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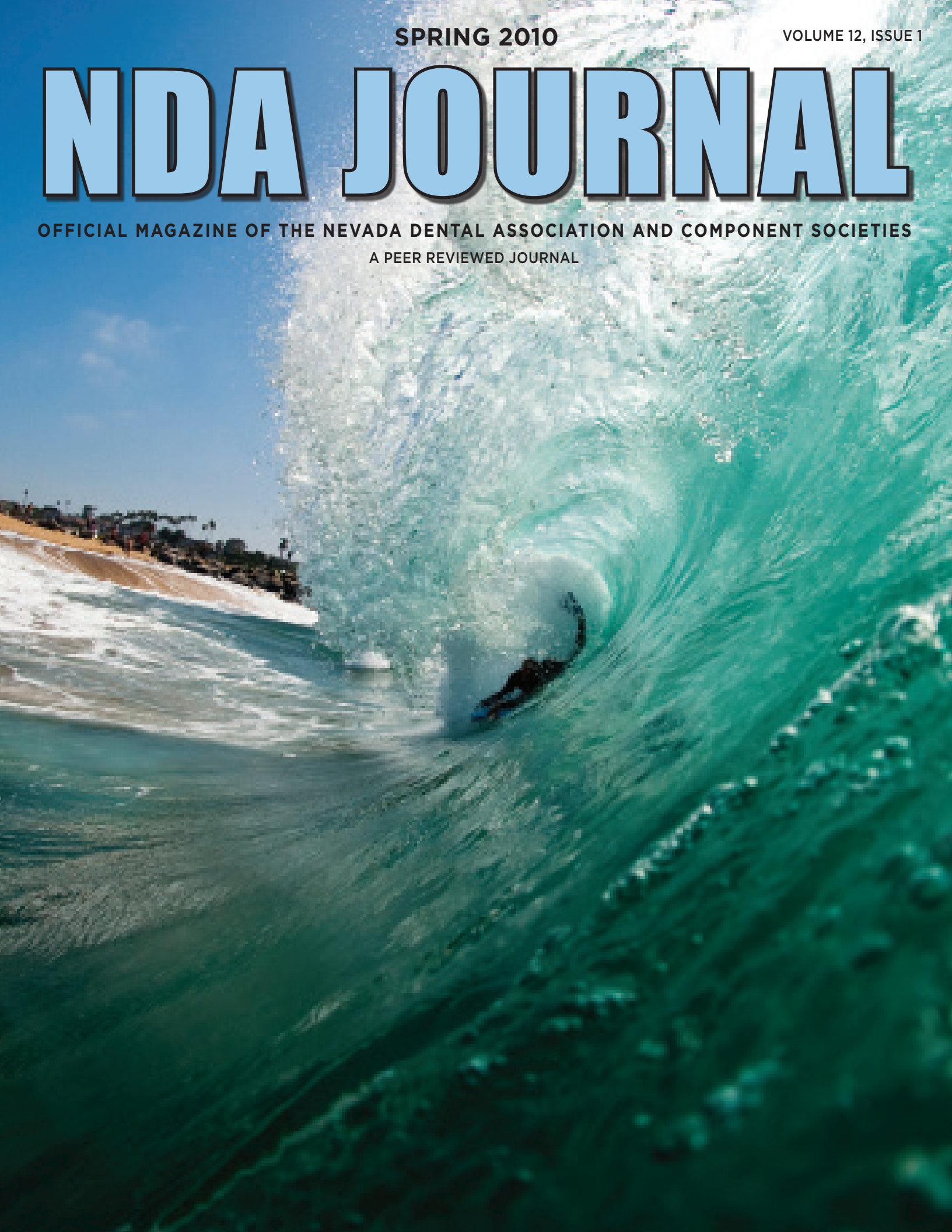
NDA JOURNAL

OFFICIAL MAGAZINE OF THE NEVADA DENTAL ASSOCIATION AND COMPONENT SOCIETIES

A PEER REVIEWED JOURNAL

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NDA JOURNAL

SPRING 2010

On the cover The Wedge, Southern California.

The Wedge is not a wave—it's a 20-foot-plus meat grinder dreamed up by the devil himself. It heaves, bends and pulverizes in ways that good little waves aren't supposed to act. The first time you swim or paddle out on a solid day, a typical thought might be, "Dang, is my chiropractor covered in my medical plan?" The Wedge is a combination of two waves that merge together, thrusting into a titanic slingshot. It takes a south swell only, refracting the swell energy off the jetty and creating a sideways wave that slings across the beach and mates with the next wave in the set. The result is what locals fittingly call a "humping effect," where the set waves jack, expand and release in unimaginable ways. So if you're feeling suicidal, or just want to watch stand-up surfers and bodyboarders play demolition derby at one of the most breathtaking natural spectacles in Southern California, it's best to show up in the morning or late afternoon. —Blair Mathieson

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Is There a Dentist in the House?

While waiting to be screened for the flight back from Honolulu to Las Vegas after the past ADA annual session, a TSA representative collapsed while checking the ID of the passenger. The collapse of course was the screener's corpus trying to do the right thing, i.e. get the brain down to heart level or lower to facilitate CNS perfusion after the syncopal event. Unfortunately, TSA colleagues, after unsuccessfully trying to hold their co-worker vertically, then tried to maneuver him into a chair. Although not really aspiring to interact with TSA any more than necessary, the chair shenanigans prompted me to step in to handle the situation. The assisted verticality was terminated and once the unusually cooperative, albeit unconscious, TSA screener was supine, his airway was opened via chin elevation and he came around in a few seconds. By that time, there were quite a few more TSA types around. Their quick diagnosis that I wasn't a terrorist or other undesirable was welcomed and I was quickly flip-flopping to the gate in short order.

