillings and other surgeries. In addition to oral surgeons and general dentists, Dr. Soliday recruits dental hygienists to educate residents on proper dental care and to distribute toothbrushes, toothpaste and other basic supplies. "We hope to change their outlook on life so they don't expect to lose all their teeth by the time they are 35."

Dr. Soliday, whose trips are sponsored by Medical Ministry International, is just one of hundreds of oral and maxillofacial surgeons who donate their time and expertise to missions all over the world. Most also pay for the surgical supplies they use and for their transportation and room and board.

In addition to setting up what amount to MASH units in remote areas to perform basic care, many of these missions work with established hospitals to do complicated reconstructive surgery, such as cleft lip repair and removal of cysts and tumors from the jaws, face and neck.

The goal is usually twofold, says Robert B. MacIntosh, DDS, a Binghamton Farms, Mich.-based oral and maxillofacial surgeon. Dr. MacIntosh has made at least one, and often three or four, overseas trips a year for the last 20 years, and works closely with Health Volunteers Overseas. The first goal is to perform surgery that may be beyond the skills and training of local surgeons. The second, and perhaps more important, is to train local dental and medical professionals in advanced surgical techniques so they can carry on when the mission leaves. "Over time we try to build up enough local expertise to put ourselves out of business."



VOLUNTEERS REPAIR AND EXTRACT TEETH IN RURAL HONDURAS

20 years behind

Vietnam is a good example of a country that desperately needs its surgical capabilities updated, says Leonard B. Kaban, DMD, MD, chair of oral and maxillofacial surgery at the Harvard School of Dental Medicine. "You have to remember that Vietnam was closed to the West from 1975 to 1996. The technological and biological advances in those 21 years was tremendous."

Dr. Kaban traveled to a hospital in Ho Chi Minh City, formerly Saigon, on a mission led by Barry Steinberg, DDS, MD, PhD, of the University of Florida, to share surgical advances that make it possible to rebuild the face with less scarring and nerve damage.

Like many such missions, this one, which is sponsored by the Lorenz-Smeenge Foundation, has developed an ongoing relationship with local surgeons and a hospital, which is important not only to develop local talent, but to ensure that patients receive proper follow-up care.

"Each year I go back and see patients I have operated on in previous years," says Eric R. Carlson, DMD, MD, of the University of Miami, who over the last five years has developed a tumor removal program at a privately owned hospital in Jabalpur, India. Between Dr. Carlson's visits, local surgeons, led by Dr. Dhiarwani Rajesh, follow his cases. They are now so highly skilled they are taking over the program. Dr. Carlson is now working to set up shop in another location.

"These areas are highly underserved," Dr. Carlson says. "You see people walking down the street with tumors on their faces the size of basketballs. There's real opportunity to do some good."

Want to help out?

Here are some organizations active in overseas missions

Health Volunteers Overseas
P.O. Box 65157
Washington, DC 20035
www.hvousa.org

Medical Ministry International
PO Box 940207
Plano, TX 75094-0207
www.mmint.org

Face the Challenge
3140-K South Peoria #168
Aurora, CO 80014-3155
www.facethechallenge.org

Better function, better look

At age 27, Coleen Mulhern-Malloy's front teeth needed caps. An underbite due to an abnormally long lower jaw was causing premature wear. "I knew I would eventually need crowns on all my teeth if I didn't do something."

Rather than accept further tooth damage, possible gum disease and increasing tooth and jaw pain, Mulhern-Malloy chose corrective jaw surgery. The resulting improvement in her bite not only slowed tooth wear, it made it possible for the Hinsdale, Ill., resident to eat apples and other firm foods. It also greatly reduced her sensitivity to sweet, hot and cold foods.

But that's not all. "It has given me a much nicer appearance," Mulhern-Malloy says. "I wasn't unhappy with the way I looked before, but it's amazing what this has done for me."



Patients are often not just pleased, but profoundly affected by the better looks jaw correction brings, says Edward Ellis III, DDS, director of the oral and maxillofacioal surgery training program at the University of Texas Southwestern Medical Center in Dallas. "The cosmetic effect can be very potent. It's not unusual to see patients undergo dramatic personality changes after this kind of surgery."

But patients rarely choose corrective jaw surgery for cosmetic purposes alone, says Roger H. Kallal, DDS, the Chicago-area oral and maxillofacial surgeon who reconstructed Mulhern-Malloy's upper and lower jaws. "There is a cosmetic aspect to this surgery, but a jaw deformity is a functional problem as well." In addition to preventing dental problems, corrective surgery can eliminate jaw pain, speech impediments, and even snoring and sleep apnea, which can lead to heart and lung disorders.

Depending on the specific problem, corrective jaw surgery can involve the upper jaw, the lower jaw or both. Lower jaws can be shortened to correct underbites and lengthened to correct overbites. The upper jaw can also be moved backward or forward, or the angle can be adjusted to achieve the best possible bite. Bones are held in place with small internal plates and screws, usually eliminating the need to wire jaws shut.

The surgery usually takes two to four hours and requires a one- or two-day hospital stay. There is usually moderate discomfort involved. "It hurt worse to have braces because my teeth were so sensitive," Mulhern-Malloy says. Swelling can persist for a few months after surgery, though after the first few weeks it's no longer apparent outside the mouth.

The bottom line for Mulhern-Malloy? "It's better aesthetically and I have a better bite. I can chew and eat anything now."

PHOTO BY RUSSELL McGONAGLE





Before reconstruction surgery

A jutting lower jaw, causing a severe underbite, is apparent in this x-ray (above) taken before Coleen Mulhern-Malloy (left) underwent corrective jaw surgery in 1996. Mulhern-Malloy's lower jaw was moved back and her upper jaw was moved forward to correct her bite. Braces, which are often applied 12 to 18 months before jaw surgery to position teeth for bite realignment, are also evident on the x-ray.

Want to know more?

For more information on corrective jaw surgery, go to *www.aaoms.org/patient3.html*. You'll find brochures on a variety of procedures involving the jaws, face, mouth and teeth.

CORRECTIVE JAW SURGERY IS TYPICALLY DONE FROM INSIDE THE MOUTH, LEAVING FEW, IF ANY, EXTERNAL SCARS.

Just do it. But wear headgear

Bicycling, rollerblading, skiing, soccer, baseball, hockey and football are but a few of the sports in today's fitness regimen. But fitness doesn't always mean safety.

"Each year, 250,000 Americans will suffer needless facial trauma from sports injuries," says Bill Nelson, DDS, a Green Bay, Wis.-based oral and maxillofacial surgeon on staff with the Green Bay Packers. These injuries include knocked out teeth, severely lacerated lips and broken jaws. "The bulk of these injuries could be prevented with proper protective equipment."

In fact, the rates of facial injury are now lower in high-contact sports where mouth guards and face masks are required, such as football and hockey, than in lower-contact sports, such as basketball and soccer, that do not require protective equipment. Mouth guards can even prevent injury in noncontact sports, such as gymnastics and tennis.

Injury prevention not only cuts needless pain and suffering, but also cuts costs. Expenses for rehabilitating just one lost tooth are more than 20 times the price of the most expensive, professional grade, custom mouth guard. All told, injuries to players younger than 14 for 29 popular sports cost the public nearly $49 million annually.

So wear protective equipment for your smile's sake. And your wallet's.

If your child is involved in sports, consider the following:

Baseball

Fact: Nearly 60,000 facial injuries annually
Recommended equipment: Catchers mask, helmet with face guard for batters and fielders, mouth guard



Bicycling

Fact: 100,000 facial injuries annually, most in children age 5-14
Equipment: Helmet (full-face motocross-style is best), mouth guard



Soccer

Fact: 4,000 facial injuries annually; just 7% of players use mouth guards
Equipment: Mouth guard

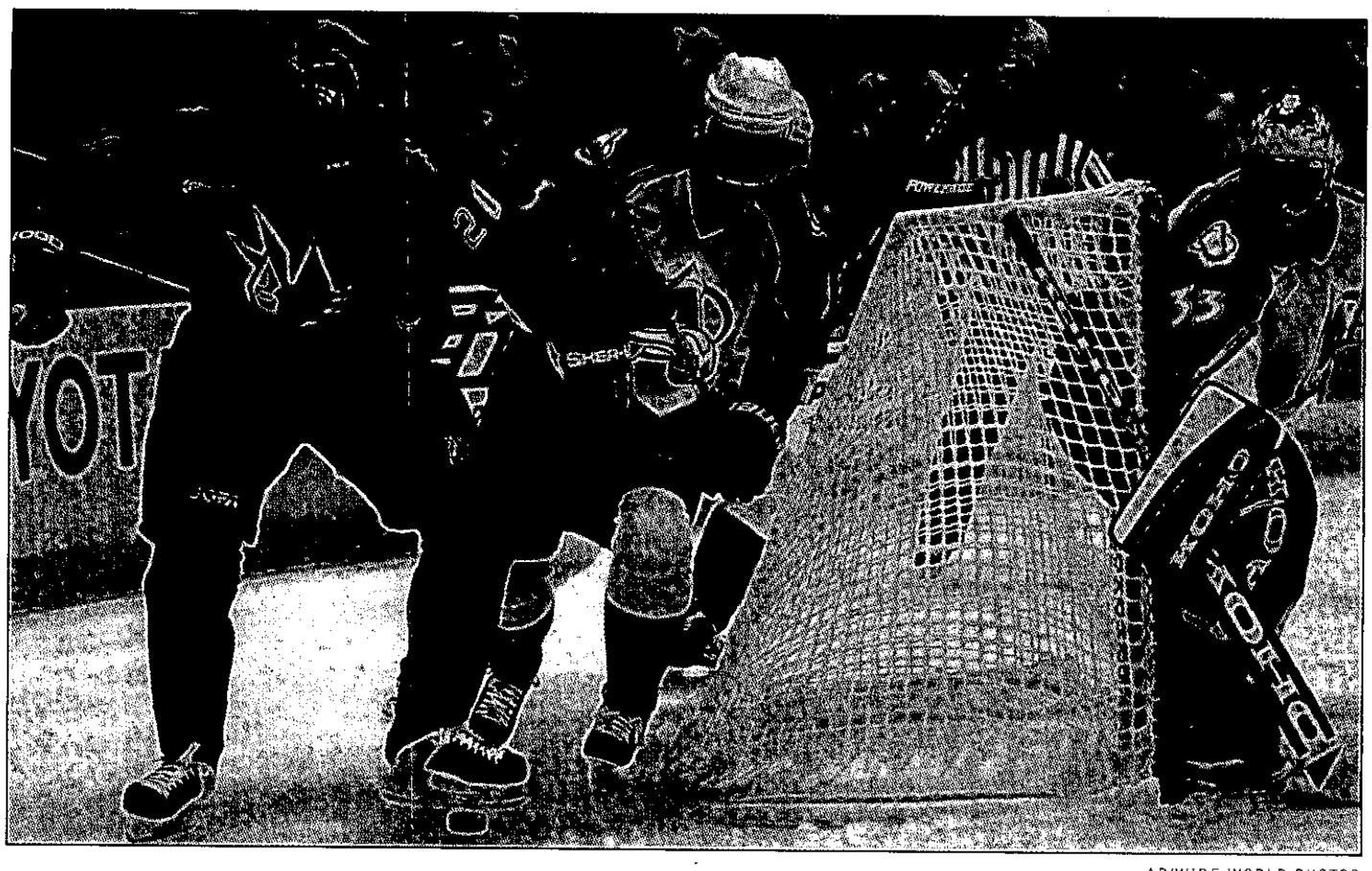
Basketball

Fact: 34% of injuries involve mouth or teeth; just 7% of players use mouth guards.
Equipment: Mouth guard

Football

Fact: Less than 1% of injuries involve face and mouth; mouth guard worn by all players. *Equipment:* Helmet, face mask, mouth guard





AP/WIDE WORLD PHOTOS

BROKEN JAW?

NO PROBLEM!

On April 9, 2000, the puck stopped here. It hit Colorado Avalanche defenseman Aaron Miller's jaw, breaking it in two places. Such an injury would keep most mere mortals home from work for days, even if work involves nothing more strenuous than sitting behind a desk.

But if you ain't tough, you ain't gonna make it in the NHL. Miller was back on the ice practicing in three days. And on the fourth day he started against the Phoenix Coyotes in the first game of the Avalanche's post season. Over the next six weeks Miller played in all 17 of the Avalanche's post-season games before his team was eliminated by the Dallas Stars in the Western Conference Finals.

Of course Miller did get a little help from a pair of Denver-area oral and maxillofacial surgeons. Within four hours of breaking his jaw on a Sunday afternoon Miller was in surgery.

Though the puck struck his face on the left side, both sides of Miller's jaw were broken. That's not unusual, says Steven R. Nelson, DDS, one of the OMSes who patched up Miller. Because the jaw is shaped like a "U" with the open end anchored to the skull, the force from a blow on one side is passed around to the opposite side, often snapping it just as if it were hit directly.

We're talking serious pain here.

In Miller's case, the puck also smashed an impacted wisdom tooth in his left jaw. Dr. Nelson and his partner Beryl Hunter, DMD, MD, removed the tooth and inserted two titanium plates to stabilize the left side of Miller's jaw. A third plate was used to repair the right side.

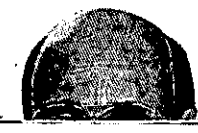
But like most of his NHL comrades, Miller bore the pain well. "These guys are very stoic," says Dr. Nelson, who, as one of the Avalanche's team oral and maxillofacial surgeons, sees a lot of injured players. Broken teeth, cheek fractures and facial lacerations are common in this rough-and-tumble game where the use of face guards is still the exception rather than the rule. "It may hurt them as much as it does you or me, but they just don't show it. They are incredible athletes with an incredible work ethic."

If Miller was in pain you couldn't tell it from his statistics. Not only did he stop his quota of shots, he scored a goal in a game against the Detroit Red Wings in the second round of the playoffs — a relatively rare event for someone playing Miller's position.

Of course, medicine helped keep the pain at bay. And the excitement of the game helped, Miller says. "It was really sore, but once you're in the game the adrenaline gets going and you don't notice it much."

Miller wore special face and mouth guards throughout the playoffs to prevent reinjuring his jaw. But he says he'll lose the shield as soon as he's fully recovered. In that he's like many of his colleagues, Dr. Nelson says. Most NHL players avoid face shields despite the risk of facial injuries.

But the tide is turning, Dr. Nelson notes. "After a player lost his eye this season, we're seeing more people wearing shields to protect their eyes."



Playing with pain

Despite breaking his jaw in two places just four days earlier, Aaron Miller, defenseman for the Colorado Avalanche (second from left above), hits the ice for the first game of the NHL playoffs. Oral and maxillofacial surgeons placed three titanium plates, restoring nearly full jaw function. Miller played a key role in bringing the Avalanche to the Stanley Cup playoffs, where they defeated the Phoenix Coyotes and the Detroit Red Wings before being ousted in the conference finals by the Dallas Stars. Miller wore a special face mask to protect his jaw during the 17 games.

A PINCH BETWEEN THE CHEEK AND GUMS CAN BE LETHAL AS A PACK A DAY

Smokeless doesn't mean harmless

Chewing tobacco causes cancer. Just ask Joe Garagiola. The renowned broadcaster and ex-major leaguer has seen dozens of friends suffer and even die from cancer of the jaw, mouth and throat. He's made it a personal crusade to eradicate chewing, or spit, tobacco from baseball — and everywhere else.

"If you don't know that cigarettes kill, you've been living in a cave for the last 20 years," Garagiola says. "But a lot of people don't know that spit tobacco is just as deadly. We've got a silent epidemic going and the only way to stop it is to get the facts out."

As chair of the National Spit Tobacco Education Program, or NSTEP, Garagiola carries that message everywhere from major league training camps to little league and community groups, breaking down the culture of tobacco use that has grown up around baseball. Often he's accompanied by colleagues who've fought cancer.

Former major leaguer Bill Tuttle was one. After 40 years of chewing and spitting, cancer ate away half his face and jaw before killing him in 1998. Ex-umpire Doug Harvey is another. The one-time voice of TV's "You Make the Call" joined the NSTEP crusade after losing half his tongue to tobacco-induced cancer in 1997.

"Cute slogans don't work. We give them the straight story," says Garagiola of his clubhouse visits. That includes graphic photos of the grotesque swelling and tissue rot that go with oral cancer as well as frank talk about things like enduring radiation burns and feeding tubes during cancer treatment.

Results of oral exams conducted by NSTEP at major league training camps this spring show the urgency of the mission. Of 401 players examined, 70% used spit tobacco. Of the 279 users, 65%, or 180, had one or more oral lesions, some of them cancerous or precancerous.

Check your mouth for cancer. **Page 4**

National statistics are just as alarming. Each year, more than 30,000 new cases of mouth and throat cancer are diagnosed. Only one-half of those diagnosed will live five years or more. About 8,000 die each year. Long-term users of spit tobacco are 50 times more likely to develop oral cancer than nonusers, and fully three-quarters of mouth and throat cancers are caused by tobacco and alcohol use.

And spit tobacco addiction is increasingly an epidemic of the young. Usage is highest among young men age 17 to 19. That's a 180-degree switch from 1970, when this age group was least likely to chew.

If there's a bright spot in this story it's that education works. Of the 279 users identified in major league training camps this year, 222 took advantage of cessation counseling to develop personal quit plans.

"It's a gross, deadly habit," Garagiola says. "If you haven't started, don't. If you are using spit tobacco, think about quitting — and get some help."

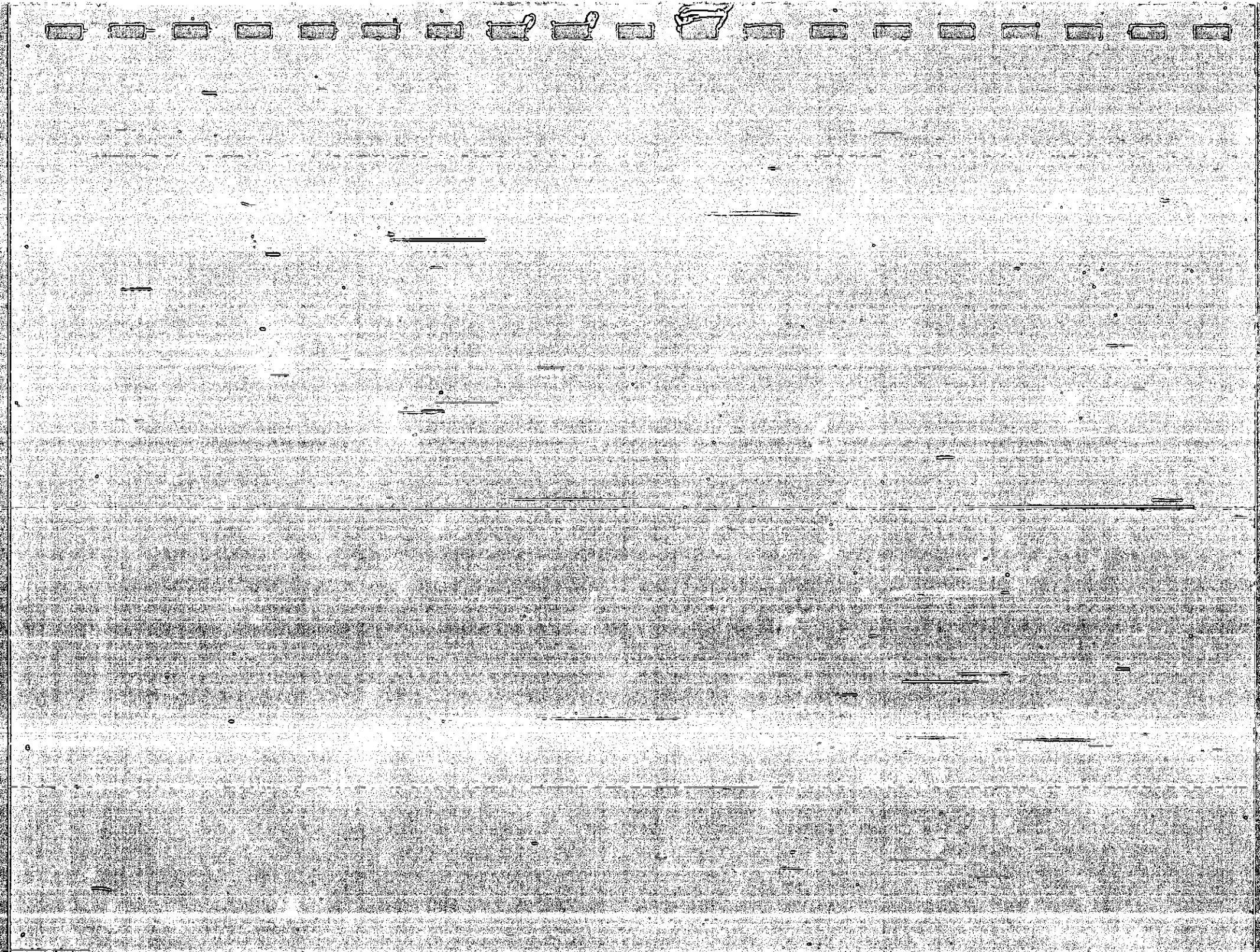


ILLUSTRATION BY DAVID M. BECK

13,000 TEETH ARE KNOCKED OUT EVERY DAY IN YOUTH SPORTING ACTIVITIES. WEAR A MOUTH GUARD.