I'm not sure why, but it seems I've had my share of rescue opportunities, even though I've never had to respond to, or even heard, "Is there a dentist in the house?"

When I was 12, my elderly neighbor's wife ran over and said her husband was suddenly ill. After hustling next door, rescue breathing was attempted upon finding Mr. Craemer apenic in his lounger chair. The paramedics arrived shortly thereafter and later and pronounced him.

On another occasion while I was stumbling out of the water on a moderately big day at the "Nasty Old Wedge" in Southern California, a mom began frantically pointing in my general direction, and shouting words that couldn't be heard because of the shore break heavies. Just then a solid mass bumped my calf. The mass turned out to be a helpless little girl who was retrieved and reunited with her mom a minute later. After a bit of vomiting, the sobbing on both their parts confirmed functional airways.

Figure 1 *Beat up at the Wedge*

While sitting in the left hand turn lane at Rainbow and Flamingo in Las Vegas heading to a Saturday morning soccer game with a few kids, I witnessed a head-on collision. The VW Bug half of the MVA finally stopped its seemingly extra slow-motion spinning in front of us and we noted the driver flopped out the passenger door, legs still in the car, head and shoulders on the ground. The kids were emphatically ordered "don't move" as the cyanotic victim was approached. C-spine support and simultaneous chin elevation resulted in a long, shuddering inspiration as he inhaled. He made it to UMC alive for his lacerated liver repair and so did the pregnant gal with a fractured femur in the other car. We made it to the soccer game after stopping at a gas station to wash the blood off my legs and arms.

Continues on page 4

Dr. Orr practices Oral & Maxillofacial Surgery in Las Vegas, is a Clinical Professor of Surgery and Anesthesiology for Dentistry at UNSOM, Professor and Chair of OMS at UNLV SDM, and is a member of the California Bar. He can be reached at editornda@nvda.org or 702-383-3711.

Once at a holiday party, a mom holding her one-year-old with one arm and a Shirley Temple with the other hand, began to open and close her mouth without accomplishing anything functional, kind of like a fish out of water. The baby was doing the same, except he was turning blue. The acute airway obstruction, caused by an ice cube, was relieved when the baby was inverted and a baby-dose Heimlich maneuver performed. The baby was returned to mom, screaming unhappily—sweet music to all that were aware of the incident.

The last rescue I'll mention occurred on the plane returning from the last AAOMS Annual Session in Toronto. The call went out, "Is there a doctor on board?" The passenger sitting next to me questioningly raised her eyebrows, knowing from prior conversation that I'm an OMS (a dental specialty). I half-heartedly explained that I usually wait for the second call, which kills two birds with one stone, so to speak: 1. one then knows the emergency didn't go away, and 2. they didn't find a "doctor" yet. After the second call, I walked back down the aisle and offered to help. The attendant wanted to know what kind of doctor I was (a sure sign that the issue is not really that emergent and indicating I could have stayed seated a little longer). The answer to attendant's question could change a bit depending on the situation. I've always wanted to answer "an attorney," but haven't had the right opportunity yet.* Anyway, diagnosing that the unconscious person in the next row being propped up against the bulkhead by another attendant wasn't going to do much better with that treatment, I said I was a surgeon (DDS/OMS, whatever, right?). That passed muster and I asked them to clear out of the row, flattened the syncopal traveler, and watched him magically regain consciousness (Yeah brain, heart, lungs, etc.!) once he was kind of supine (airplane seat fashion).

Figure 2 *Optional response to a call for in-flight assistance*

The attendant then asked if we needed to divert (I hate that question) and I replied I wasn't sure but it appeared he'd be just fine, and I'd observe for a bit. He was fine and we made it to Las Vegas on time.

Dentists are particularly well-positioned to be of assistance in certain emergencies, such as airway compromise or perioral hemorrhage along with dental alveolar trauma in the field and certainly more prepared for many other emergencies than most of the lay public.

Based on personal experience, the chances of having the opportunity to help with an emergency are great, perhaps even several times during one's lifetime. How one responds depends on the situation. This issue of the *Journal* includes several recollections from dentists, with lessons to be learned in each.

Good Samaritan statutes were put in place to encourage those with expertise in emergencies to rescue. It doesn't take much thought to understand that Good Samaritan statutes were necessary because, unfortunately, individuals, including health professionals, were sued after rescues. Today, Good Samaritan statutes do afford charitable individuals a good degree of protection for good faith rescue attempts. Conduct that can negate these statutes' protection include billing the victim for services rendered or leaving the victim in a worse condition than found. Billing for out-of-facility emergencies is fairly self-explanatory, but leaving victims in a more compromised condition does not necessarily mean finding them alive and having the rescue precede death. An example of a more compromised patient would be a found victim with a broken leg that the rescuer offers to transport to a hospital. If the victim was not delivered to the hospital, and perhaps dropped off even further from it, the rescuer would have left the victim in a less optimal situation, and Good Samaritan protection would not hold.

Dentists are particularly well-positioned to be of assistance in certain emergencies, such as airway compromise or perioral hemorrhage along with dental alveolar trauma in the field, and certainly more prepared for many other emergencies than most of the lay public.

Who wouldn't rather have a DDS or DMD helping with a foreign body in the upper airway than a PhD, JD, DC, DO or MD without such anatomical familiarity? As the Boy Scouts say, be prepared, be helpful, be kind, and be brave. ◆

**Please see "Is there a JD in the House?" in this issue.*

Robert H. Talley, DDS, CAE
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Plans are underway for our Annual Summer Meeting at the Hotel Del Coronado in San Diego on July 8–10, 2010. You will find registration material in this issue of the *Journal*. I hope you consider attending our meeting and bringing your family to one of the best beaches in Southern California. The hotel rate is phenomenal for this resort. We will be offering a four-hour course at the meeting on the new CDC guidelines for dentistry. This is a new requirement for licensure renewal.