2003

Goes w/ HB 201



New Hampshire Dental Society

New Hampshire Society of Oral & Maxillofacial Surgery

Issues Relating to the Definition of Dentistry

New Hampshire's Current Statutory Definition of Dentistry

Title XXX Occupations and Professions

Dentist and Dentistry

(Section 317-A:20, NH Dental Practice Act)

TITLE XXX
OCCUPATIONS AND PROFESSIONS

CHAPTER 317-A
DENTISTS AND DENTISTRY

Examinations and Licenses

Section 317-A:20

317-A:20 Practice of Dentistry. –

I. A person shall be regarded as practicing dentistry within the meaning of this chapter who:

(a) Uses or permits to be used, directly or indirectly, for profit or otherwise, for that person or for any other person, in connection with the person's name, the word "dentist', or "dental surgeon', or the title "D.D.S.' or "D.M.D.', or any other words, letters, titles, or descriptive matter, personal or not, which directly or indirectly imply the practice of dentistry;

(b) Owns, leases, maintains, or operates a dental business in any office or other room or rooms where dental operations are performed, or directly or indirectly is manager, proprietor, or conductor of the same;

(c) Directly or indirectly informs the public in any language, orally, in writing, or in printing, or by drawings, demonstrations, specimens, signs, or pictures that the person can perform or will attempt to perform dental operations of any kind; or

(d) Undertakes, by any means or method, gratuitously or for a salary, fee, money, or other reward paid or granted directly or indirectly to that person or to any other person, to diagnose or profess to diagnose, to treat or profess to treat, or prescribe for or profess to prescribe for any of the lesions, diseases, disorders, or deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures;

(e) Extracts human teeth or corrects malpositions thereof or of the jaws;

(f) Except on the written prescription of a duly licensed dentist and by the use of impressions or casts made by a duly licensed and practicing dentist, directly or indirectly by mail, carrier, personal agent, or by any other method, furnishes, supplies, constructs, reproduces, or repairs prosthetic dentures, bridges, appliances, or other structures to be used and worn as substitutes for natural teeth, or adjusts the same;

(g) Administers dental anesthetics, either general or local; or

(h) Engages in any of the practices included in the curricula of recognized dental colleges.

II. Any dentist who wishes to administer general anesthesia, deep sedation, or conscious sedation shall apply to the board for the appropriate permit and pay an application fee set by the board in accordance with RSA 317-A:12, XII-a.

III. Nothing in this section shall prevent:

(a) Regularly licensed physicians or surgeons from:

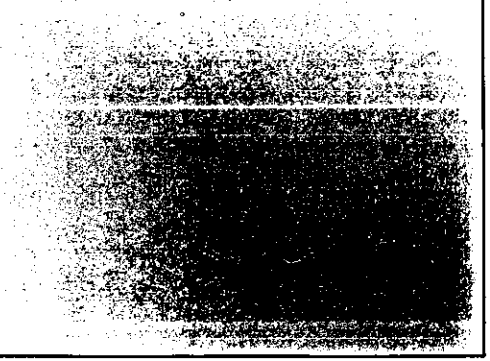
(1) Treating or prescribing for lesions, diseases, disorders, or deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures;

(2) Extracting human teeth or administering anesthetics;

(3) Using or prescribing drugs or other remedies.

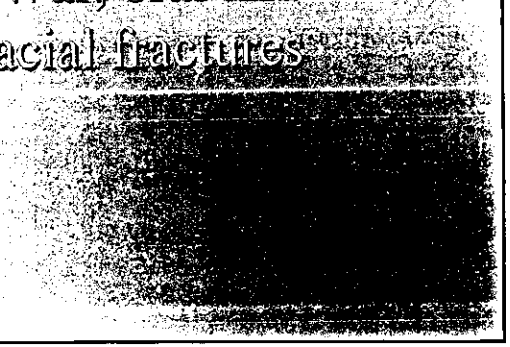
(b) Students from performing dental operations under the supervision of a registered dentist at a state institution or competent instructors within a dental school, college, or dental department of a university recognized by the board.

Since New Hampshire's Current Definition of Dentistry was passed, the practice of dentistry, and specifically oral and maxillofacial surgery (OMFS) has evolved significantly.



Evolution of the Specialty

- Although many people associate oral and maxillofacial surgery with the mouth, oral surgeons have always operated on the other structures of the face.
- Some of the pioneering work in cleft palate and facial fractures was done by oral surgeons in the early 1900's.
- Oral surgeons were among the founding fathers of the specialty of plastic surgery in the late 1920's.
- Over the past half century, oral and maxillofacial surgery has evolved from mouth surgery alone to the treatment of the entire face.
- During World War II, the Korean War and the Vietnam War, oral and maxillofacial surgeons became involved with complex facial fractures and soft tissue injuries.



Definition of Maxillofacial:

Steadman's Medical Dictionary defines **maxillofacial** as "pertaining to the jaws and face, particularly with reference to specialized surgery of this region."

Oral & Maxillofacial Surgery
The Surgical Specialty of Dentistry

- Oral & maxillofacial surgery (OMFS) is the surgical specialty of dentistry.
- The training and practice overlap in some areas with other surgical specialties.
- OMFS complete hospital residency training alongside physicians, taking part in medical and surgical rotations at the same level as the medical residents.
- Therefore, as a result of their specialized education and training in dentistry, medicine, and surgery, oral and maxillofacial surgeons are licensed by dental boards to perform procedures that are also performed by medical doctors.

Oral & Maxillofacial Licensure and Procedures

In New Hampshire, Oral & Maxillofacial surgeons currently:

- Perform hospital admission history and physical exams.
- Administer general anesthesia.
- Repair complex facial fractures including the cranium (frontal sinus) orbit (orbital contents and associated structures) cheekbones and jaw joints.
- Harvest bone, skin, fat, and nerve to be grafted to the face.
- Treat major facial infections and lacerations.
- Manage inpatient hospital treatment, including but not limited to, blood loss and transfusion, management of lab tests, and patient care in the Intensive Care Unit.
- Oral & maxillofacial surgeons are held to the same standard of care as physicians.

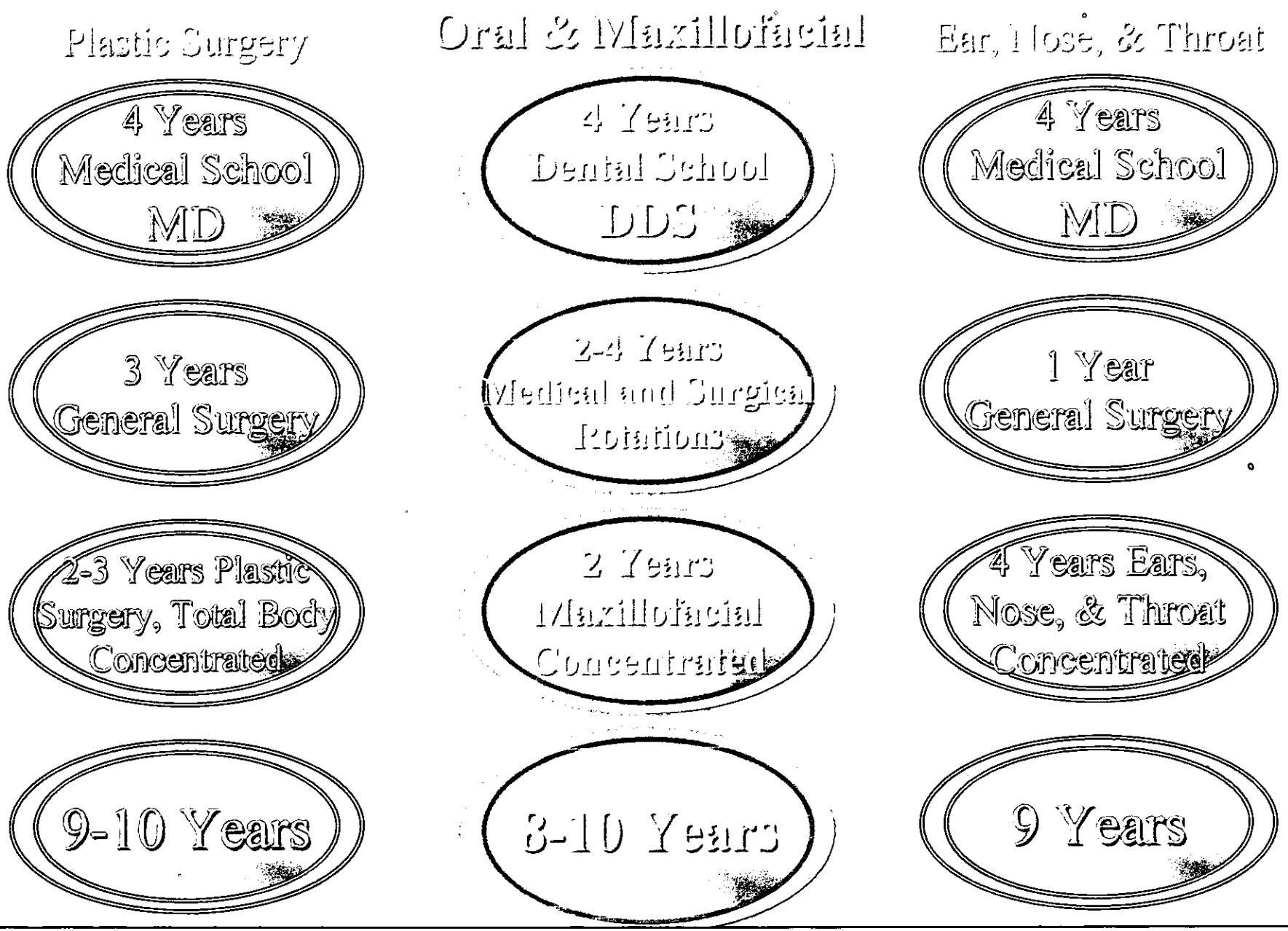
Oral & Maxillofacial Surgical Training

4-6 years post dental school, accredited hospital based residency programs for a total of 8-11 years post graduate study.

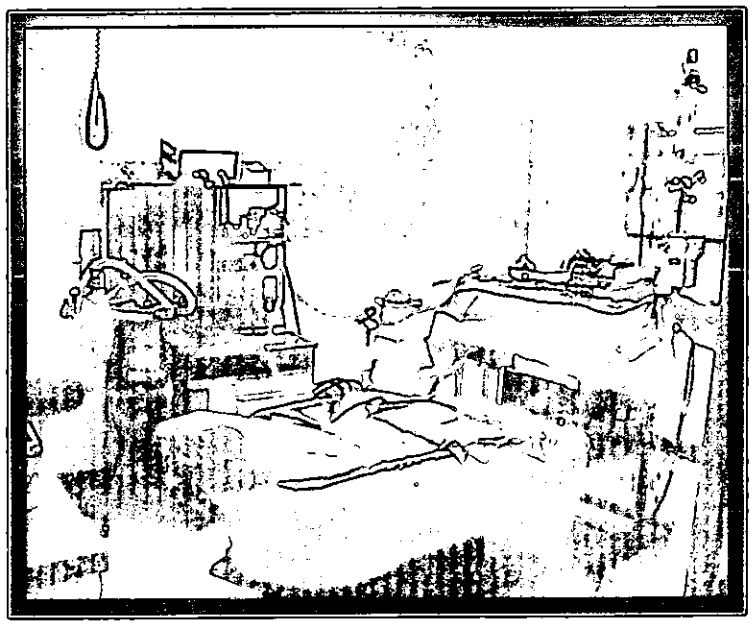
Hospital residency rotations over 4-6 years include:

- Medicine
- Medical ER
- Surgical ER
- Trauma ER
- Cardiology
- General Surgery
- Neurosurgery
- Anesthesia
- Pathology
- PLSA ENT

Education & Training Comparisons

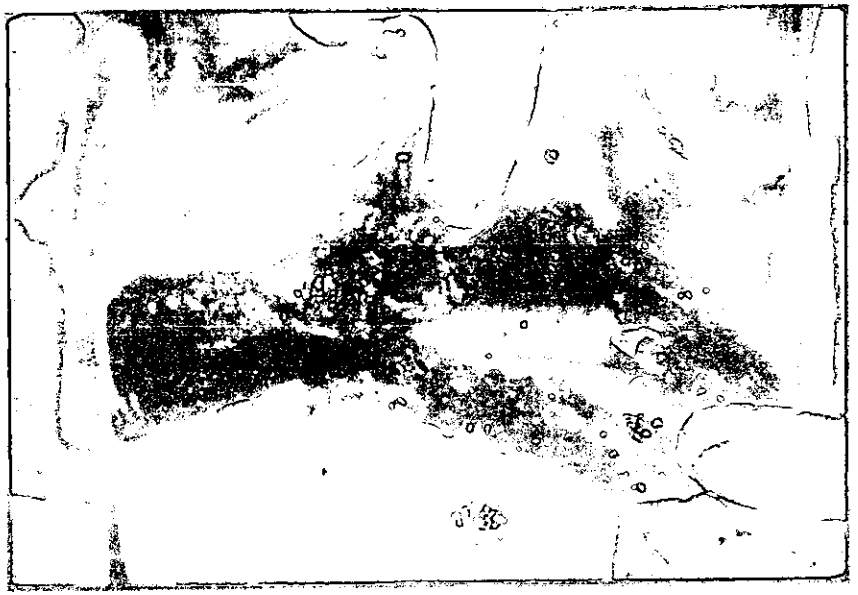


Examples of Scope of Current Oral & Maxillofacial Surgery Practice



Note: The following section contains graphic oral & maxillofacial surgical pictures. If you are sensitive to such pictures, you may wish to avoid this section

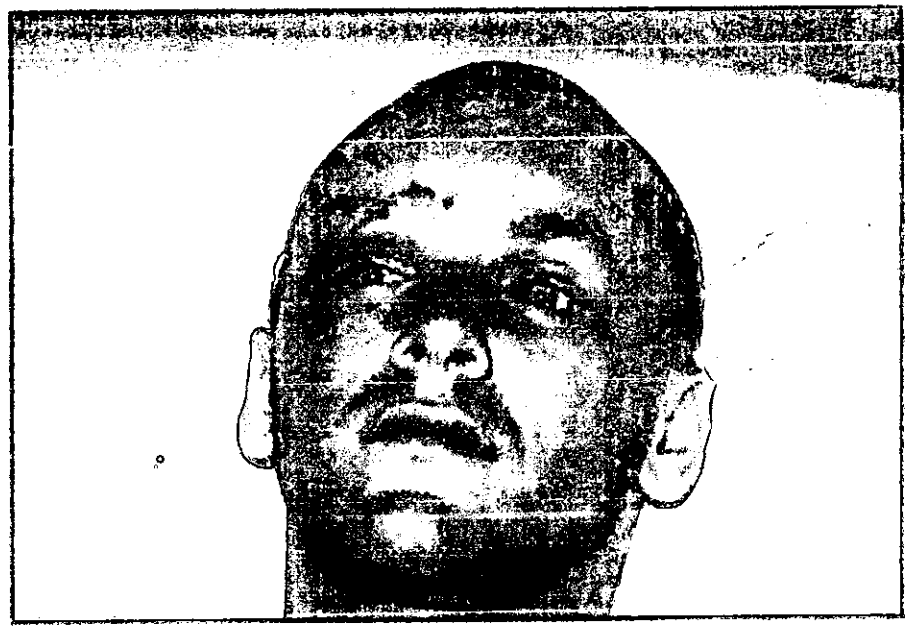
Laceration Repair with Anatomic Considerations





Complex Maxillofacial Trauma





Severe Hard & Soft Tissue Injury







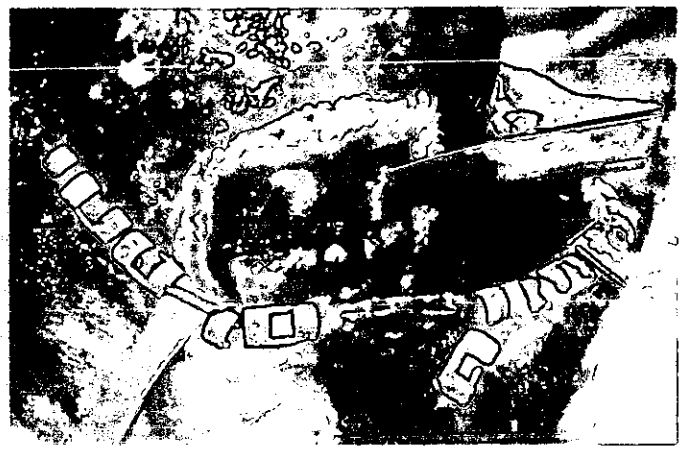
Harvest of Distal Bone Grafts for Application to the Oral and Maxillofacial Region

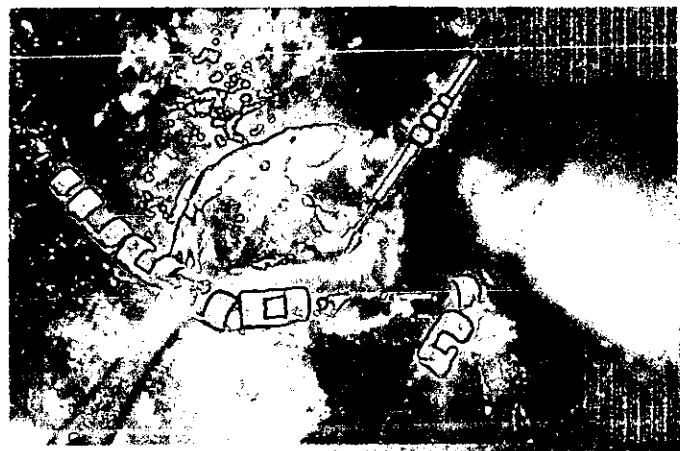




Iliac Crest (Hip Bone)

Harvest of Distal Bone Grafts for Application to the Oral and Maxillofacial Region



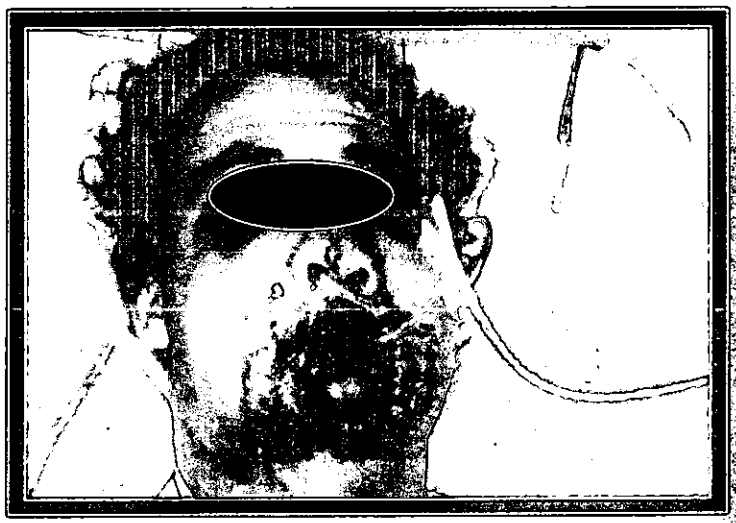


Cranial Bone (skull)