Our next Laser Safety Course will be on June 18, 2010 at the UNLV School of Dental Medicine. This is a one-day course which satisfies the board requirement for laser safety. The course description and registration form are included in this *Journal*.

My thanks to the NDA, SNDS and NNDS membership committees for their work in making calls to dentists during our membership drive. It is not too late to pay your dues if you have not done so. Please call the NDA office.

The legislative committee has been hard at work interviewing candidates running for office this year. We have been concentrating on those offices with open seats due to term limits, and there are a lot of them. Also we will wait until the primary election is finished before we make decisions on financial contributions from the association. It should be another exciting year in politics. ◆

In Memoriam

Mario E. Gildone, DDS

July 16, 1921–March 14, 2010

The Northern Nevada Dental Society regretfully informs you with heartfelt sadness and deep respect that Dr. Mario E. Gildone passed away on March 14. Dr. Gildone was loved by all: his family, his friends, his former patients, and colleagues. He was a great man and a mentor to many.

The Gildone family has asked for privacy at this time and request that you please do not contact Mrs. Ida Mae Gildone, as she is in the hospital and is ill. There will be a memorial service at a later date to be determined by the Gildone family.

Please keep Ida Mae and the entire Gildone family in your thoughts and prayers during this very difficult time.

Dr. Gildone was honored, in memoriam, at the 8th Annual Mario Gildone Lifetime Achievement Award dinner on April 8, 2010. ◆

NDA President's Message

Peter Balle, DDS

The beautiful weather is upon us. I just returned from Chicago for the AARD meeting and I understand why we live in Las Vegas. We are lucky to have some of the best weather in the nation aside from a couple of months of sweltering heat in the summer.

While I was in Chicago I ran into a Michigan Dental Association (MDA) officer who handed me a copy of their monthly journal. The front page had the image of a red stop sign and below it read "Insurance Bullying."

What the cover page referred to is the MDA's consorted effort to bring forward legislation to their state legislatures to stop dental insurance companies from setting maximum fees for non-covered services. The MDA is mounting a campaign against the dental insurance industry. They are being proactive in response to their members' complaints to insurance companies' meddling in fees set by dental offices. Participating dental offices over the past few years have been forced to accept maximum fees set by insurance companies that are not even covered.

The insurers claim that these new policies are designed to expand number of people covered by dental benefits and promote access to care. This is a ruse for insurances to be more competitive amongst each other at the expense of dental practices. Insurers have not limited their intrusion in Michigan and as you are probably aware have had their hands in Nevada. Nevada dentists are already struggling with the brutal economy and it is not fair that dental offices have to suffer the insurance plans cost cutting measures.

Even though insurance companies may be operating within the law, wouldn't it be better if Nevada dentists also bring forth legislation like Rhode Island—and now Michigan—to make it illegal for insurance companies to dictate fees beyond their policy limits? Nevada dentists would benefit from legislation that prohibits insurers from setting fees for services they don't pay for.

Your NDA lobbyist Jeanette Belz helps us daily. As a small but strong organization we need to make our voices heard in the Legislature for positive change for our members. We have a PAC (political action committee) and a budget to help fight our battles. We seem to be always on the defense. Wouldn't it be better to be proactive to help shape laws that benefit the quality of dentistry in Nevada?

It is better to take on an issue while it is smoldering than waiting until it becomes a full-blown inferno. Our members should make their voices heard. If you are aware of issues that are not being addressed or have a concern about how we can make dental practice better in Nevada, please let us know. Contact your NDA office and make your voice be heard. Put your organization to work for you.

As for great weather, our summer meeting will be held at the beautiful Coronado hotel in San Diego, California this July 8–10.

I hope to see you there! ◆

Nevada State Board of Health Report

By Jade Miller, DDS

As I write my final report as the dental representative to the Board of Health, I have bittersweet feelings. First, I am proud and honored to represent my profession on this board. I sincerely appreciate the support I have received from my colleagues over the past 10 years. I enjoyed serving as chair (only the 2nd dentist) for the maximum term of four years. What an experience! I have chosen not to be reappointed because of increased commitments with the Board of Dental Examiners and American Academy of Pediatric Dentistry District VI Trustee responsibilities.

I am pleased to welcome our representative appointed by the Governor, **Monica Ponce, DDS** from Las Vegas. I know the citizens of Nevada are in great hands and dentistry will be very well represented.

Since my last report at the NDA Annual Meeting, the Board has and will continue to be busy adopting regulation related to laws and actions from this past legislative session. Regulations have or are being drawn up to be adopted by the Board from the successful bills. To highlight some of the regulations that will affect dentistry, here are the ones currently undergoing rulemaking. These and others will continue to evolve.

- One having the most impact to the Maxillofacial/Oral Surgeons practicing under a medical license in our profession is the passage of AB 123. The effect will be to **require maintance of accreditation by a national organization and annual inspections**. Although the language and regulations have not been adopted it will also affect outside physician anesthesia/sedation providers that come into dental offices and provide GA/sedation for patients.

  AB 123—Revises provisions governing certain offices of physicians and related facilities and surgical centers for ambulatory patients. This bill requires each physician and surgical center for ambulatory patients to maintain current accreditation by a nationally recognized accrediting organization approved by the State Board of Health. Requires the State Board of Health to prescribe regulations to carry out the provisions of this bill, including fees for the issuance and renewal of permits. AB 123 was approved by the Governor on May 22, 2009 and becomes effective on January 1, 2010.