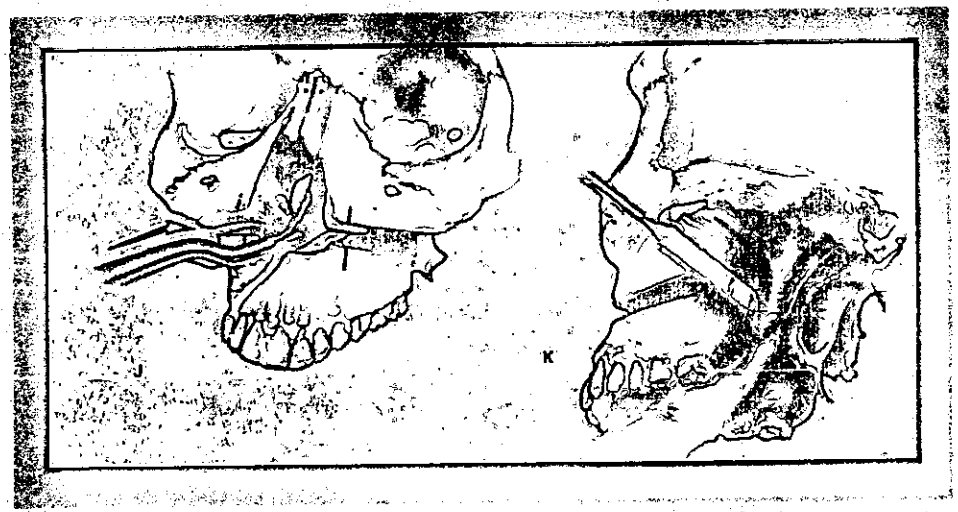
Maxillofacial Gunshot Wounds

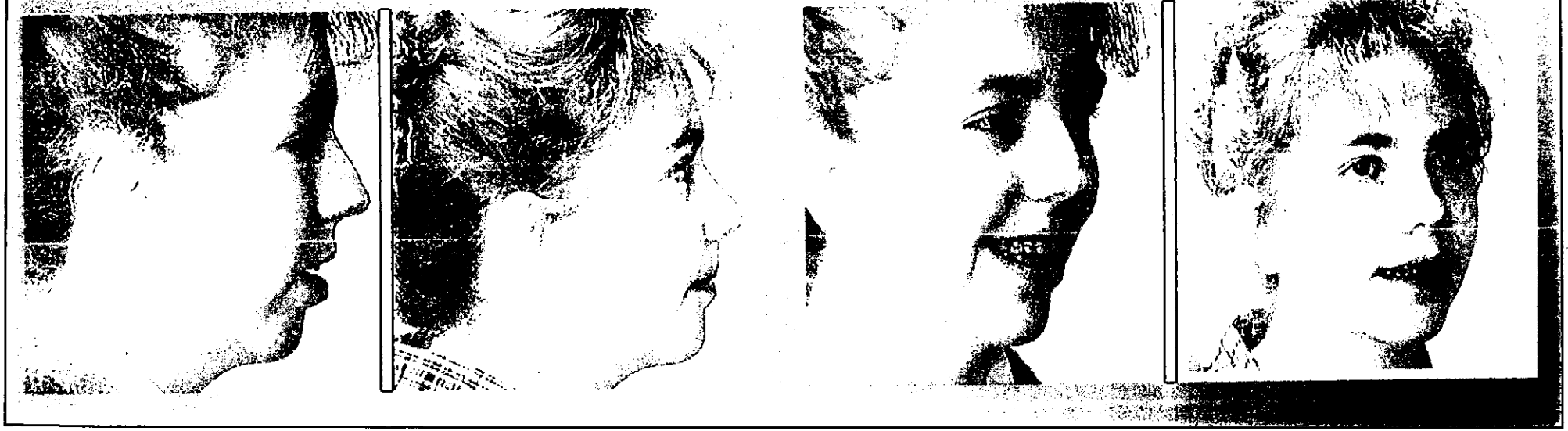




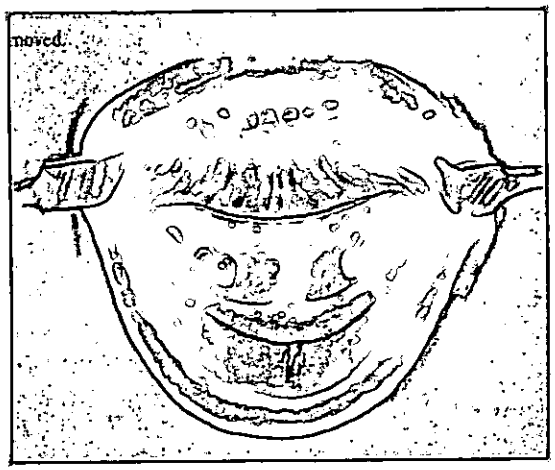


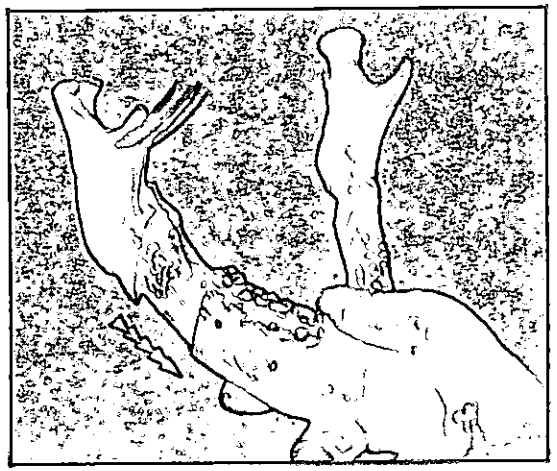
Corrective Surgery of the Jaw and Facial Skeleton



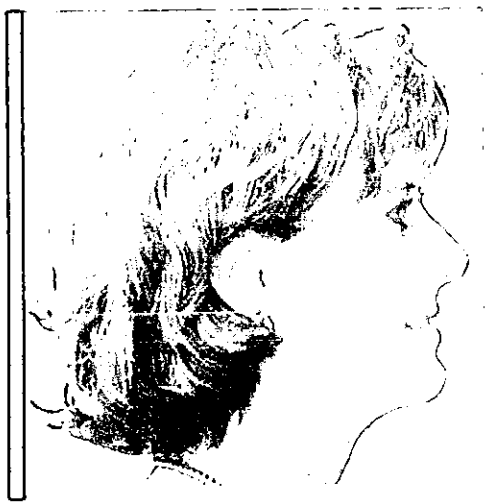


Corrective Surgery of the Jaw and Facial Skeleton













Hemifacial Microsomia

Otomandibular dysostosis is a variable, progressive, and asymmetric underdevelopment of the craniofacial skeleton, external ear, and facial soft tissues including nerves and muscles. The deformity involves structures derived from the first and second branchial arches.





Reconstruction of Facial Skeleton Using Rib Grafts



Restored Form and Function



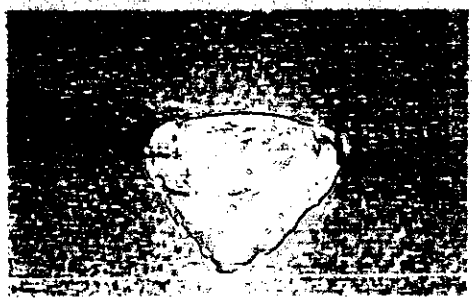
Pathology





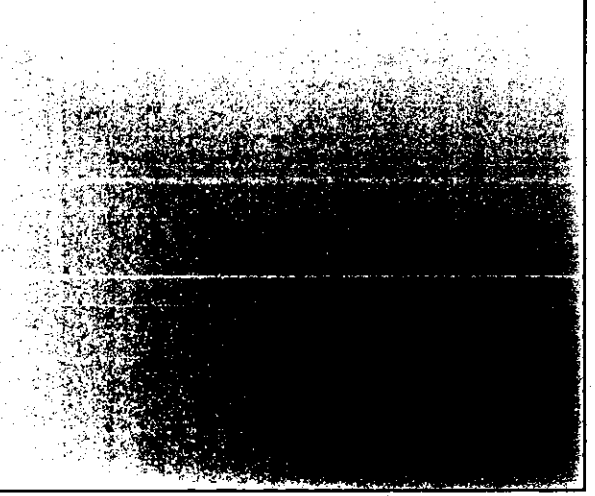


Squamous cell carcinoma (cancer) of lower lip



A Potential Problem

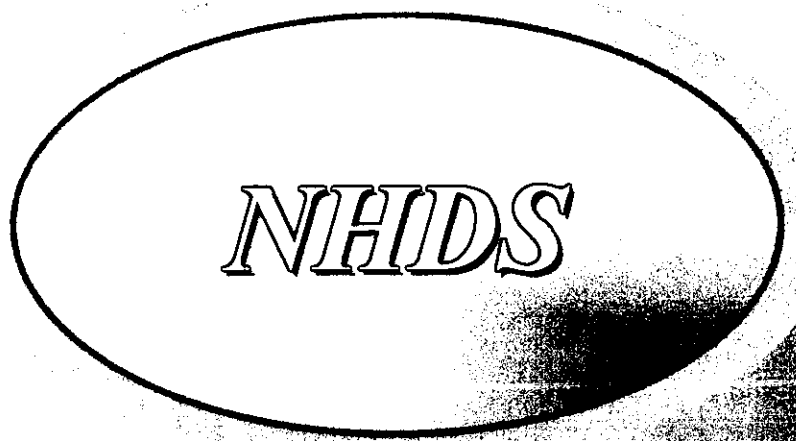
- In some states, attempts have been made to interpret the definition of dentistry to restrict the current scope of practice of oral and maxillofacial surgeons.
- Any attempt to use the current definition of dentistry to restrict the scope of practice could unfairly limit the practice of every oral and maxillofacial surgeon in the State.



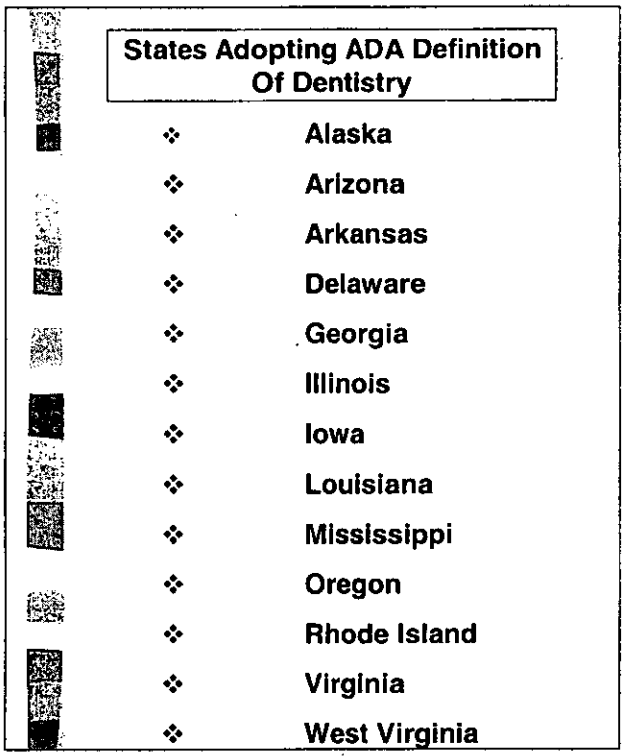
The Solution

- Enact the A.D.A. definition of dentistry and that of all its specialties.
- "Dentistry" is defined as the evaluation, diagnosis, prevention and treatment (nonsurgical, surgical, or related procedures) of diseases, disorders and conditions of the oral cavity, maxillofacial area, and/or adjacent and associated structures and their impact on the human body; provided by a dentist within the scope of her/his education, training and experience, in accordance with the ethics of the profession and applicable law.

The NH Dental Society and the NH Society of Oral & Maxillofacial Surgery respectfully request your assistance and support in this effort.



Thank you for your valuable time.



Since 1997, When the ADA House of Delegates recognized the new definition of dentistry, thirteen states have amended their dental practice acts and/or regulations to adopt the ADA definition. In Illinois, the Department of Professional Regulation adopted the ADA definition. Prior to 1997, twenty states, including some of those above, had incorporated the term "associated structures" in their acts, a term which provides statutory support for contemporary OMS practice related to esthetic/cosmetic and other maxillofacial procedures.

States which include the term "associated structures" include Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Iowa, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota and West Virginia.

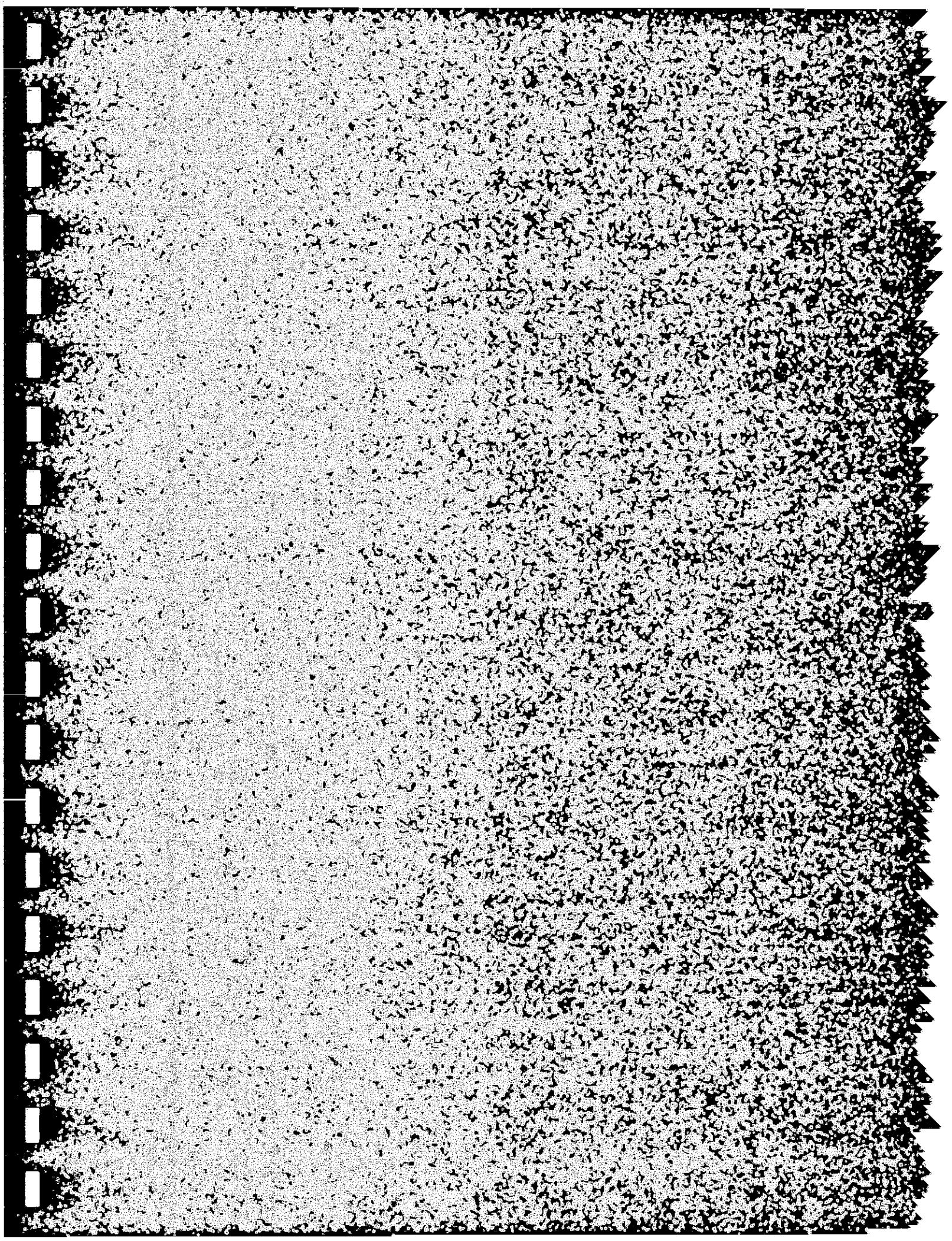
ADA Definition of Dentistry, adopted by House of Delegates 1997

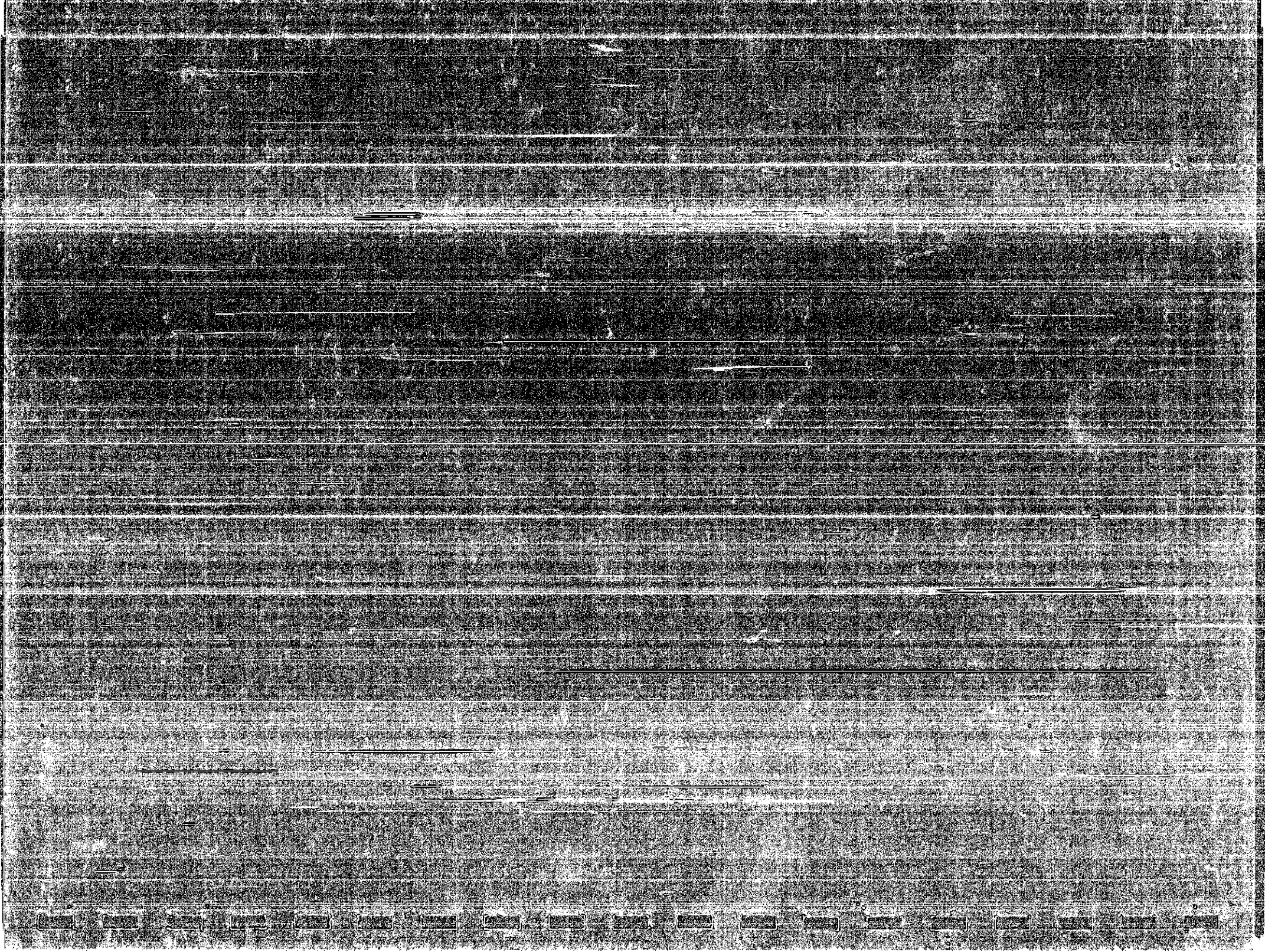
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ADA Report 13 on the Definition of Dentistry

- ADA Report 13 defines ADA intent to develop a a definition that is "open-ended and allows for the evolution of the profession of dentistry."

- Report 13 recommends that the ADA Definition of Dentistry be incorporated into the list of ADA specialty definitions so that states and others have guidance to interpret the definitions in totality or in conjunction with each other.





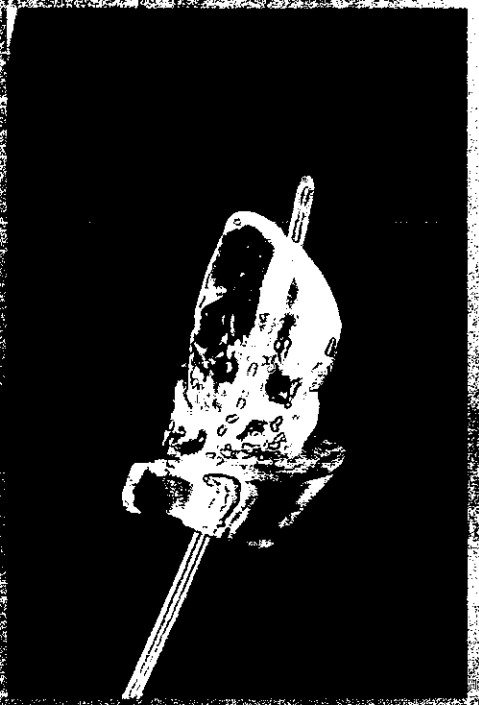
Oral and Maxillofacial Surgery and Prosthodontics

Prosthetic Treatment of Structures Associated With the Teeth And Jaws

Intranasal Kaposi's Sarcoma





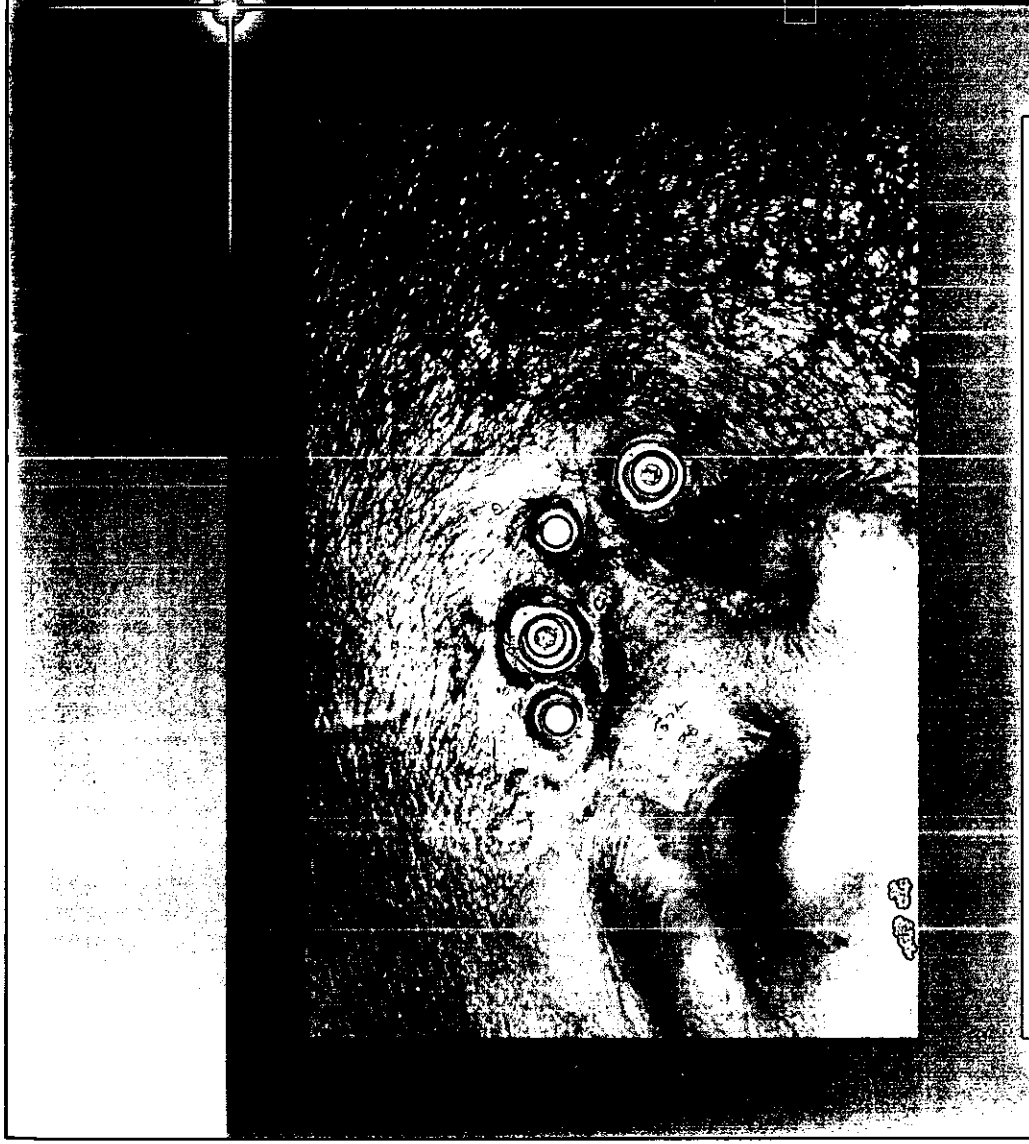


Ear Reconstruction





Ear Prosthesis With Implant Retention

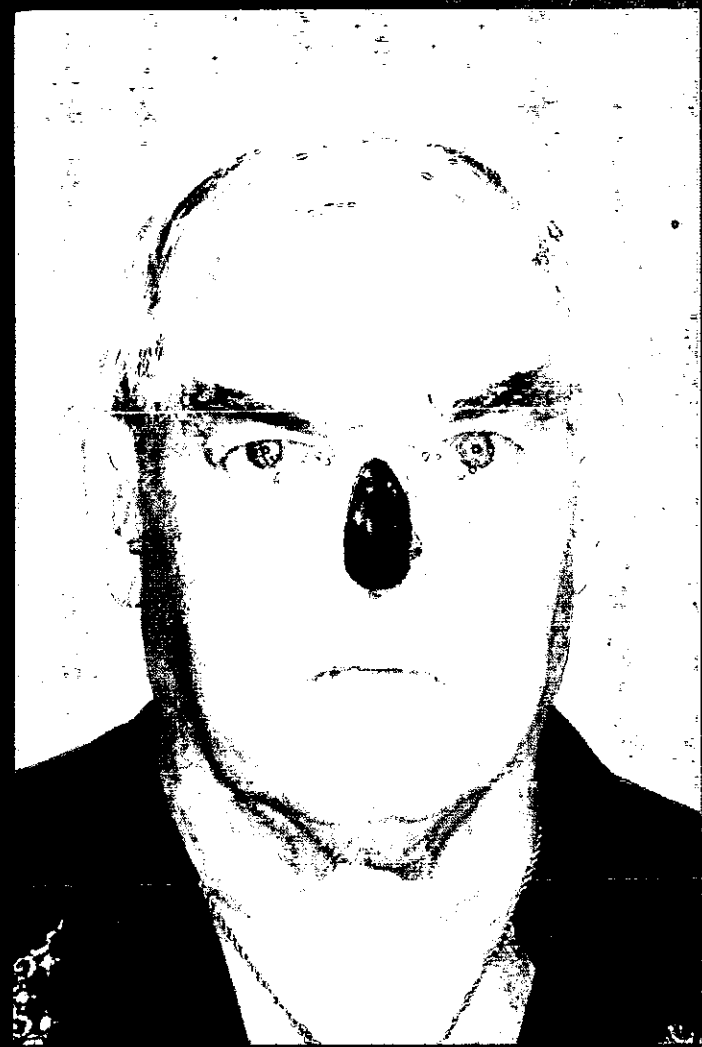




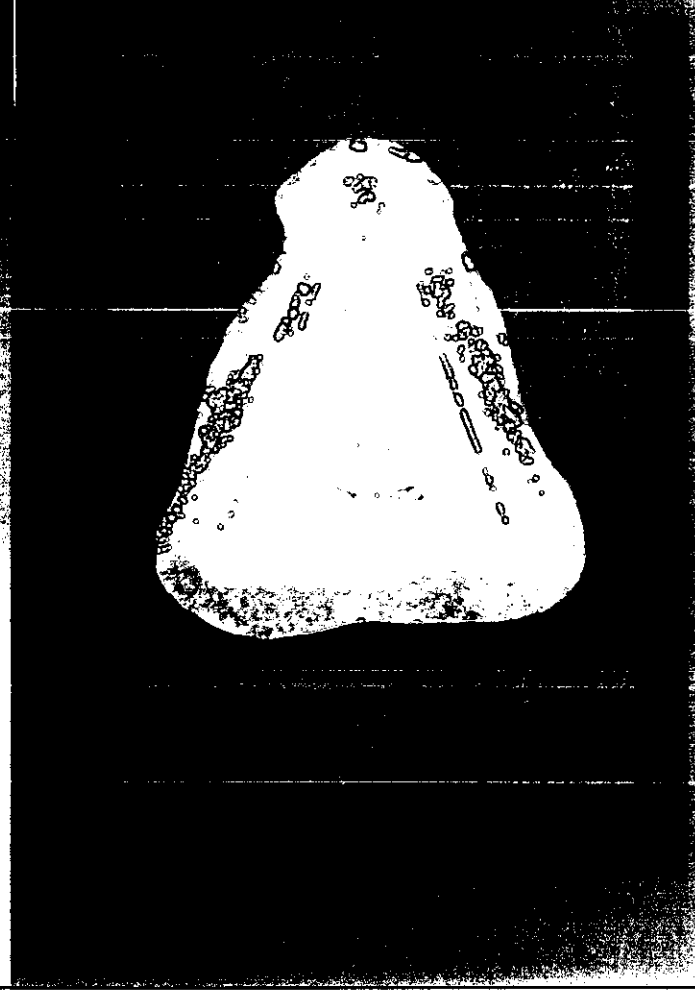
Nasal Prosthesis



Nasal Prosthesis

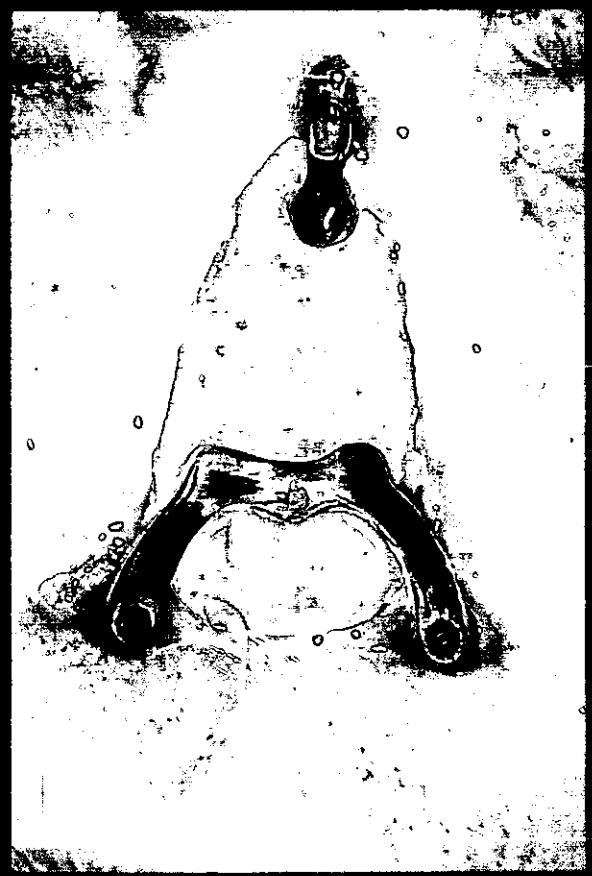


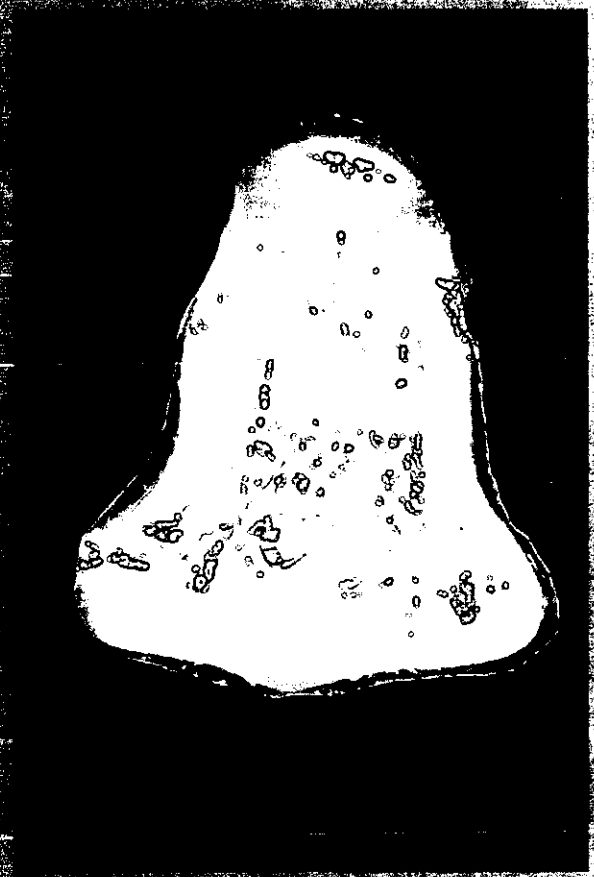
Nasal Prosthesis With Medical Adhesive Retention



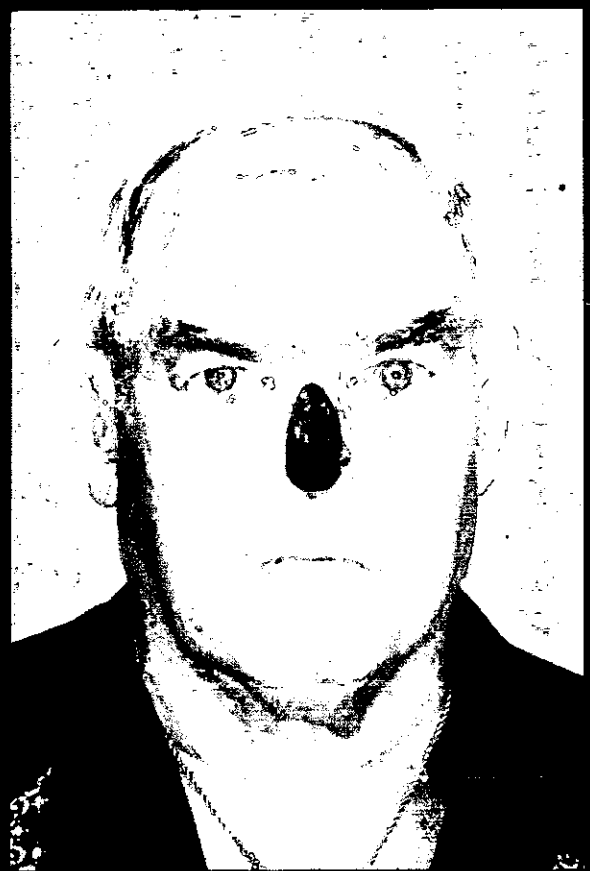


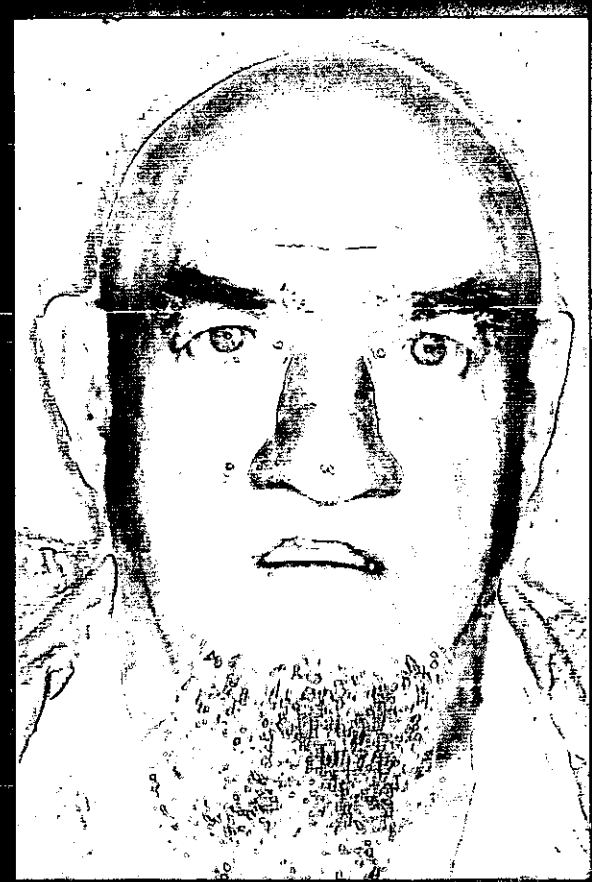
Nasal Prosthesis With Implant Retention





Nasal Prosthesis With Implant Retention





Ocular Prosthesis

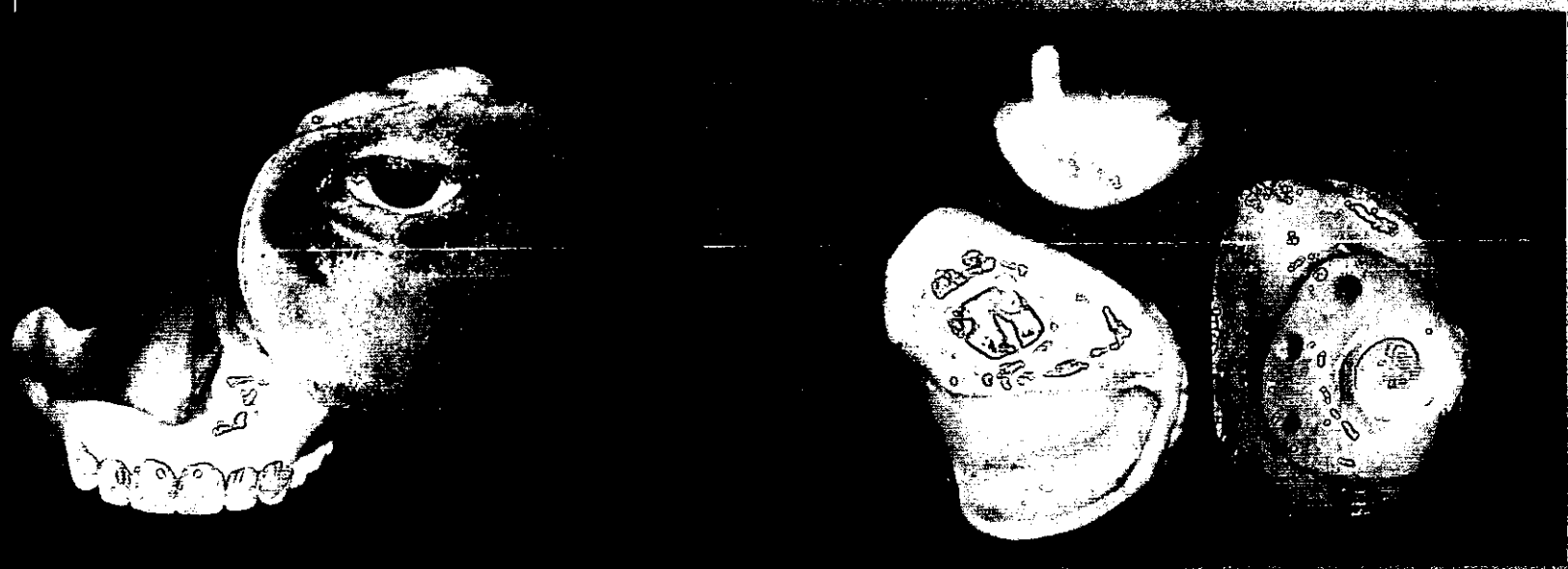




Orbital Maxillofacial Prosthesis



Orbital Maxillofacial Prosthesis



Orbital Maxillofacial Prosthesis





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In Bill Folder

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OF THE TENNESSEE DENTAL ASSOCIATION
FALL 2002

Dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law.