- **X-rays/Radiological Services.** You probably received a survey from the State about proposed changes to Radiological Services. To read entire document go to: http://health.nv.gov/Agendas/HCQC/2010/2010-02-25_R185-08RP2.pdf

  Some of the proposed changes related to dentistry are:

  1) Handheld portable x-rays devices are now allowed (Nomad by Aribex Corp).
  2) Radiation monitoring of employees. These are intended for medical/radiation exposure risk personnel. In my experience with monitoring my dental office personnel I have not detected any exposure.

  If this regulation is approved there will not be a requirement to have dental employees wear radiation monitoring badges.

  Each licensee and registrant shall advise each of its workers annually of their exposure to radiation or radioactive material as shown in records maintained by the licensee or registrant pursuant to NAC 459.3665. An annual report of the exposure in that monitoring year must be provided to each person monitored pursuant to NAC 459.339 if:(a) The person's occupational dose exceeds 1 mSv (100 mrem) total effective dose equivalent or 1 mSv (100 mrem) to any individual organ or tissue; or (b) The person requests his or her annual dose report.

- **Maintaining Health Care Records.** Patient health care records must be maintained until a person reaches 23 years of age and have been retained at least 5 years before they can be destroyed. You must provide a written statement to patients and have appropriate signage posted. Regulations are currently being adopted but to see full bill SB 17 go to: www.leg.state.nv.us/75th2009/Bills/SB/SB17_EN.pdf

- CDC has released H1N1 guidelines—**Prevention of 2009 H1N1 Influenza Transmission in Dental Health Care Settings**. To see full CDC guidelines go to: www.cdc.gov/OralHealth/infectioncontrol/factsheets/2009_h1n1.htm

- **Infection Control.** CDC also has a document from 2003 that is still the standard for infection control in dental offices titled, "Guidelines for Infection Control in Dental Health-Care Settings — 2003". To see the full document go to: www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

  This is an important document that you are required to follow in your offices.

  As a caveat if you provide dentistry in a medical facility like a hospital or ambulatory surgery center, be aware there may be different infection control requirement for those facilities. Which could affect infection control of your instruments, single use or multiple use dispensed dental materials? To see the full document go to: www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf

  I would talk to your facility about what they require.

- Lastly amongst the mundane, occasionally there is something the board rules on that is one of those things you will always remember. For me one of those was: **Approval of a Compliance Agreement with The Shady Lady Ranch.** It allowed changes to regulations that were not gender specific to allow for male sex workers to be employed. The testimony was interesting!

It has been a pleasure to serve our profession on this Board. Welcome Dr. Ponce! ◆

Nevada Chapter: Committee of the New Dentist

By David White, DDS

On January 23, ADA worked with the NDA to organize the Nevada Chapter of the Committee on the New Dentist. This Committee will serve as a branch of the NDA, to provide a voice for our State's new dentists (those whom have been in practice 10 years or less). The committee is currently working on a licensure checklist which will be presented to senior dental students. Hopefully this will help to fast track these individuals from students to active dentists. In addition, the committee will be reaching out to the state's new dentists informing them of the benefits of membership and educating them on issues which could drastically change their short careers (etc. midlevel provider).

To view the committee's mission statement or find a list of committee members, please visit www.nvda.org. We look forward to serving the members of the NDA, and furthering a united association.

If you are interested in becoming a member of the committee or have issues you would like to see addressed, please feel free to contact me any time at whitedav@umich.edu or 775-287-7960. ◆

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Dr. William Chen has authored a number of clinical articles on dental lasers and lectures nationally and internationally. He is the co-founder of the World Clinical Laser Institute and serves on their advisory board. His other honors and memberships include: Fellowship and Mastership of the Academy of General Dentistry, Mastership and Educator of the Academy of Laser Dentistry, Mastership of the World Clinical Laser Institute, Fellow of the American College Dentists and Fellow of the International College of Dentists. He was the chief investigator for BIOLASE in getting FDA clearance for complete laser root canal therapy and bone applications. He is the founder and director of the Chen Laser Institute, and international laser education and training organization.

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Thursday, July 8

Executive Committee Meeting	3–5 PM
President's Reception	6–9 PM

Friday, July 9

Joel F. Glover Fun Run & Breakfast	6:30 AM
Continuing Education: CDC Guidelines	8 AM–12 NOON
North-South Golf w/lunch	10 AM–2 PM
Beach BBQ (steak and lobster)	6–9 PM

Saturday, July 10

Pliney Phillips Breakfast	8–9 AM
House of Delegates	9 AM–12 NOON
American College of Dentists Lunch	1 PM

Registration Form

NDA 92nd Annual Summer Meeting, July 8–10, 2010
Hotel Del Coronado • San Diego, California

Event	Time	Number Attending	Fee (per person)	Total Payment
Registration—NDA Member/Spouse/Child		_____	$0	
Registration—Non-NDA member (required)		_____	$ 150	_____
Registration—Non-ADA member (required)		_____	$ 200	_____
Thursday, July 8				
Executive Committee Meeting	3–5 PM	_____	$ 0	
President's Reception (Adult)	6–9 PM	_____	$ 75	_____
President's Reception (Child 5–12)	6–9 PM	_____	$ 45	_____
Friday, July 9				
Joel F. Glover Fun Run & Breakfast	6:30 AM	_____	$ 35	_____
Continuing Education: CDC Guidelines	8 AM–12 NOON	_____	$ 130	_____
North-South Golf w/lunch	10 AM–2 PM	_____	$ 160	_____
Beach BBQ (steak and lobster) Adult	6–9 PM	_____	$ 135	_____
Beach BBQ (kid's menu) Child (5–12)	6–9 PM	_____	$ 45	_____
Saturday, July 10				
Pliney Phillips Breakfast	8–9 AM	_____	$ 45	_____
House of Delegates	9 AM–12 NOON	_____	$ 0	
American College of Dentists Lunch (only ACD members and spouses)	1 PM	_____	$ 75	_____
		Grand Total		

Note: Registrations will be accepted until July 2, 2010. Registrations after this date will be onsite only. No refunds given past July 2, 2010. Hotel reservations and pricing are only guaranteed through June 10, 2010.