(As adopted by the 1997 ADA House of Delegates.)

Oral and Maxillofacial Surgery in Tennessee

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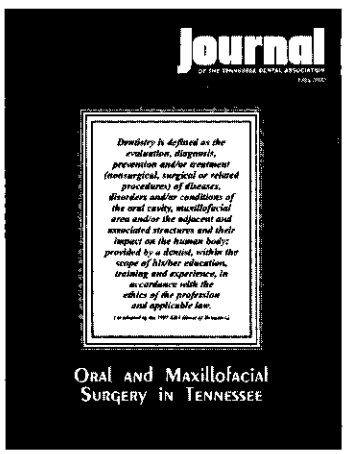
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See Page 79 for E-Mail Submission of Manuscripts

2003 ANNUAL SESSION
Nashville, Tennessee
MAY 22 - 25



Cover: *This issue of the Journal is devoted to Oral and Maxillofacial Surgery in Tennessee. The ADA Definition of Dentistry appears on the cover.*

Journal
OF THE TENNESSEE DENTAL ASSOCIATION
VOLUME 82, NUMBER 3, FALL 2002

5 Editorial

6 Guest Editorial

9 "President's Address"
Stephen A. Brooks, D.D.S., F.A.C.D., F.I.C.D.

11 "Actions of the House of Delegates — 135th Annual Session"

16 "The Jack E. Wells Memorial Dedication to Dentistry Award — Dr. R. Benjamin Alley"

18 Photographs of the 135th Annual Session in Chattanooga

22 "Self Inflicted Shotgun Wound to the Face: A Case Report
Larry W. Weeda, Jr., D.D.S. Ernest S. Woodard, D.D.S.

27 "Cleft Craniofacial"
J. W. Hudson, D.D.S.

34 "The Oral and Maxillofacial Surgeon's Role in the Diagnosis and Treatment of Oral Cancer"
J. Michael McCoy, D.D.S.

39 "Management of Complex Multi-Space Odontogenic Infections"
Terrance A. Bratton, D.D.S. D. Carl Jackson, D.D.S.
Tania Nkungula-Howlett, D.D.S. Charles W. Williams, D.D.S.
C. Ray Bennett, D.D.S.

48 "Obstructive Sleep Apnea: A Case Report
J. David Johnson, Jr., D.D.S. Scott B. Boyd, D.D.S., Ph.D.

52 "Combined Orthognathic and Facial Aesthetic Surgery with Case Reports"
J. Greg Anderson, D.D.S. Thomas J. Laney, M.D., D.D.S.

58 "Guidelines for Management of Disorders of the Temporomandibular Joint and Related Structures"
H. David Hall, D.M.D., M.D. Ralph G. Merrill, D.D.S., M.Sc.D.
Bruce Sanders, D.D.S.

65 "Maxillofacial Treatment by Dentists in the U.S. Military"
Jesse T. Mitchell, D.D.S. J. David Johnson, Jr. D.D.S.

69 "Management of Complex Facial Fractures"
Jack E. Gotcher, Jr., D.M.D., Ph.D. Kenneth W. Livesay, D.M.D.

74 "Associated Structures"
J. David Johnson, Jr., D.D.S.

78 General News & In Memoriam

79 Instructions for Submitting E-Mail Manuscripts to the *Journal*

MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS

The *Journal of the Tennessee Dental Association* (ISSN 0040-3385) is published quarterly. The business office mailing address is 2104 Sunset Place, Nashville, TN 37212 – The e-mail address is: tda@tendental.org. Editorial communications and scientific manuscripts should be addressed to Dr. H. Clifton Simmons III, 1916 Hayes Street, Nashville, TN 37203, and, if possible, e-mailed as an attachment to journal@tenndental.org. The Tennessee Dental Association disclaims all responsibility for the opinions and statements of all alleged facts made by contributors to this journal unless such opinions or statements have been adopted by the association. The subscription rate is $9.50 yearly or $5.00 single issue — SourceBook is $20.00 single issue — (U.S.); $20.00 yearly or $17.50 single issue — SourceBook is $25.00 single issue — (Canada); $25.00 yearly or $20.00 single issue — SourceBook is $30.00 single issue — (Foreign). All subscriptions are payable in advance. Payments should be mailed to the office of the Business Manager. Journal article reprint orders must be received in the Business Manager's office 30 days prior to month of issue to obtain lowest price. Periodical postage paid at Nashville, Tennessee. POSTMASTER: Send address changes to the *Journal of the Tennessee Dental Association*, P.O. Box 120188, Nashville, TN 37212.

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Parameters and Pathways:

Clinical Practice
Guidelines for Oral and Maxillofacial Surgery
(AAOMS ParPath 01)

Version 3.0

American Association of Oral and Maxillofacial Surgeons

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Clinical Practice
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Version 3.0
Supplement to the Journal of Oral and Maxillofacial Surgery

American Association of Oral and Maxillofacial Surgeons

TABLE OF CONTENTS

Section Title **Page**

Table of Contents **INT-1**

Authors **INT-5**

Preface to the Third Edition **INT-7**

Preamble and Introduction **INT-8**

Application of Parameters of Care to Clinical Practice **INT-10**

Applicability and Utility of Parameters of Care to Patient Care **INT-11**

Clinical Pathways **INT-12**

Coding and Nomenclature **INT-13**

History of the Parameters of Care for Oral and Maxillofacial Surgery **INT-15**

International Endorsements **INT-17**

Acknowledgments **INT-20**

Patient Assessment **PAT-1**
- Introduction PAT-2
- Preamble PAT-2
- General Criteria, Standards, and Considerations for Patient Assessment PAT-2
- Special Considerations for Pediatric Patient Assessment PAT-4
- Patient Assessment PAT-5
- Selected References PAT-9
- Clinical Pathway for Patient Assessment for Emergency Hospital Admission and Discharge PAT-12

Anesthesia in Outpatient Facilities **ANE-1**
- Introduction ANE-2
- General Criteria, Standards, and Considerations for Anesthesia in Outpatient Facilities ANE-2
- Special Considerations for Pediatric Anesthesia in Outpatient Facilities ANE-6
- Special Considerations for Anesthesia Management of the Pregnant Patient in Outpatient Facilities ANE-7
- Local Anesthesia ANE-8
- Conscious Sedation ANE-9
- Deep Sedation/General Anesthesia ANE-11
- Selected References ANE-16
- Clinical Pathway for Deep Sedation/General Anesthesia ANE-23

Dentoalveolar Surgery **DEN-1**
- Introduction DEN-2
- General Criteria, Standards, and Considerations for Dentoalveolar Surgery DEN-2
- Special Considerations for Pediatric Dentoalveolar Surgery DEN-6
- Odontogenic Infections DEN-7
- Erupted Teeth DEN-10
- Unerupted and Impacted Teeth (Other than Third Molars) DEN-13
- Third Molars DEN-16
- Deformities and Defects of the Dentoalveolar Complex DEN-19
- Selected References DEN-24
- Clinical Pathway for the Management of Third Molars DEN-33

Oral and Craniomaxillofacial Implant Surgery **IMP-1**
Introduction IMP-2
General Criteria, Standards, and Considerations for Oral and Craniomaxillofacial Implant Surgery IMP-2
Special Considerations for Pediatric Oral and Craniomaxillofacial Implant Surgery IMP-6
Special Considerations (Neurologic Dysfunction, Neuromuscular Deformities, Inadequate Orthodontic Anchorage, Tissue Intolerance to Prosthetic Materials) IMP-7
Partial Edentulism IMP-8
Isolated Partial Edentulism in an Aesthetic Zone IMP-10
The Totally Edentulous Mandible IMP-12
The Totally Edentulous Maxilla IMP-14
The Reconstructed Mandible (Partially and Totally Edentulous) IMP-17
The Reconstructed Maxilla (Partially and Totally Edentulous) IMP-19
Irradiated Bone IMP-22
The Reconstructed Alveolar Cleft IMP-25
Developmental or Acquired Craniofacial Deformity IMP-28
Selected References IMP-30
Clinical Pathway for the Management of Partial Edentulism IMP-48

Surgical Correction of Maxillofacial Skeletal Deformities **SKE-1**
Introduction SKE-2
General Criteria, Standards, and Considerations for Surgical Correction of Maxillofacial Skeletal Deformities SKE-2
Special Considerations for Surgical Correction of Pediatric Maxillofacial Skeletal Deformities SKE-7
Mandibular Prognathism/Hyperplasia SKE-8
Mandibular Retrognathism/Hypoplasia SKE-9
Mandibular Asymmetry SKE-11
Maxillary Hyperplasia SKE-12
Maxillary Hypoplasia SKE-14
Apertognathia (Open Bite) SKE-16
Selected References SKE-18
Clinical Pathway for the Management of Retrognathic Mandible SKE-31

Cleft and Craniofacial Surgery **CLE-1**
Introduction CLE-2
General Criteria, Standards, and Considerations for Cleft and Craniofacial Surgery CLE-3
Special Considerations for Pediatric Cleft and Craniofacial Surgery CLE-6
Primary Cleft Lip Deformities CLE-7
Primary Cleft Palate Deformities CLE-8
Velopharyngeal Incompetence CLE-10
Residual Cleft Lip and/or Nasal Deformities Requiring Secondary Management CLE-11
Maxillary Alveolar Cleft Deformities CLE-13
Residual Maxillofacial Skeletal Deformities Requiring Secondary Management CLE-15
Craniofacial Deformities: Those Not Requiring an Intracranial Approach for Repair CLE-18
Craniofacial Deformities: Primary Craniosynostosis Requiring Release Through an Intracranial Approach CLE-20
Craniofacial Deformities: Secondary Craniosynostosis Requiring Release Through an Intracranial Approach CLE-22
Orbital and/or Naso-orbital Deformities CLE-25
Selected References CLE-27
Clinical Pathway for the Management of Primary Cleft Palate Deformities CLE-34

Trauma Surgery **TRA-1**
Introduction TRA-2
General Criteria, Standards, and Considerations for Trauma Surgery TRA-2

Trauma Surgery (continued)
Special Considerations for Pediatric Trauma Surgery TRA-6
Fractured Teeth TRA-7
Luxated and/or Exarticulated Teeth TRA-8
Alveolar Process Injuries TRA-10
Mandibular Angle, Body, Ramus, and Symphysis Injuries TRA-13
Mandibular Condyle Injuries TRA-15
Mandibular Condyle Dislocation TRA-17
Maxillary Injuries TRA-19
Zygomatic Injuries TRA-21
Orbital Injuries TRA-23
Nasal Bone Injuries TRA-25
Naso-Orbital-Ethmoid Complex Injuries TRA-27
Frontal Bone and Frontal Sinus Injuries TRA-30
Oral/Perioral Soft Tissue Injuries TRA-32
Auricle Injuries TRA-34
Scalp Injuries TRA-36
Periorbital Soft Tissue Injuries TRA-38
Perinasal Soft Tissue Injuries TRA-41
Facial Soft Tissue Injuries TRA-42
Upper Airway Obstruction TRA-45
Selected References TRA-47
Clinical Pathway for the Management of Mandibular Angle, Body, Ramus and Symphysis Injuries TRA-58

Temporomandibular Joint Surgery TMJ-1
Introduction TMJ-2
General Criteria, Standards, and Considerations for Temporomandibular Joint Surgery TMJ-2
Special Considerations for Pediatric Temporomandibular Joint Surgery TMJ-6
Masticatory Muscle Disorders TMJ-7
Internal Derangement TMJ-8
Degenerative Joint Disease TMJ-11
Rheumatoid Arthritis TMJ-13
Infectious Arthritis TMJ-16
Mandibular Dislocation: Recurrent or Persistent TMJ-19
Ankylosis and Restricted Jaw Motion TMJ-21
Condylar Hyperplasia or Hypoplasia TMJ-24
Gouty Arthritis TMJ-26
Selected References TMJ-29
Clinical Pathway for the Management of Internal Derangement TMJ-37

Diagnosis and Management of Pathologic Conditions PTH-1
Introduction PTH-2
General Criteria, Standards, and Considerations for Diagnosis and Management of Pathologic Conditions PTH-2
Special Considerations for Pediatric Diagnosis and Management of Pathologic Conditions PTH-6
Cysts of Bone PTH-7
Malignant Tumors of Bone PTH-9
Benign Tumors of Bone PTH-12
Osteomyelitis PTH-15
Osteoradionecrosis PTH-18
Metabolic and Dystrophic Diseases of Bone PTH-21
Cysts of Soft Tissue PTH-23
Benign Tumors of Soft Tissue PTH-25
Malignant Tumors of Soft Tissue PTH-27
Vascular Malformations of Soft Tissue PTH-30
Mucosal Diseases PTH-33

Diagnosis and Management of Pathologic Conditions (continued)
Salivary Gland Diseases: Cysts, Benign and Malignant Tumors PTH-35
Salivary Gland Infections PTH-37
Salivary Gland Diseases: Other Local or Systemic PTH-39
Selected References PTH-42
Clinical Pathway for the Management of Benign Tumors of Bone (Ameloblastoma) PTH-49

Reconstructive Surgery REC-1
Introduction REC-2
General Criteria, Standards, and Considerations for Reconstructive Surgery REC-2
Special Considerations for Pediatric Reconstructive Surgery REC-6
Defects of the Mandible and Associated Soft Tissues REC-7
Defects of the Maxilla and Associated Soft Tissues REC-12
Defects of the Zygoma and Associated Soft Tissues REC-17
Orbital Defects REC-21
Nasal Defects REC-24
Defects of the Frontal Bone and Associated Soft Tissues REC-27
Neurologic Defects REC-30
Selected References REC-33
Clinical Pathway for the Management of Defects of the Mandible and Associated Soft Tissues REC-49

Cosmetic Maxillofacial Surgery COS-1
Introduction COS-2
General Criteria, Standards, and Considerations for Cosmetic Maxillofacial Surgery COS-2
Special Considerations for Pediatric Cosmetic Maxillofacial Surgery COS-6
Chin Deformities COS-7
Maxillofacial Contour Deformities COS-8
External Ear Deformities COS-10
Maxillofacial Lipomatosis COS-11
Eyelid Deformities COS-13
Nasal Deformities COS-14
Cervicofacial Soft Tissue Redundancy COS-16
Forehead and Brow Deformities COS-17
Cutaneous Tissue Deformities COS-19
Hair Pattern Deformities COS-21
Selected References COS-23
Clinical Pathway the Management of Microgenia COS-31

Glossary GLO-1

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The following AAOMS members served on the Special Committee on Parameters of Care and its revision subcommittees. These individuals authored the eleven clinical sections that constitute the *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath 01).* The Subcommittee Chairs edited the final draft of the *Parameters and Pathways : Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath 01)* and will oversee future parameters of care and related performance improvement activities within the specialty. Board of Trustee Liaisons and AAOMS Support Staff are acknowledged here.

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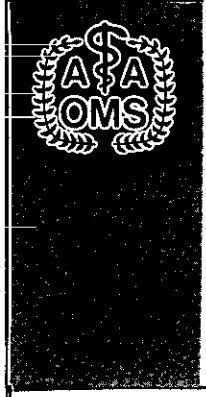
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A word to the wise on

WISDOM TEETH

Your teen's mouth may seem big. But when wisdom teeth — technically known as third molars — begin to appear, there generally won't be enough room for them in the jaw. As soon as it's clear that third molars will not grow in normally they should be removed, the latest research recommends. Early extraction lessens the risk that your teen will experience impaction or partial eruption — and the complications that often result.

An impacted tooth remains below the gum, often completely surrounded by bone. If left in place, the tissue sac around it can fill with fluid, becoming a cyst. Such cysts can hollow out the jaw, resulting in permanent damage to other teeth, the jawbone and even the nerves of the face and lips. Worse yet, tumors may develop that require complex surgery to remove.

Likewise, a partially erupted tooth — one that only comes in part way — stands a much greater chance of infection than a tooth that comes in completely. Partially erupted third molars threaten the health of adjacent teeth and can push an entire row of teeth out of line as they grow in.

✪ Did you know?
Complication rates are much higher for wisdom teeth removed from older adults.

Keep an eye on third molars

So how likely is it that there won't be enough room for third molars in your child's mouth?

"It varies by population, but in areas where the water is fluoridated and there is good preventive dental care available, 80% or more of wisdom teeth will have to be removed," says Louis K. Rafetto, DMD, an oral and maxillofacial surgeon, or OMS, based in Wilmington, Del. Dr. Rafetto is a member of the American Association of Oral and Maxillofacial Surgeons' Third Molar Task Force, which has developed detailed recommendations to help your dentist and surgeon determine when wisdom teeth should be removed.

These recommendations call for monitoring development of the four third molars from the early teens to early adulthood. Using x-rays and physical examinations, your dentist and an oral and maxillofacial surgeon can usually spot problems before painful complications arise.

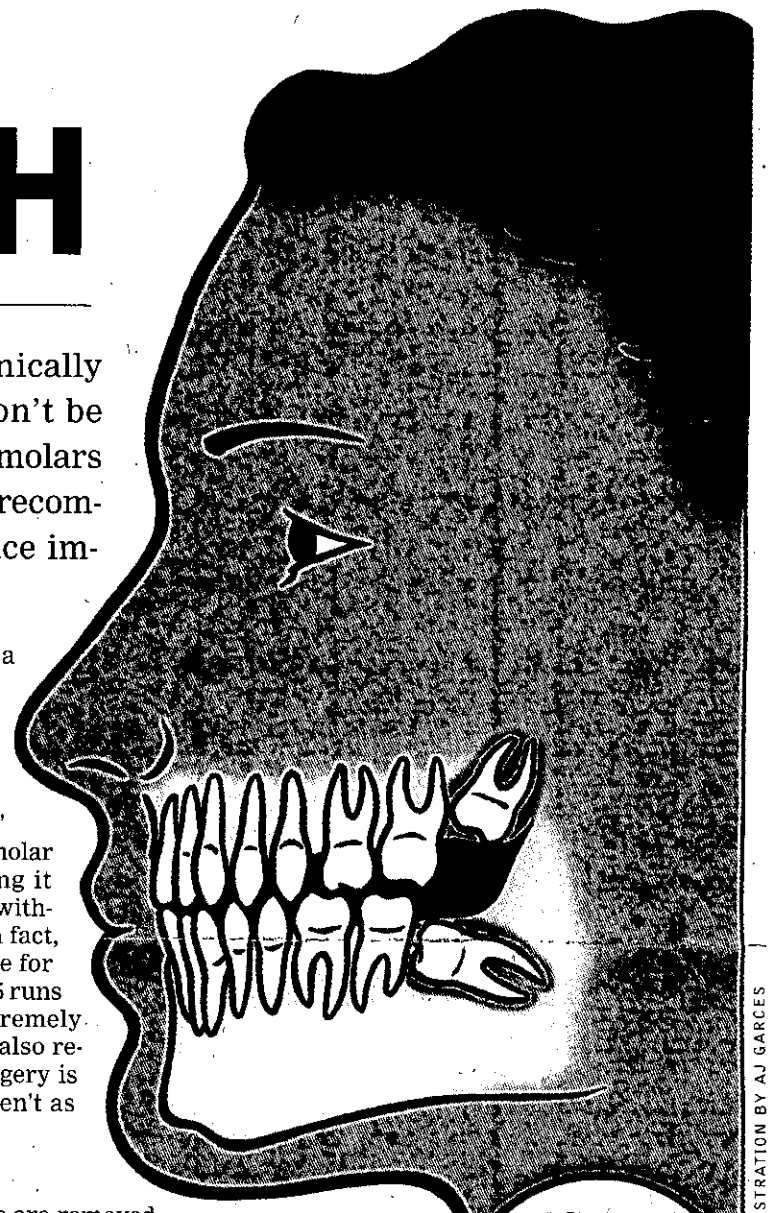
Should these exams suggest wisdom teeth be removed, it's best to do it as early as possible, says Robert T. Lindner, DDS, a Greensburg, Pa.-based oral and maxillofacial surgeon who is also a member of the AAOMS Third Molar Task Force. "There's less chance of complications with a younger patient."

That's partly because third molar roots continue to grow, making it more difficult to remove them without disturbing other tissues. In fact, the incidence of nerve damage for third molar removal after age 35 runs as high as 10%, while it is extremely rare for teenagers. Teenagers also recover a lot quicker and the surgery is easier because their bones aren't as dense, Dr. Rafetto explains.

What to expect

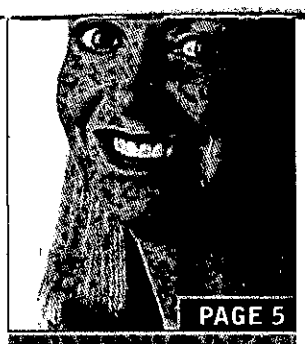
Generally, all four third molars are removed at once. The procedure is usually done in an office setting under sedation and local anesthesia, Dr. Lindner says. After surgery, patients recover for about an hour and then go home. "There's usually swelling and moderate discomfort for a few days afterward, but pain medication takes care of it."

Removal of wisdom teeth by oral and maxillofacial surgeons has become so common that it's practically a right of passage for teenagers in the United States. "A lot of my friends have had it done," says 16-year-old Kayla Wittich of Wausau, Wis., who recently had her wisdom teeth removed. "It wasn't nearly as bad as I thought it might be. My doctor was very nice and with the medicine I didn't feel or remember a thing. It was awesome."



EARLY REMOVAL of impacted wisdom teeth can prevent pain, crowding of existing teeth, infection and even tumors.

ILLUSTRATION BY AJ GARCES



PAGE 5

Also inside

WATCH YOUR MOUTH FOR CANCER
Self-exam guide.
Page 4

NEW FACE, NEW YOU
Corrective jaw surgery can offer a new lease on life.
Page 5

IN SPORTS
Joe Garagiola chews out spit tobacco.
Back page

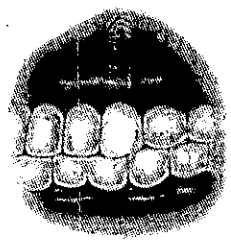
So long, dentures and bridges

Dental implants are here to stay

Not many years ago, when you lost permanent teeth you had two replacement choices: dentures or bridges. But dentures can fit poorly, causing pain and difficulty chewing and speaking. And there's nothing like waking up to your teeth in a glass of water to make you feel old.

While bridges reside in your mouth 24/7, they can create other problems. Installing bridges usually requires grinding down and capping adjacent teeth. That exposes otherwise healthy teeth to decay and gum disease — not to mention the extra stress of supporting a replacement tooth. And bridges typically last no more than seven to 15 years.

Dental implant



A more "natural" alternative

Today there's a better choice — dental implants.

Because they replace the tooth's root as well as its visible crown, implant-mounted replacement teeth are far stronger, more comfortable and usually much longer-lasting than dentures, bridges or single crowns.

"Implants directly stimulate the jaw bone. Implants help prevent the loss of bone, chronic denture sores and additional tooth loss often associated with dentures," explains Michael S. Block, DMD, an oral and maxillofacial surgeon at the Louisiana State University School of Dentistry who has also organized several AAOMS seminars on dental implants.

In most cases, placing dental implants is a two-part process.

During the first phase, an oral and maxillofacial surgeon places a titanium implant about the size of a natural tooth root directly in the jawbone. The implant is then covered with gum tissue and allowed to bond with the bone for three to six months. A temporary removable tooth or denture is usually fitted to fill the space.

Once the implant has securely bonded to the bone the second phase begins. The implant is uncovered and a post is attached that protrudes through the gum, much as natural teeth do. A restorative dentist caps it all off with a permanent crown.

The result is a replacement tooth that looks and acts just like the original. You care for it the same way too: regular brushing, flossing and professional cleaning are all that's needed.

Implants can also be used to anchor partial bridges or removable dentures, offering better fit and stability than dentures supported by natural tissue alone.

More than **90%** of dental implants remain in place for 20 years or more.

Implants have successfully been placed in people ranging from age 15 to over 100.

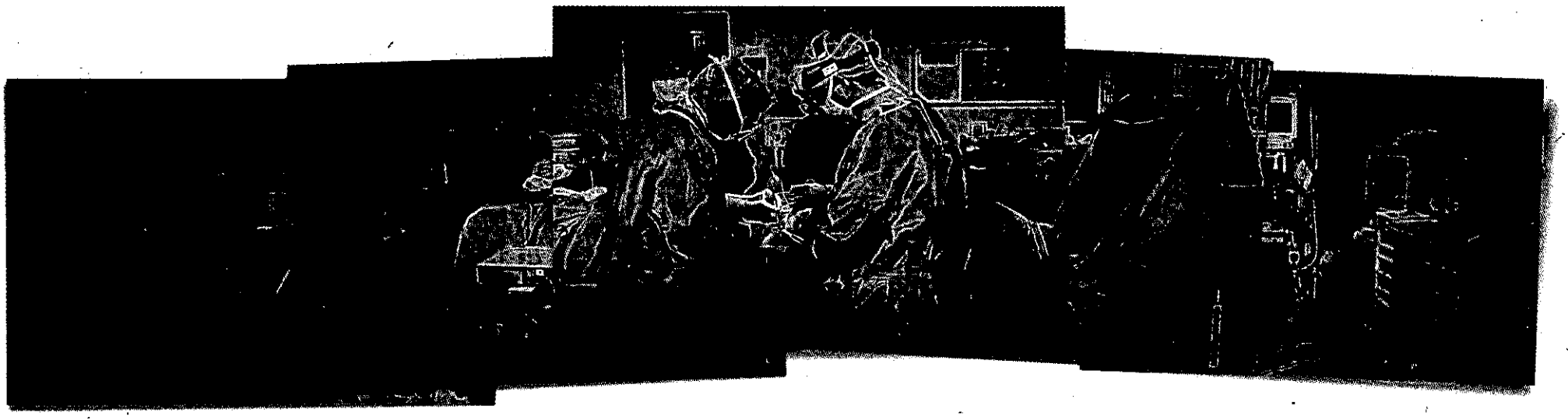
But does it hurt?

Getting an implant is generally less painful than having a tooth pulled, says Gilbert R. Triplett, DDS, PhD, an oral and maxillofacial surgeon at the Baylor College of Dentistry in Dallas. "My patients often tell me 'you gave me pain medicine but I didn't need it.'" Swelling, bruising and moderate discomfort are the most common post-implant problems. They generally clear up within a few days.

Overall, dental implants have a spectacular success rate. More than 90% of implants placed 20 years ago or more are still in place. "If the surrounding tissues remain healthy, implants have a potentially unlimited life span," Dr. Triplett says.

Dr. Block expects implants will continue to grow in popularity. "For most people they are a superior tooth replacement option."

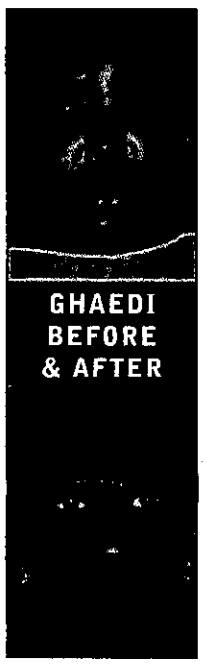
ORAL AND MAXILLOFACIAL SURGEONS CORRECT ALL KINDS OF CONDITIONS OF THE FACE, JAWS AND MOUTH.



IT'S ALL IN A DAY'S WORK FOR ORAL AND MAXILLOFACIAL SURGEONS

Saving faces

The last thing Golpar Ghaedi remembers about her accident is trying to hang onto the hood of her careening SUV. Struck from behind, she had been thrown through the windshield of her truck as it rolled down an embankment and onto a Chicago expressway. But memory is merciful. What Ghaedi doesn't recall is hitting the pavement face first, breaking virtually every bone in her face.



GHAEDI BEFORE & AFTER

"My mother tried to keep me away from mirrors in the hospital," Ghaedi says. But as she awaited surgery last November, the 23-year-old caught a glimpse of herself in a glass door. "I was afraid I would never look the same."

Enter oral and maxillofacial surgeon, or OMS, Mark J. Steinberg, DDS, MD, of Chicago's Loyola University Medical Center. In a single 15-hour operation, he reconstructeded Ghaedi's skull, cheekbones and jaw, repaired a shattered eye socket with an implant, and, with assistance from a neurosurgeon, examined bone fragments that had penetrated Ghaedi's brain. With no evidence of brain damage, they left the shards in place rather than risk disturbing delicate brain tissue to remove them.

The surgery was a success. Not only has Ghaedi recovered full use of her jaws and facial muscles, she also regained her good looks. "I thought I would have huge scars on my face, but there are only a few small ones you can barely see," she says. "I am very pleased with the results."

She was surprised to learn of Dr. Steinberg's specialty. "I thought a plastic surgeon would be working on my face. I didn't realize he had a dental background until after the surgery. I didn't know oral surgeons did this."



PHOTOS BY RUSSELL McGONAGLE

The real ER

Injure your face and chances are an oral and maxillofacial surgeon, like Dr. Mark J. Steinberg will do the repairs. He heads the OMS training program at Chicago's Loyola University Medical Center.

Four years of hospital training

Dr. Steinberg's role in trauma surgery is not unusual. "Trauma management is involved in 35% to 40% of our training," notes Douglas P. Sinn, DDS, chair of the division of oral and maxillofacial surgery at the University of Texas Southwestern Medical Center in Dallas. In fact, Level I Trauma Centers are required to have oral and maxillofacial surgeons on staff.

Before specializing in oral and maxillofacial surgery, OMSs must complete four years of hospital training in internal medicine, general surgery, plastic surgery, neurosurgery, and ear, nose and throat surgery. Some complete an additional two years of training in which they receive a medical degree, though most enter practice following residency training. "What matters isn't the degree, it's the surgical training," Dr. Steinberg says.

In addition to trauma, OMSes routinely remove complex tumors and repair congenital deformities, such as cleft palates. These surgeries require extensive reconstructive techniques, including bone grafts and implants. They use cutting-edge technologies, such as cryosurgery in which a super-cooled probe is inserted after a tumor is removed, preventing the return of cancer by freezing any remaining cancer cells. They also reconstruct soft tissues and do elective cosmetic procedures on the face, including the nose, lips, palate and ears.

Dental training, which emphasizes jaw alignment and

LESS PAIN, MORE GAIN THROUGH RESEARCH

Less pain. Quicker recovery. Smaller scars. Stronger bones. These are benefits patients enjoy from advances in oral and maxillofacial surgery over the last few years. Here are a few examples:

Level I trauma centers are required to have oral and maxillofacial surgeons on call. Dr. Sinn has repaired facial injuries caused by everything from gunshots to being gored by bulls. "I'm from Texas and there are a lot of rodeo injuries here."

In many parts of the country, these specialists do the lion's share of surgery for head and face injuries. "We are required to be able to treat the whole facial skeleton and soft tissues," says Mark R. Stevens, DMD, a Miami-based OMS whose group takes trauma call at Jackson Memorial Hospital, one of the nation's premier trauma centers.

Oral and maxillofacial surgeons gain their surgical skills through a four-year hospital residency. They train alongside medical doctors in disciplines including interDental training, which emphasizes jaw alignment and correcting the bite, is essential in doing complex reconstructions, Dr. Stevens says. "If you get the bite right, you have a big part of the puzzle solved. It helps you put the fractured bones back in the right place."

Dental training also emphasizes working inside the mouth. The more repair work that can be done from inside the mouth, rather than through external incisions, the fewer visible scars — a big plus for patients.

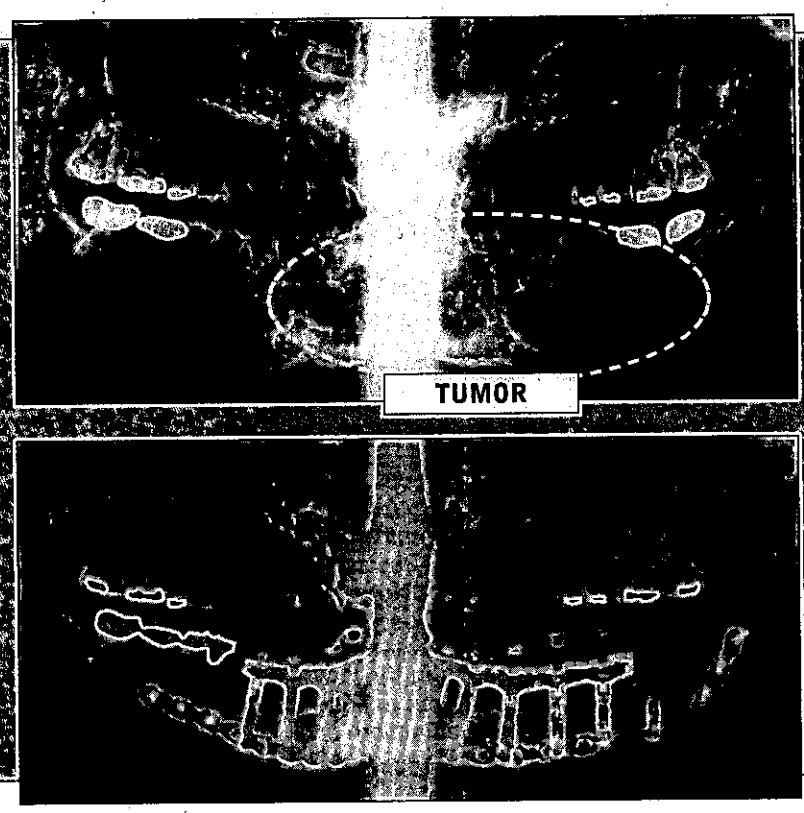
Many of these techniques are used in elective cosmetic surgery. Advances in technologies such as lasers make it possible to smooth the skin and minimize scarring.

"Function and cosmetics go together," Dr. Sinn points out. "The best outcome is to have both."

A NEW JAW

Ravaged by cancer, rebuilt by doctors

Extensive bone grafts and dental implants were used to rebuild this jaw after a large tumor was removed. The tumor is visible as a dark shadow on the top x-ray to the right, which was taken before surgery. The x-ray below it shows the metal plates used to hold in place the bone graft used to reconstruct the jaw. Implants that were used to replace lost teeth are also clearly visible.



Promotion of tissue growth. Artificial bone proteins, as well as growth factors drawn from the patient's own blood, promote quicker bone growth and healing, making bone grafting a more reliable and flexible option in reconstructing faces. DNA transfer techniques aid wound repair and recovery. And new surgical appliances guide the natural growth process to lengthen bones that would have required extensive reconstruction and grafting just a few years ago.

New materials. OMSes have mostly eliminated the second surgery most children once underwent to remove screws and plates used in reconstructive surgery. Hardware is now made from advanced materials that are dissolved and absorbed by the body over time.

Minimally invasive surgery. New fiber optic instruments make it possible for OMSes to perform complex surgery through very small incisions from inside or outside the mouth. Quicker recovery, less pain and smaller, if any, visible scars are the result.

One-day implants. Rather than wait six months between receiving a dental implant and getting a replacement tooth, some patients can walk out with a new tooth the same day an implant is installed. Advances in implant design and new installation techniques make it possible.

Cosmetic surgery. Advances in computer graphics programs allow patients to see how they'll look after surgery. New laser techniques smooth skin and reduce scarring for a better aesthetic outcome.

ORAL & MAXILLOFACIAL SURGERY

Much more than extracting teeth

By Donald F. Booth, DMD, and Francis P. DiPlacido, DMD

As leaders of the American Association of Oral and Maxillofacial Surgeons, we're often asked just what exactly oral and maxillofacial surgeons do. Most people know us as the doctors who extract wisdom teeth. We do that and much more.

Reading this publication has probably given you a better idea of the broad scope of oral and maxillofacial surgeons, or OMS, activities and procedures. Now here's the official definition from the American Dental Association:

"Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial region."

In plain English, that means OMSes are trained to do just about any surgery or cosmetic procedure to correct just about any kind of problem with the mouth, jaws, facial structures and neck. We do everything from correcting cleft palates to rebuilding jaws, cheeks, noses, eye sockets and foreheads damaged in accidents. We remove complex tumors as well as impacted and nonrecoverable wisdom teeth. We also do other complex dental extractions. We do bone grafts and dental implants to restore jaws. Using the same implant technology, we place supports for prosthetic ears, noses and even eyes and eyebrows. Much of our work involves cosmetics. Whether it is following reconstructive surgery or as elective cosmetic procedures, we change the profiles of faces, reshape noses and remove extra facial tissue.

As with any surgical specialist, dental or medical, OMSes receive rigorous training. It starts with four years of dental school in which candidates learn general dentistry. Depending on the school, they earn a DDS (doctor of dental surgery) or DMD (doctor of dental medicine) degree.

After earning a dental degree, prospective oral and maxillofacial surgeons move on to a hospital-based residency program that lasts at least four years. Competition is intense for these OMS training slots — only about 170 are available each year and most programs will only consider candidates in the top 10% of

What oral and maxillofacial surgeons do

- Provide safe and effective office anesthesia.
- Extract impacted and nonrestorable teeth (dentoalveolar surgery)
- Replace lost teeth (dental implants)
- Perform corrective jaw surgery (orthognathic surgery)
- Remove complex tumors (oncologic surgery)
- Rebuild faces damaged by injury or disease (reconstructive surgery)
- Relieve jaw pain (TMJ surgery)
- Perform cosmetic surgery of the face, jaws and neck

SAFE AND EFFECTIVE, THE CORNERSTONE OF OUTPATIENT SURGERY

Office anesthesia

There was a time when a shot of whiskey and a bite on a bullet were the standard for surgical pain control. How much pain you could endure was often a determining factor in how extensive surgery could be or even whether you got it at all.

There's been a whole lot of progress since then.

Today, patients routinely undergo everything from tooth extractions to implant placement and even the occasional corrective jaw surgery — with no pain and no memory of the procedure — right in the oral and maxillofacial surgeon's office. Advanced office anesthesia techniques make it possible.

These techniques also make office anesthesia safe. While the extremely rare office surgery adverse outcome may grab the headlines, the real news is that office anesthesia is administered without incident thousands of times daily, and is at least as safe as anesthesia performed in a hospital setting.



Preparation makes perfect

This remarkable safety record is no accident. It's the result of years of specialized training, state dental board regulation, office standards development, rigorous onsite inspection programs and a team approach to managing anesthesia, says Michael J. Stronczek, DDS, a Fort Wayne, Ind.-based OMS, who is the incoming chair of the American Association of Oral and Maxillofacial Surgeons' Committee on Anesthesia. "If you're going to do anesthesia in the office you have to be well-prepared."