Name _____ ADA Number _____

Guest(s) _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Accepted forms of payment are: check payable to NDA, Visa, MasterCard and AMEX. Please indicate below.

Credit Card Number _____ Expiration Date _____ Security Code _____

Name on card _____ Email _____

Billing Address _____

Authorized Signature _____

Mail or fax completed form to:
Nevada Dental Association
8863 W Flamingo Rd, Ste 102
Las Vegas, NV 89147
702-255-4211
Fax: 702-255-3302

Hotel Reservations:
Hotel Del Coronado
San Diego, CA
800-468-3533
Group name: Nevada Dental Assn.
Room Rates: $289

Vehicle Reservations:
Hertz Car Rentals
800-654-2210
Meeting Code:
CDP #1349878

Is There a Duty to Rescue?

By Daniel L. Orr II, DDS, PhD, JD, MD

While encouraging others, including doctors, to rescue, the question of whether there is a duty to rescue arises.

A recent trauma case from Las Vegas illustrates the issue.

According to the March 8, 2010 *Las Vegas Review Journal*, a domestic violence situation lead to the death of one and critical injuries to three others, including the alleged perpetrator after the LVMPD responded.

One victim, a young woman holding a baby, was literally shot between the eyes. She ran to a neighbor's apartment seeking aid and asylum. Although the neighbor agreed to call 911, he asked her to leave. The victim did leave, and was granted entry at another neighbor's and was subsequently transported to the hospital. *(See photos 1–4)*

Did either neighbor have a duty to rescue? Legally, the answer is no. Generally, only professional rescuers "on the job" have a duty to rescue (e.g. lifeguards). For instance, the United States Supreme Court has ruled that even police have no duty to rescue.

Another more well-known non-rescue case from Nevada was the murder of Sherice Iverson. In May 1997 college student Jeremy Strohmeyer murdered Sherice in Primm, Nevada. Strohmeyer's friend, David Cash, saw the crime in process but did not attempt to stop it or report it. Cash was later quoted in *Los Angeles Times* and *Long Beach Press Telegram* news articles saying: "I'm not going to get upset over somebody else's life. I just worry about myself first. I'm not going to lose sleep over somebody else's problems," and, "I'll get my money out of this" and other remarks perceived by the public as inappropriate.

Harsh as it may seem at first glance, courts have ruled that society cannot force individuals to rescue. Reasoning for this posture is that rescues may involve potential harm to the rescuer, for instance, the first neighbor above was caring for a baby at the time of the shootings. Should he have been required to expose himself and also his child to potential danger? In addition, a law requiring rescues would lead to civil and criminal prosecution for non-rescuers, who would then be required to defend themselves in court.

The Nevada legislature did later pass AB267 which requires individuals to report reasonably suspected violent criminal activity directed towards minors. "Reasonable" will have to be determined when a suit is filed against someone who allegedly fails to act reasonably. Since the passage of AB267, reports have indeed been filed that have helped victims, but unfortunately, have also disrupted innocent families for long periods of time.

As dentists, do we have a duty to rescue for dental issues? Do dentists have the same legal responsibility as paid rescuers? While each situation needs to be evaluated on its own particular circumstances, some general guidelines apply. The ADA Principles of Ethics and Code of

Professional Conduct, Section 4.B, reads: "Dentists shall be obliged to make *reasonable* arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make *reasonable* arrangements for emergency care."

The ADA guideline seems pretty straightforward, but as is always the case, things can get complicated. The upcoming May 2010 *OOOOE* editorial by Editor James Hupp, "Emergency Patients: Who has the ultimate duty to provide care?" relates another sad story of a dental emergency case gone terribly awry.

Defining *reasonable* is a legal issue for the ages. As professionals, the public depends on us to judiciously make that call. Many dentists in Nevada who sign up for emergency room call have seen a number of dental patients, unhappy to one degree or another, because they have not been able to contact their dentist for advice after recent treatment. The patients have either been told to "go to an emergency room" by an answering machine, just figured that out themselves, or determined to do so after asking other non-dentist friends or family members. Unfortunately, emergency rooms are generally not a good facility to diagnose or treat dental concerns. It seems more reasonable for dentists who are unavailable for their patients to consider arranging for actual live dentist coverage from a colleague when necessary. ◆