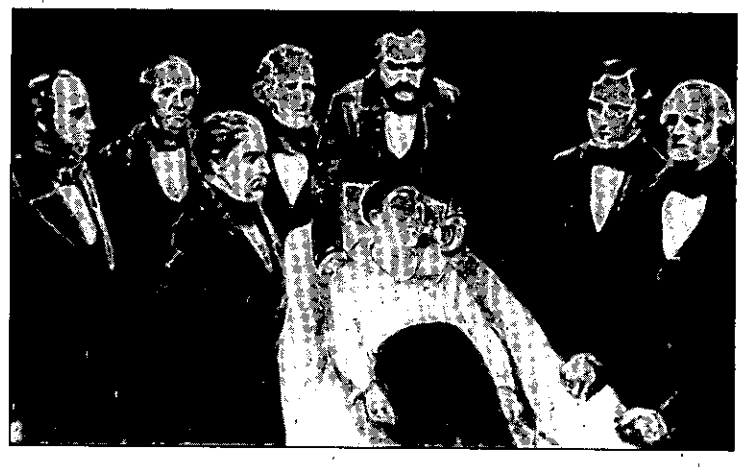
That preparation starts with residency training. During the additional four-years of hospital training that dentists undergo to become oral and maxillofacial surgeons, four or more months are spent on the medical anesthesia service. No other medical specialists (except anesthesiologists) spend as much time training in anesthesiology. In addition, residents provide anesthesia services for adults and children throughout their four years of training.

Oral and maxillofacial surgeons also complete certification in advanced cardiac life support, so they are prepared to assist a patient in the rare case when an anesthesia problem does occur.

Once in practice, OMSes must comply with extensive office anesthesia standards developed and constantly reviewed and updated by the AAOMS and state dental boards. These standards include using anesthesia monitoring equipment, such as pulse oximeters to measure the amount of oxygen in the patient's blood, and cardiac life support equipment. The standards also require OMSes to have assistants specially trained in anesthesia and life support on the anesthesia team. The AAOMS offers anesthesia assistant training programs ensuring assistants are prepared to provide optimum care.

To ensure that OMSes keep their anesthesia skills up to date, office anesthesia is subject to strict oversite by state regulators. Most states require OMSes to obtain anesthesia permits and submit to periodic office inspections to retain their permits. These inspections include a review of compliance with office anesthesia standards, condition and calibration of monitoring equipment, and an assessment of the OMS' anesthesia skill.

In many states, the state inspectors are them-



Then and now

Oral surgeon William P. G. Morton demonstrates anesthesia for the first time in 1846. A modern anesthesia team (top) includes an oral and maxillofacial surgeon directing assistants trained in anesthesia and life support, using sophisticated monitoring equipment.

While local anesthesia is sufficient to block the pain of most oral and maxillofacial procedures, patients usually want something more, Dr. Stronczek says. "What I often hear from patients is 'I don't want to know what you're doing or remember what happened.' "

OMSes work with patients to ensure an appropriate level of sedation. Depending on the patient's health, level of anxiety and the procedure, choices range from mild sedation, in which the patient may still be aware of what is happening but doesn't care; to deep sedation, where the patient is responsive but doesn't remember what happens; to general anesthesia, in which the patient is completely unconscious during the procedure. It's up to the doctor and the patient to decide the best course.

In any case, anesthesia in the OMS office is at least as safe as in a hospital. Using local anesthetics in conjunction with sedative agents reduces the total amount of anesthetic needed, reducing risk and speeding recovery. Patients recover quickly and go home in a short time following surgery.

As technology and insurance payment rules drive more and more surgery to an outpatient setting, many of

their dental school class.

During residency, OMSes train alongside future anesthesiologists, internists, general surgeons, plastic surgeons, ear, nose and throat surgeons, and emergency physicians. Some complete an extra two years of training in an integrated OMS/MD program to obtain a medical degree. Many take fellowships for extra training in advanced surgical techniques.

Upon completion of the minimum four years dental school and four years hospital training OMSes become full members of the health care team. Dentists and physicians alike refer patients to OMSes for diagnosis and treatment of oral and maxillofacial problems. And OMSes share call with medical and dental colleagues in trauma centers and local hospitals.

Most of all, OMSes are dedicated to patient welfare. Whether it's an injury, congenital defect or disease of the face, jaws or mouth, you can count on an OMS to provide a high standard of care.

Drs. Booth and DiPlacido have both served recently as presidents of the American Association of Oral and Maxillofacial Surgeons.

American Association of Oral and Maxillofacial Surgeons

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selves practicing OMSes. "It's an opportunity for both the inspector and the inspectee to pick up tips on the latest techniques," says Paul G. Sims, DDS, a Butte, Mont.-based OMS who heads the AAOMS Committee on Anesthesia. The goal is to ensure that OMSes are providing the safest and most appropriate anesthesia for their patients.

the techniques OMSes have developed are being adopted by other specialties, including ear, nose and throat surgeons, plastic surgeons, and orthopedic surgeons. "We've been doing this for years," Dr. Sims notes. "The other specialties are just getting started."

KEY QUESTIONS

The American Association of Oral and Maxillofacial Surgeons recommends you ask the following questions before having a procedure done:

1. What are the doctor's credentials?
Make sure your surgeon is properly trained. Membership in the American Association of Oral and Maxillofacial Surgeons ensures your doctor has extensive training in surgery and anesthesia. To become an AAOMS fellow, surgeons must be board certified.

2. Is your doctor trained and experienced in the procedure you seek?
Your chances of a good surgical outcome are better with doctors experienced in the particular procedure you are undergoing. Oral and maxillofacial surgeons are uniquely qualified to perform routine and complex procedures. Ask your family dentist or physician for an appropriate referral.

3. Are there any patients with whom you can speak?
Firsthand references can help you assess how your surgeon's skills, follow-up and manner meet with your expectations.

4. Is the procedure covered by medical or dental insurance?
Many oral and maxillofacial procedures are covered by one or the other or both. Be sure to discuss this with your surgeon or office staff. It could affect your out-of-pocket expense. Some cosmetic and elective procedures are not covered.

5. What are the risks involved with the procedure?
Risk is inherent in all surgery. The AAOMS requires surgeons to discuss the risks and benefits of surgery and inform patients of treatment options before surgery.

6. How long is the recovery period?
Recovery periods vary greatly by procedure and the health of the patient. Be sure to discuss this with your surgeon.

7. Where will the procedure be performed?
Most procedures can be safely and comfortably done in an office setting. But sometimes a hospital is indicated.

AAOMS
the symbol of excellence

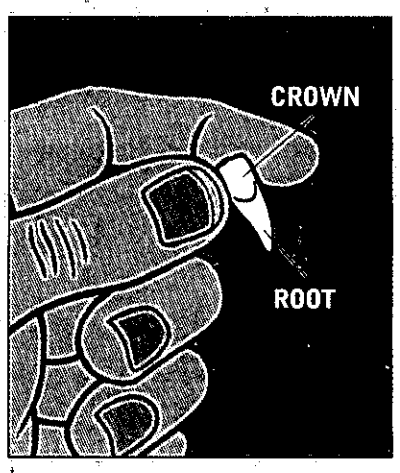
Looking for an oral and maxillofacial surgeon? The symbol of the American Association of Oral and Maxillofacial Surgeons is your assurance of excellence. While other doctors may perform some aspects of oral and maxillofacial surgery, only members or fellows in good standing with the AAOMS may display the AAOMS symbol. It ensures that the OMS you choose is fully trained and certified in oral and maxillofacial surgery. To become a fellow, OMSes must also be board certified by the American Board of Oral and Maxillofacial Surgery. The AAOMS symbol guarantees that your OMS complies with rigorous continuing education requirements and submits to periodic office inspections, ensuring that all procedures and office personnel meet national standards. The AAOMS symbol. Look for it.

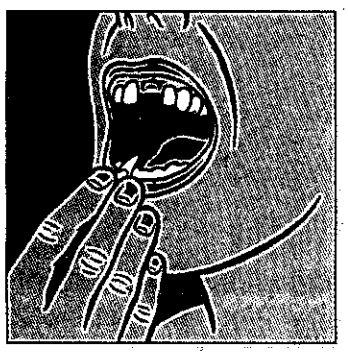
PULL-OUT SECTION

First Aid Tips

KNOCKED-OUT TEETH

● Seek immediate help from an oral and maxillofacial surgeon. Most knocked-out teeth can be saved if cared for properly and reimplanted within 40 to 60 minutes. Call your family dentist for an emergency referral or go to a hospital emergency department where the on-call OMS can assist you.
● Find tooth and hold by crown only.





● Rinse tooth; do not rub. Avoid contact with root.
● Replace tooth in socket, cover with gauze or tissue, and bite down to stabilize it. Or store tooth temporarily in cold milk or salt water, or between cheek and gum.
● Do not allow tooth to dry out.

BROKEN TOOTH

● Clean injured area; apply ice.
● Save tip of tooth. Contact your family dentist immediately. He or she may be able to reattach the broken part.

FACIAL CUTS

● Cover wound with a clean dressing. Apply pressure.
● Do not remove blood-soaked dressing.
● Add additional cloth and apply pressure.
● Go to a hospital emergency department, where the oral and maxillofacial surgeon on call can assist you. Often, broken jaws or other injuries inside the mouth must be repaired before facial cuts can be closed.

CUTS INSIDE THE MOUTH

● Gently rinse mouth with cold water.
● Bite on gauze, clean cloth or tissue and apply pressure to the wound.
● Go to a hospital emergency department, where the oral and maxillofacial surgeon on call can assist you. Often, an OMS must address injuries inside the mouth before external injuries can be repaired.

ILLUSTRATIONS BY AJ GARCES

JAW INJURY

The U-shaped lower jaw often suffers multiple breaks. An upper jaw fracture may cause visible distortion of the face.

If your teeth fit together normally when you close your mouth:
● Apply ice to control swelling.
● Take ibuprofen or similar pain medicine to control pain.
● Restrict diet to soft foods.
● If there is no improvement in 24 hours, call an oral and maxillofacial surgeon for an evaluation.

If your teeth do not fit together normally when you close your mouth:
● Consult an oral and maxillofacial surgeon immediately.
● Gently align the jaws.
● Immobilize the jaw by wrapping a cloth or gauze bandage under the chin and tying it securely over the head.
● Apply ice to control swelling.



BROKEN NOSE

● Gently pack nose with gauze or tissue.
● Apply ice. Do not blow nose.

HEAD AND NECK INJURY

● Do not move victim without professional assistance.
● Immobilize head by placing rolled towels on either side.



● Keep victim warm to reduce risk of shock.
● If unconscious, clear mouth. Hold tongue forward to maintain open airway.

Under the weather?

MAYBE AN OMS CAN HELP

Your jaws, face and mouth are made up of countless bones, muscles and soft tissues. When they're all working together as they should, you feel good. But even a small problem in any one of them can cause pain, disturb your sleep, or even threaten your life. Below are symptoms that may indicate a problem your oral and maxillofacial surgeon can evaluate and treat.

Chronic facial pain or headache

Facial and head pain can result from several problems. Grinding your teeth is one. This often can be corrected with physical therapy and mouth splints. Misaligned jaws or displaced cartilage in the jaw joints are other possible causes. Either can place unusual stress on muscles, nerves and bones, leading to tension and pain. These problems can also be treated with physical therapy and medicine, though surgery may be necessary.

Snoring and sleep apnea

While there are many causes of snoring, problems with the soft tissues in the mouth and throat are often the culprits. This can be treated with oral appliances or surgical reduction of excess palate tissue. Snoring may also indicate sleep apnea, though sleep apnea may occur without snoring. Sleep apnea is a serious condition in which the airway is obstructed during sleep, leading to constant awakenings to clear the airway. If someone close to you has noticed you stop breathing during sleep or often wake up abruptly, gasping for air, consult your oral and maxillofacial surgeon for evaluation and treatment.

Jaw pain and popping

Noise and pain in the jaws and limited jaw mobility while chewing and talking is often caused by internal damage to the joints connecting the jaw to the skull. Often the discs that cushion the temporomandibular joints slip out of place or wear over time. Treatment options range from medication to bite

Watch your mouth for cancer

While shaving on Thanksgiving in 1996, Louie F. Peede, DMD, noticed an unusual shadow under the right side of his jaw. The small lump he found there turned out to be cancer. Within a few weeks, the Denver oral and maxillofacial surgeon underwent surgery to remove his cancerous tonsils and 52 lymph nodes from his jaw and neck. Fortunately, the cancer had not spread beyond the one swollen lymph node. Dr. Peede underwent six weeks of radiation therapy, and the cancer has not reappeared.

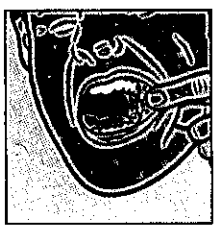
But due to the amount of muscle removed during surgery, Dr. Peede was off work for two years. He's not bitter, though. "It's lucky I had it checked within two weeks," he says. If he hadn't? "Ultimately I would have died."

Dr. Peede recommends thoroughly checking your mouth, jaws and neck at least once a month for signs of oral cancer. He also recommends a quick check every day when brushing your teeth. "What you're looking for is anything that wasn't there the day before," Dr. Peede says. Note any lumps, bumps, sores or discolored spots. And if you find something, have it checked immediately by an oral and maxillofacial surgeon.

Also, when visiting your family dentist ask for a cancer exam as part of your regular checkup. If your dentist finds anything suspicious ask for a referral for a comprehensive exam by an oral and maxillofacial surgeon.

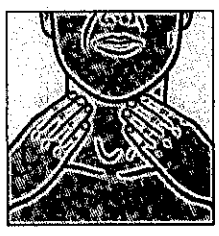
How to conduct a self-exam for oral cancer



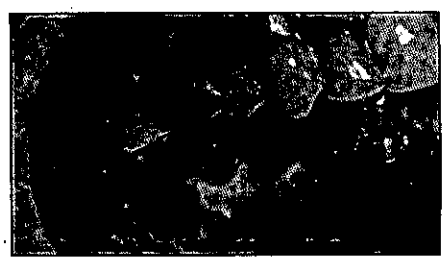


- Remove any dental appliances.
- Look and feel inside your lips and the front of gums.
- Tilt your head back to examine and feel the roof of your mouth.
- Pull your cheek out to see the inside of it and the back gums.
- Stick out your tongue, look at all surfaces.
- Feel for lumps or enlarged nodes (glands) in both sides of the neck and under the lower jaw.





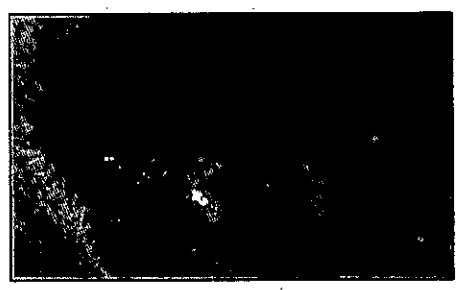
WHAT IT LOOKS LIKE



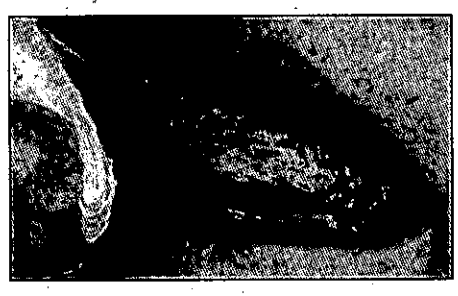
Whitish spots on gums or lips. Have it checked.



Dark spot on lip. Could be a bruise or cancer. Have it checked.



Swelling of the lip. This salivary cyst is benign, but should be removed.



Whitish spot on tongue. Could be cancerous or precancerous. Check it.

Overbite or underbite

Overbites and underbites are often caused by growth problems in the upper jaw, lower jaw, or both. Beyond their generally negative impact on appearance, misaligned bites can cause problems chewing and speaking, and can lead to premature tooth wear. Braces alone may be enough to alleviate the problem in many cases, but surgery is sometimes necessary.

Tooth pain

Tooth decay is the most common cause of tooth pain. But if your family dentist can find no obvious decay, pain could be due to other problems, including impacted teeth, tooth grinding or cysts. Ask your family dentist for an appropriate referral to an oral and maxillofacial surgeon, who can evaluate and treat these conditions.

Oral or facial swelling

Swelling in the mouth and face may be caused by many problems, including blocked salivary glands, erupting wisdom teeth, facial infections, cysts or even tumors. Using x-rays and an oral exam, an oral and maxillofacial surgeon can identify the cause and treat the problem.

Lumps, bumps or sores in mouth

Oral growths, sores, lumps or bumps could be signs of cancer and should be monitored closely. If they don't go away within two weeks, or if they go away and come back, or if they bleed, they should be examined by an oral and maxillofacial surgeon, and possibly sampled for laboratory analysis.

For more information

Call 1-(800)-IMPLANT *(467-5268)* or visit our Web site at *www.aaoms.org*

A Mission of MERCY

Word spreads quickly in rural Honduras when U.S. dental care volunteers arrive. People walk for hours or even days over gravel mountain trails — often barefoot — to reach the clinic during the two weeks it is open.





Now he can smile

Cleft palates are common in many parts of the world. Repairing them is a major emphasis of overseas missions by U.S. oral and maxillofacial surgeons.

"The average family income in the area we visit is $300 to $400 per year," explains J. Thomas Soliday, DDS, a Gaithersburg, Md.-based oral and maxillofacial surgeon who has led missions to remote regions of this Central American country every year for the last five years. "They can't afford shoes for their children until their feet stop growing, and sometimes not even then."

Dental care, even basics such as daily brushing and fluoridated water, is also largely unavailable or unaffordable for most residents. As a result, tooth decay is rampant. "Some of these people open their mouths and there is nothing left but roots," Dr. Soliday says. "The pain they go through has got to be excruciating."

Dr. Soliday's goal is not just to relieve that pain, but to prevent it. His team of general dentists and oral and maxillofacial surgeons perform hundreds of extractions, fillings and other surgeries. In addition to oral surgeons and general dentists, Dr. Soliday recruits dental hygienists to educate residents on proper dental care and to distribute toothbrushes, toothpaste and other basic supplies. "We hope to change their outlook on life so they don't expect to lose all their teeth by the time they are 35."

Dr. Soliday, whose trips are sponsored by Medical Ministry International, is just one of hundreds of oral and maxillofacial surgeons who donate their time and expertise to missions all over the world. Most also pay for the surgical supplies they use and for their transportation and room and board.

In addition to setting up what amount to MASH units in remote areas to perform basic care, many of these missions work with established hospitals to do complicated reconstructive surgery, such as cleft lip repair and removal of cysts and tumors from the jaws, face and neck.

The goal is usually twofold, says Robert B. MacIntosh, DDS, a Binghamton Farms, Mich.-based oral and maxillofacial surgeon. Dr. MacIntosh has made at least one, and often three or four, overseas trips a year for the last 20 years, and works closely with Health Volunteers Overseas. The first goal is to perform surgery that may be beyond the skills and training of local surgeons. The second, and perhaps more important, is to train local dental and medical professionals in advanced surgical techniques so they can carry on when the mission leaves. "Over time we try to build up enough local expertise to put ourselves out of business."



VOLUNTEERS REPAIR AND EXTRACT TEETH IN RURAL HONDURAS

20 years behind

Vietnam is a good example of a country that desperately needs its surgical capabilities updated, says Leonard B. Kaban, DMD, MD, chair of oral and maxillofacial surgery at the Harvard School of Dental Medicine. "You have to remember that Vietnam was closed to the West from 1975 to 1996. The technological and biological advances in those 21 years was tremendous."

Dr. Kaban traveled to a hospital in Ho Chi Minh City, formerly Saigon, on a mission led by Barry Steinberg, DDS, MD, PhD, of the University of Florida, to share surgical advances that make it possible to rebuild the face with less scarring and nerve damage.

Like many such missions, this one, which is sponsored by the Lorenz-Smeenge Foundation, has developed an ongoing relationship with local surgeons and a hospital, which is important not only to develop local talent, but to ensure that patients receive proper follow-up care.

"Each year I go back and see patients I have operated on in previous years," says Eric R. Carlson, DMD, MD, of the University of Miami, who over the last five years has developed a tumor removal program at a privately owned hospital in Jabalpur, India. Between Dr. Carlson's visits, local surgeons, led by Dr. Dhiarwani Rajesh, follow his cases. They are now so highly skilled they are taking over the program. Dr. Carlson is now working to set up shop in another location.

"These areas are highly underserved," Dr. Carlson says. "You see people walking down the street with tumors on their faces the size of basketballs. There's real opportunity to do some good."