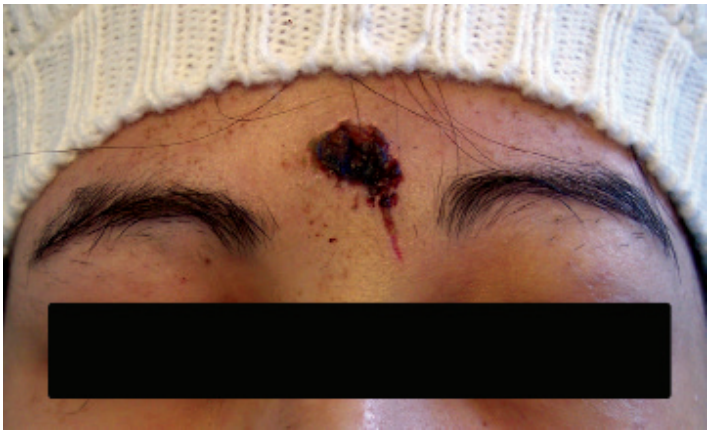


Photo 1 *GSW entrance*

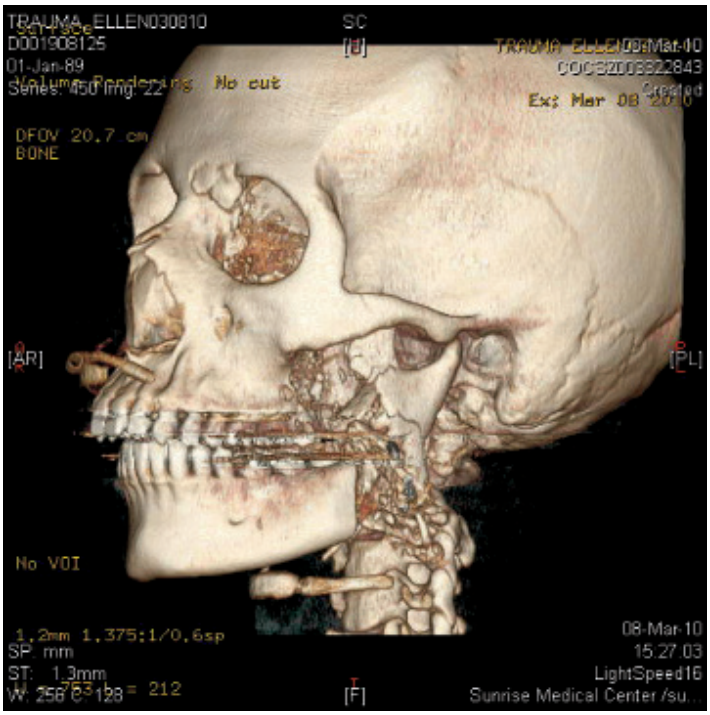


Photo 3 *3D CAT reconstruction of missile path from entrance→ frontal sinus→ orbit→ maxillary sinus→ infratemporal fossa→ mandibular angle. The bullet then passed into the neck and chest, lodging in the scapula.*

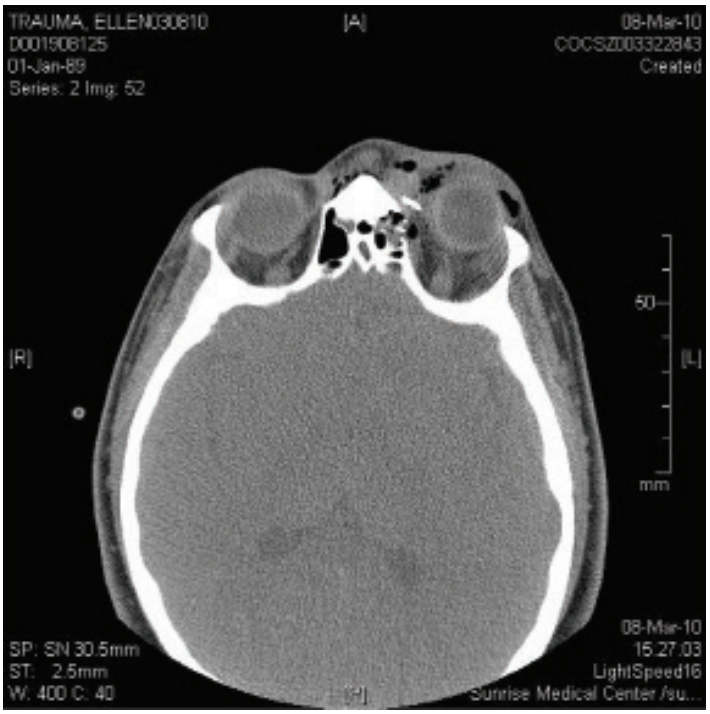


Photo 2 *Axial Tomography demonstrating proptosis OS*

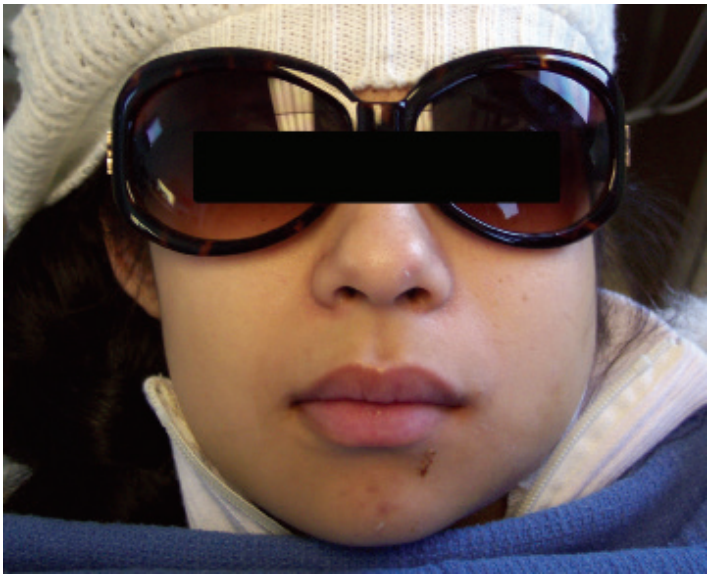


Photo 4 *Patient after discharge from hospital after reconstruction.*

Dentists respond:

Have *you* assisted in an emergency?

Fred Quarnstrom

During my professional years, I have experienced five trauma/rescue events; none of them resulted in death.

The first incident occurred while I was flying to Mexico to catch an ADSA cruise. I was presenting a lecture at the conference on Oral Conscious Sedation, so I had my monitoring equipment, pulse ox, blood pressure cuff, and stethoscope in my carryon luggage. I walked forward on the plane to use the facilities and saw a man in his 60s or 70s with his eyes rolled back and looking as pale as new-fallen snow. He did respond slightly when he was spoken to. A flight attendant placed a cold cloth on his forehead. I introduced myself as a dentist and asked if I could help. She told me to go sit down.

I used the facilities and on my way back to my seat, I again offered assistance explaining that I had a residency in anesthesiology and had monitoring equipment with me in my carryon. Again she told me to go back to my seat. I explained to her that my wife was an RN who worked in an emergency department at a trauma center. If she did not want my help; I would get my wife. I was told to go sit down; she needed no help.

Short of a confrontation ending in my arrest when we arrived in Mexico, I went back to my seat. I guess she was right, the elderly man walked off the plane two hours later. It would have been nice to have a report on his vitals when he arrived at his destination. I would have felt very bad if I had not made a scene had he died. I did write American Airlines to report the incident. I received an answer from American Airlines explaining that their attendants were trained in handling such problems.

About a month later, my second incident involved a fellow who fainted right at our feet on an airplane. I caught him going down, eased him to the deck and raised his feet. We were both in the aisle of the plane. We raised his feet to keep him on his back and he was back with us in seconds. He was an auto executive who was running on about three hours of sleep for the previous three days. He was also borderline diabetic. This time all I could do was monitor his pulse (about 35) until it came back to a normal rate. Again, we were flying on American Airlines but this time they gave us a bottle of wine as we left the flight.

The last incident on an airplane was a fellow who got sick and vomited after drinking some wine. He was an AIDS patient taking a medication that reacted with the wine. My wife responded to this one because she had the aisle seat. The attendants were freaking out because of risks attributed to the AIDS virus and the fact that there was vomit. We got another bottle of wine for helping.

These all happened about 10 years ago in a timeframe of about three months. During this same timeframe, I caught two women who fainted at weddings and got them safely to the floor.

I found that leaning a chair back with the person's feet elevated by the base of the chair is a great way to elevate the feet. In fact, if you have one person lift the legs of the chair and another person lift the back of the chair you can make a shift stretcher to get them into the hall or fresh air where there were fewer people and cooler temperatures.

Both incidents were on a hot day after a long ceremony, a long time since a meal and after drinking a glass of wine. In one case, a retired radiologist came up and said, "She is tanking. She is going down. We had better call the paramedics."

I said, "Actually she is getting much better let's give her a few minutes.

He said, "I am a doctor what is a dentist doing treating her?"

I said, "Doctor, be my guest, she is in your hands."

He called the paramedics and by the time they arrived she was feeling much better, was fully conscious and they would not transport her. The doctor had insisted that an ambulance be called. She ended up being very unhappy with the doctor and her large medical bill.

The second incident involved a psychiatrist at a wedding of another psychiatrist. There were at least four other MD psychiatrists present. They all stood around and let the dentist (me) handle the syncope. It did not dawn on me at the time that all these folks were MDs. As it turns out, the dentist was better equipped to handle syncope than the psychiatrists.

Oh, I forgot about the neighbor who had an MI but survived. I did little more than hold hands until the paramedics got here. On the first incident, I met the firemen and said, "I am a dentist, we have a fellow having a heart attack."

He said, "How would you know?" So I took him into the house. He took one look and called for the medic unit.

I also experienced a neighbor have a cardiac arrest while playing racketball. We performed CPR on him immediately. A physician was playing at the court next door and came over to help. He took over the compressions and left me to breathe for him, mouth to mouth. Our friendship was stretched a bit when he vomited, but I continued. Then I vomited and continued. He was flat line and even with multiple shocks he never recovered. He was 39. They worked on him for over an hour at our trauma center but his heart simply would not beat.

While in Vietnam during the war, I worked on medic evacuation flights. We had a Marine with a lung wound and a chest tube. When I got to the "B Med" MASH Hospital, I got off the chopper holding the drainage jug. The triage officer asked his condition. I said he needs surgery right away.

He looked at my dental insignia and said, "How would you know?"

I held up the jug with a liter of blood that had collected in the last 15 minutes we were in the chopper. My response was, "Is this adequate documentation you pompous SOB."

He sent him directly to surgery. I did not make a friend that day, but it had been a long stressful night.

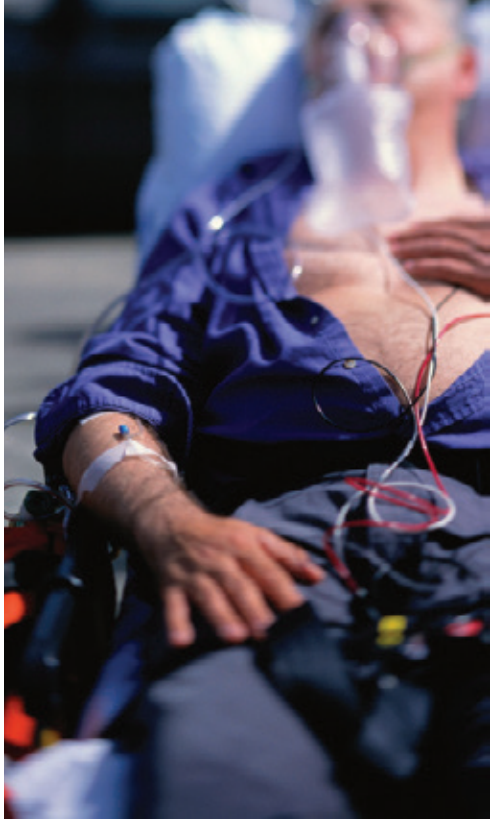
I hope these cases are of value. I must be living a better life as I have not seen another case in the last eight years. Regardless, I may be bad luck to be around. ◆

More stories on page 18

John Leyman

I have responded twice—both on airplane flights. The first time was in February 1980 on a return flight from Chicago to Los Angeles (after taking my ADSA Fellowship Oral Exams!). The second time was a couple of years later returning from Honolulu. Both were because the victims had "difficulty breathing" caused by anxiety. It never made much sense to me since both incidences occurred mid-flight and it seems to me that the worst anxiety-inducing time would be during take-off and landing.