Want to help out?

Here are some organizations active in overseas missions

Health Volunteers Overseas
P.O. Box 65157
Washington, DC 20035
www.hvousa.org

Medical Ministry International
PO Box 940207
Plano, TX 75094-0207
www.mmint.org

Face the Challenge
3140-K South Peoria #168
Aurora, CO 80014-3155
www.facethechallenge.org

CORRECTIVE JAW SURGERY SAVES TEETH, IMPROVES APPEARANCE

Better function, better look

At age 27, Coleen Mulhern-Malloy's front teeth needed caps. An underbite due to an abnormally long lower jaw was causing premature wear. "I knew I would eventually need crowns on all my teeth if I didn't do something."

Rather than accept further tooth damage, possible gum disease and increasing tooth and jaw pain, Mulhern-Malloy chose corrective jaw surgery. The resulting improvement in her bite not only slowed tooth wear, it made it possible for the Hinsdale, Ill., resident to eat apples and other firm foods. It also greatly reduced her sensitivity to sweet, hot and cold foods.

But that's not all. "It has given me a much nicer appearance," Mulhern-Malloy says. "I wasn't unhappy with the way I looked before, but it's amazing what this has done for me."



Patients are often not just pleased, but profoundly affected by the better looks jaw correction brings, says Edward Ellis III, DDS, director of the oral and maxillofacioal surgery training program at the University of Texas Southwestern Medical Center in Dallas. "The cosmetic effect can be very potent. It's not unusual to see patients undergo dramatic personality changes after this kind of surgery."

But patients rarely choose corrective jaw surgery for cosmetic purposes alone, says Roger H. Kallal, DDS, the Chicago-area oral and maxillofacial surgeon who reconstructed Mulhern-Malloy's upper and lower jaws. "There is a cosmetic aspect to this surgery, but a jaw deformity is a functional problem as well." In addition to preventing dental problems, corrective surgery can eliminate jaw pain, speech impediments, and even snoring and sleep apnea, which can lead to heart and lung disorders.

Depending on the specific problem, corrective jaw surgery can involve the upper jaw, the lower jaw or both. Lower jaws can be shortened to correct underbites and lengthened to correct overbites. The upper jaw can also be moved backward or forward, or the angle can be adjusted to achieve the best possible bite. Bones are held in place with small internal plates and screws, usually eliminating the need to wire jaws shut.

The surgery usually takes two to four hours and requires a one- or two-day hospital stay. There is usually moderate discomfort involved. "It hurt worse to have braces because my teeth were so sensitive," Mulhern-Malloy says. Swelling can persist for a few months after surgery, though after the first few weeks it's no longer apparent outside the mouth.

The bottom line for Mulhern-Malloy? "It's better aesthetically and I have a better bite. I can chew and eat anything now."

PHOTO BY RUSSELL McGONAGLE





Before reconstruction surgery

A jutting lower jaw, causing a severe underbite, is apparent in this x-ray (above) taken before Coleen Mulhern-Malloy (left) underwent corrective jaw surgery in 1996. Mulhern-Malloy's lower jaw was moved back and her upper jaw was moved forward to correct her bite. Braces, which are often applied 12 to 18 months before jaw surgery to position teeth for bite realignment, are also evident on the x-ray.

Want to know more?

For more information on corrective jaw surgery, go to *www.aaoms.org/patient3.html*

You'll find brochures on a variety of procedures involving the jaws, face, mouth and teeth.

CORRECTIVE JAW SURGERY IS TYPICALLY DONE FROM INSIDE THE MOUTH, LEAVING FEW, IF ANY, EXTERNAL SCARS.

Just do it. But wear headgear

Bicycling, rollerblading, skiing, soccer, baseball, hockey and football are but a few of the sports in today's fitness regimen. But fitness doesn't always mean safety.

"Each year, 250,000 Americans will suffer needless facial trauma from sports injuries," says Bill Nelson, DDS, a Green Bay, Wis.-based oral and maxillofacial surgeon on staff with the Green Bay Packers. These injuries include knocked out teeth, severely lacerated lips and broken jaws. "The bulk of these injuries could be prevented with proper protective equipment."

In fact, the rates of facial injury are now lower in high-contact sports where mouth guards and face masks are required, such as football and hockey, than in lower-contact sports, such as basketball and soccer, that do not require protective equipment. Mouth guards can even prevent injury in noncontact sports, such as gymnastics and tennis.

Injury prevention not only cuts needless pain and suffering, but also cuts costs. Expenses for rehabilitating just one lost tooth are more than 20 times the price of the most expensive, professional grade, custom mouth guard. All told, injuries to players younger than 14 for 29 popular sports cost the public nearly $49 million annually.

So wear protective equipment for your smile's sake. And your wallet's.

If your child is involved in sports, consider the following:

Baseball
Fact: Nearly 60,000 facial injuries annually
Recommended equipment: Catchers mask, helmet with face guard for batters and fielders, mouth guard



Bicycling
Fact: 100,000 facial injuries annually, most in children age 5-14
Equipment: Helmet (full-face motocross-style is best), mouth guard

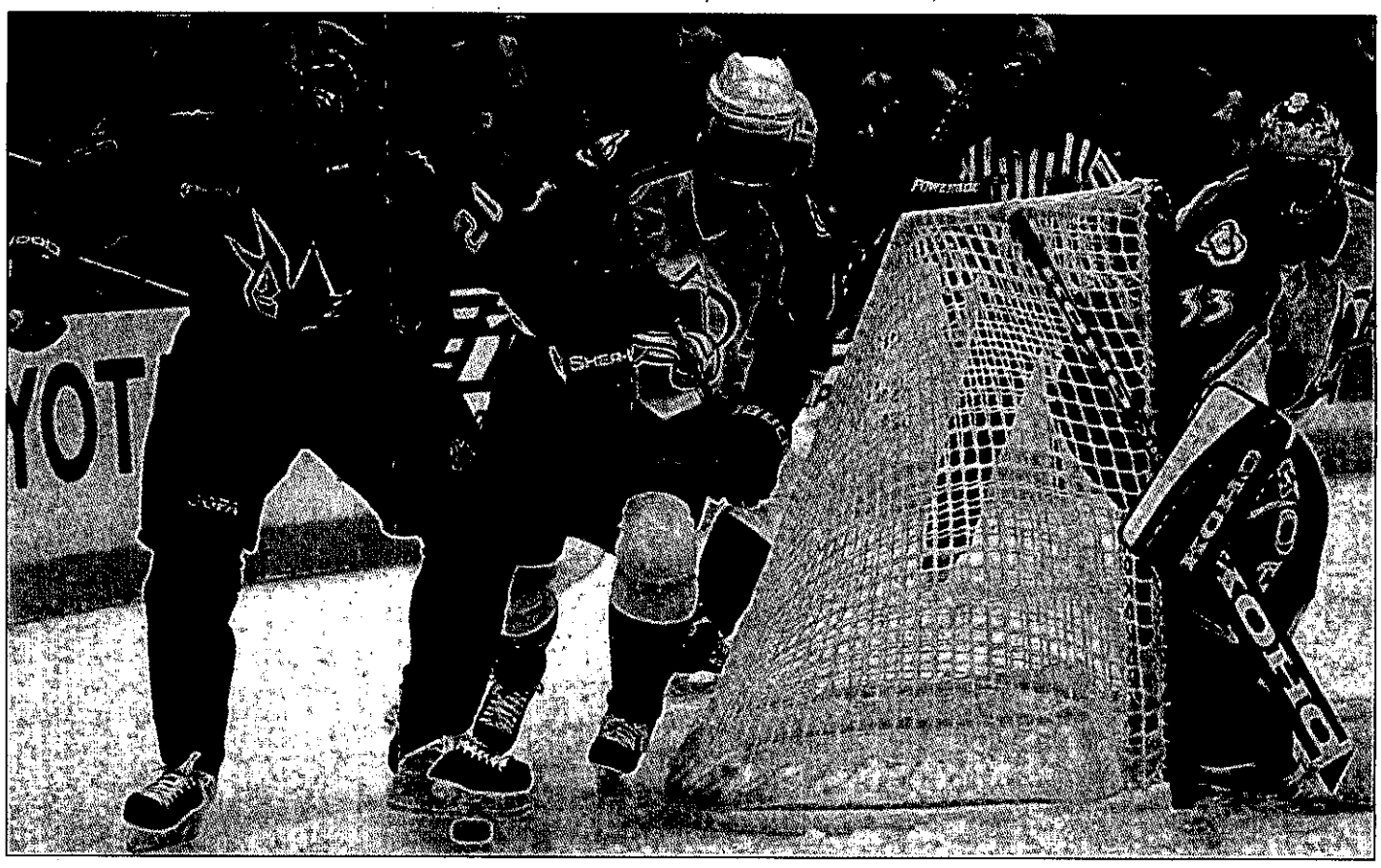


Soccer
Fact: 4,000 facial injuries annually; just 7% of players use mouth guards
Equipment: Mouth guard

Basketball
Fact: 34% of injuries involve mouth or teeth; just 7% of players use mouth guards.
Equipment: Mouth guard

Football
Fact: Less than 1% of injuries involve face and mouth; mouth guard worn by all players. *Equipment:* Helmet, face mask, mouth guard





AP/WIDE WORLD PHOTOS

BROKEN JAW?

NO PROBLEM!

On April 9, 2000, the puck stopped here. It hit Colorado Avalanche defenseman Aaron Miller's jaw, breaking it in two places. Such an injury would keep most mere mortals home from work for days, even if work involves nothing more strenuous than sitting behind a desk.

But if you ain't tough, you ain't gonna make it in the NHL. Miller was back on the ice practicing in three days. And on the fourth day he started against the Phoenix Coyotes in the first game of the Avalanche's post season. Over the next six weeks Miller played in all 17 of the Avalanche's post-season games before his team was eliminated by the Dallas Stars in the Western Conference Finals.

Of course Miller did get a little help from a pair of Denver-area oral and maxillofacial surgeons. Within four hours of breaking his jaw on a Sunday afternoon Miller was in surgery.

Though the puck struck his face on the left side, both sides of Miller's jaw were broken. That's not unusual, says Steven R. Nelson, DDS, one of the OMSes who patched up Miller. Because the jaw is shaped like a "U" with the open end anchored to the skull, the force from a blow on one side is passed around to the opposite side, often snapping it just as if it were hit directly.

We're talking serious pain here.

In Miller's case, the puck also smashed an impacted wisdom tooth in his left jaw. Dr. Nelson and his partner Beryl Hunter, DMD, MD, removed the tooth and inserted two titanium plates to stabilize the left side of Miller's jaw. A third plate was used to repair the right side.

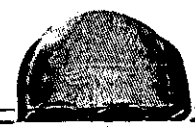
But like most of his NHL comrades, Miller bore the pain well. "These guys are very stoic," says Dr. Nelson, who, as one of the Avalanche's team oral and maxillofacial surgeons, sees a lot of injured players. Broken teeth, cheek fractures and facial lacerations are common in this rough-and-tumble game where the use of face guards is still the exception rather than the rule. "It may hurt them as much as it does you or me, but they just don't show it. They are incredible athletes with an incredible work ethic."

If Miller was in pain you couldn't tell it from his statistics. Not only did he stop his quota of shots, he scored a goal in a game against the Detroit Red Wings in the second round of the playoffs — a relatively rare event for someone playing Miller's position.

Of course, medicine helped keep the pain at bay. And the excitement of the game helped, Miller says. "It was really sore, but once you're in the game the adrenaline gets going and you don't notice it much."

Miller wore special face and mouth guards throughout the playoffs to prevent reinjuring his jaw. But he says he'll lose the shield as soon as he's fully recovered. In that he's like many of his colleagues, Dr. Nelson says. Most NHL players avoid face shields despite the risk of facial injuries.

But the tide is turning, Dr. Nelson notes. "After a player lost his eye this season, we're seeing more people wearing shields to protect their eyes."



Playing with pain

Despite breaking his jaw in two places just four days earlier, Aaron Miller, defenseman for the Colorado Avalanche (second from left above), hits the ice for the first game of the NHL playoffs. Oral and maxillofacial surgeons placed three titanium plates, restoring nearly full jaw function. Miller played a key role in bringing the Avalanche to the Stanley Cup playoffs, where they defeated the Phoenix Coyotes and the Detroit Red Wings before being ousted in the conference finals by the Dallas Stars. Miller wore a special face mask to protect his jaw during the 17 games.

A PINCH BETWEEN THE CHEEK AND GUMS CAN BE LETHAL AS A PACK A DAY

Smokeless doesn't mean harmless

Chewing tobacco causes cancer. Just ask Joe Garagiola. The renowned broadcaster and ex-major leaguer has seen dozens of friends suffer and even die from cancer of the jaw, mouth and throat. He's made it a personal crusade to eradicate chewing, or spit, tobacco from baseball — and everywhere else.

"If you don't know that cigarettes kill, you've been living in a cave for the last 20 years," Garagiola says. "But a lot of people don't know that spit tobacco is just as deadly. We've got a silent epidemic going and the only way to stop it is to get the facts out."

As chair of the National Spit Tobacco Education Program, or NSTEP, Garagiola carries that message everywhere from major league training camps to little league and community groups, breaking down the culture of tobacco use that has grown up around baseball. Often he's accompanied by colleagues who've fought cancer.

Former major leaguer Bill Tuttle was one. After 40 years of chewing and spitting, cancer ate away half his face and jaw before killing him in 1998. Ex-umpire Doug Harvey is another. The one-time voice of TV's "You Make the Call" joined the NSTEP crusade after losing half his tongue to tobacco-induced cancer in 1997.

"Cute slogans don't work. We give them the straight story," says Garagiola of his clubhouse visits. That includes graphic photos of the grotesque swelling and tissue rot that go with oral cancer as well as frank talk about things like enduring radiation burns and feeding tubes during cancer treatment.

Results of oral exams conducted by NSTEP at major league training camps this spring show the urgency of the mission. Of 401 players examined, 70% used spit tobacco. Of the 279 users, 65%, or 180, had one or more oral lesions, some of them cancerous or precancerous.

Check your mouth for cancer. **Page 4**

National statistics are just as alarming. Each year, more than 30,000 new cases of mouth and throat cancer are diagnosed. Only one-half of those diagnosed will live five years or more. About 8,000 die each year. Long-term users of spit tobacco are 50 times more likely to develop oral cancer than nonusers, and fully three-quarters of mouth and throat cancers are caused by tobacco and alcohol use.

And spit tobacco addiction is increasingly an epidemic of the young. Usage is highest among young men age 17 to 19. That's a 180-degree switch from 1970, when this age group was least likely to chew.

If there's a bright spot in this story it's that education works. Of the 279 users identified in major league training camps this year, 222 took advantage of cessation counseling to develop personal quit plans.

"It's a gross, deadly habit," Garagiola says. "If you haven't started, don't. If you are using spit tobacco, think about quitting — and get some help."



ILLUSTRATION BY DAVID M. BECK

Complete Document

Can Be Viewed

In Bill Folder

Good of HB 201

Oral and Maxillofacial Surgery

Education, Training & Scope of Practice

Education & Training in Oral and Maxillofacial Surgery

Definitions of Special Areas of Dental Practice	1
Editorial	1
Oral and Maxillofacial Surgery Terminology	1
Evolution of Dentistry and its Recognized Specialties	1
ADA Definition of Dentistry	1
What is Oral and Maxillofacial Surgery?	2
Commonly Asked Questions about Oral & Maxillofacial Surgery	2
Accredited Advanced Training Programs in Oral and Maxillofacial Surgery	2
Comparisons of Training	2
Committee on Residency, Education and Training Statement	2
Commission on Dental Accreditation / Dental and Dental Specialty Programs	2
Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery	2
Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery	2
Clinical Practice Guidelines for Oral and Maxillofacial Surgery / Cosmetic Maxillofacial Surgery	2
Oral and Maxillofacial Surgery Services in the Emergency Department	2
Guidelines to Hospital Credentialing in Oral and Maxillofacial Surgery Procedures	2
Clinical Privilege White Paper	2
Joint Oregon "Scope of Dental Practice" definition	2
As I see it ... by Paul A. Ebert	2
Peer Review Due Process or Professional Assassination?	3
American Board of Medical Specialties / 2000 Annual Report & Reference Handbook	3
Professional Practice Authority (Determining which practitioners are permitted to provide what services)	3
Continuing Competence (the role in ensuring the continued competence of health care practitioners)	3
Miscellaneous articles	4
States Adopting the ADA Definition of Dentistry	4
Editorial by Richard Carols Tatum, DDS, MPH	4
A Summary of States' Definitions of Dentistry	4
1999 OE A 598 Definition of Dentistry Law	4
Licensure of Specialists	4
Testimonials, Statements, Cases and Appeals	4

Division of Advanced Education and Professional Affairs

Voting Sheets

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

EXECUTIVE SESSION on HB 201

BILL TITLE: **relative to the definition of the practice of dentistry.**

DATE: February 11, 2003

LOB ROOM: 100 SH

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Schulze

Seconded by Rep. Dexter

Vote: 18-0 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 18-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Ray F. Langer, Clerk

OFFICE OF THE HOUSE CLERK 2003 SESSION

EXECUTIVE DEPARTMENTS AND ADMINISTRATION

Bill #: HB201 **Title:**

PH Date: 2/5/03 **Exec Session Date:** 2/11/03

Motion: ITL **Amendment #:**

MEMBER	YEAS	NAYS
O'Neil. Michael. Chairman		
Hamel. Albert W. V Chairman	1	
Langer. Rav F	2	
Goulet. Maurice E	3	
Zolla. William R		
Allan. Nelson S	4	
Dexter. Judson K	5	
Hall. Charles Q	6	
Robertson. Carl G	7	
Bergin. Peter F	8	
LaFlamme. Paul G	9	
Milligan. Robert H	10	
Field. William D	11	
Fitzgerald. James M	12	
Mavbeck. Margie	13	
Clavton. William K		
Schulze. Joan H	14	
DeJoie. John	15	
Irwin. Anne-Marie	16	
Pilotte. Maurice L	17	
Sullivan. Francis B	18	
	18	0

TOTAL VOTE:
Printed: 1/6/2003

Committee Report

COMMITTEE REPORT

COMMITTEE: **Executive Departments and Administration**

BILL NUMBER: **HB 201**

TITLE: relative to the definition of the practice of dentistry.

DATE: February 11, 2003 CONSENT CALENDAR YES ☒ NO ☐

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

The sponsoring organizations have requested that this bill be reported out as inexpedient to legislate so that they can work on a further bill, which would better define their needs.

Vote 18-0.

Rep. Joan H. Schulze
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

CONSENT CALENDAR

Executive Departments and Administration

HB 201, relative to the definition of the practice of dentistry. **INEXPEDIENT TO LEGISLATE** Rep. Joan H. Schulze for Executive Departments and Administration: The sponsoring organizations have requested that this bill be reported out as inexpedient to legislate so that they can work on a further bill, which would better define their needs. **Vote 18-0.**

Subj:	**Dental Bill**
Date:	2/10/2003 6:46:04 PM Eastern Standard Time
From:	scuradds@mindspring.com
To:	victorschulze@cs.com
Received from Internet: click here for more information	

Hi Joan,

I wanted to follow up with you regarding the "scope of practice" bill.

Apparently the disciplines involved, NH Board of Dental Examiners, NH Dental Society and NH Medical Society jumped into the legislative process before having their goals defined.

It is my understanding that the current Practice Act of Dentistry is working but does need some tweaking. The groups are now working to define what they are looking for in the bill. At that time, a new bill will be introduced.

For now, they are looking for the CURRENT LEGISLATION BE KILLED. All three groups are in agreement on this.

So if your committee could work to kill this, that would be great. (I guess the word is Inexpedient to Legislate).

Let me know if you would like more info.

Regards,

Stephen Ura

HB 201

The sponsoring organizations have requested that the bill be Reported out as Inexpedient to Legislate (Killed) so that they can work on a further bill which would better define their needs.

Joan Schulze