PS: American Airlines sent me a thank you letter after the first incident. ◆



Mort Rosenberg

I've responded a number of times over the years during travels. Almost all people were hypoglycemic with 2–3 chest pain patients.

Once I was told I was not needed because a doctor was present; then the doctor fainted and then I was very much needed. (In addition, the doctor hit his head, momentarily lost consciousness and bled all over the anginal passenger).

I performed CPR at least 30 years ago at the Miami Airport with my dear friend Tom Quinn. He delivered a roundhouse precordial thump on the victim and amazingly people just continued to walk around and through us during the event that ended badly for victim and us (covered with vomit; and those were in the days when everyone checked their bags). ◆

Joel M. Weaver

A close friend is a fantastic surgeon who originally was from a Middle-eastern country that has a dictator not so friendly to the US. My friend is fairly short in stature and has a fairly strong accent, but is very Americanized, very articulate, and easily understood. He had been visiting relatives in this previous home-country and was returning to the US on a plane full of other Americans. This transatlantic international flight was returning to the US a year or two after 9/11 and my friend had on a checkerboard head covering similar to that worn by Yasser Arafat.

He responded to an inflight call for a doctor and, although he believed that the patient had some significant medical problems, he thought that he had stabilized the man so that the plane didn't have to divert to New York but could continue to Chicago. They were a little more than half way across the Atlantic Ocean so turning back was not an option. The captain wanted to discuss the doctor's diagnosis and whether to divert to New York or continue to Chicago, so my friend was asked to walk to the front of the plane and knock on the locked cockpit door to gain entrance. Then he and the pilot could talk over the options in private. Apparently diverting the plane to the closest airport is a huge financial and paperwork problem for the airlines—rather than being just like an extra bus stop for a passenger who missed his stop.

The passengers in first class near the cockpit door may have heard the original call for a doctor, but didn't know that my friend was treating the sick passenger in the back of the plane. He noticed that they looked very nervous and frightened when a man dressed in traditional Arab clothing began pounding on the cockpit door.

He thought that any minute, several of the big, strong males in first class would jump on him, thinking that he was a hijacker. He told the pilot of his concerns, so the pilot casually walked to the back of the plane with my friend while maintaining a casual conversation with him to allay the passengers' fears. ◆

Stanley F. Malamed

I've responded to six of emergency calls on flights—both domestically and internationally.

When I ring the call button, I always mention that I am not a physician but a dentist anesthesiologist who can likely be of assistance. This offer has never been turned down.

Most of these emergencies are related to fear of flying (i.e. panic attacks). Two of the episodes were related to hypoglycemia.

On a flight from LAX to Chicago on a DC-10, I was asked by the flight attendant to check on a man sitting in the middle of five seats that she thought might be dead. She very specifically said I should *NOT* use the word "dead" when discussing with her what I found. Turns out he was dead….

I told the flight attendant that he was not well and the captain diverted our flight to Denver. (If a captain notifies the control tower that a passenger has died onboard, when the plane lands, the plane is quarantined—thus screwing up even more of the airline's schedule.) Paramedics met the flight crew at the door, moved him off the plane onto a gurney and pronounced him dead in the jetway. Our plane was able to take off almost immediately.

My experience has been that most frequently those who respond to the "Is there a doctor in the house?" call are (1) EMTs and paramedics and (2) RNs. In reality these are the persons who in "'real life" are the first responders. ◆

Is There a JD in the House?

By Peter Geraghty, American Bar Association

You have a solo practice in civil rights litigation under the name John Smith, Attorney at Law. You also teach part time at a local community college where you offer a course on the introduction to constitutional law. Can you refer to yourself as Dr. John Smith?

State bar opinions are split over whether a lawyer may refer to himself as "Dr." or "Doctor." **See** Maher, *Lawyers Are Doctors, Too* 92 ABAJ 24 (2006). The analysis usually turns on whether the issuing ethics committee determines that the use of the term would be false or misleading under their state version of Rule 7.1 *Communications Concerning a Lawyer's Services* of the ABA Model Rules of Professional Conduct. Rule 7.1 states:

> A lawyer shall not make a false or misleading communication about the lawyer or the lawyer's services. A communication is false or misleading if it contains a material misrepresentation of fact or law, or omits a fact necessary to make the statement considered as a whole not materially misleading.

The Ethics Committee of the Texas Supreme Court issued opinion 550 (2004) on this topic in which it withdrew an earlier opinion that had prohibited lawyers from referring to themselves as "Doctor" or "Dr." and concluded:

> The Committee is of the opinion that under the Rules the use of the title "Dr.," "Doctor," "J.D." or "Doctor of Jurisprudence" is not, in itself, prohibited as constituting a false or misleading communication. The Committee recognizes that other professions, such as educators, economists and social scientists, traditionally use title "Dr." in their professional names to denote a level of advanced education and not to imply formal medical training. There is no reason in these circumstances to prohibit lawyers with a Juris Doctor or Doctor of Jurisprudence degree from indicating the advanced level of their education.

However, while use of the title alone is generally permitted, the context in which the title is used may cause use of the title to be a false or misleading communication. For example, a lawyer otherwise qualified to use the title of "Dr." who advertises as "Dr. John Doe" in a public advertisement for legal services in connection with medical malpractice or other areas involving specialized medical issues may be making a misleading statement as to the lawyer's qualifications and may be creating an unjustified expectation about results the lawyer can achieve. Unless accompanied by an appropriate, prominent statement of qualifications and disclaimers, such use of the title "Dr." could readily mislead prospective clients and thus violate the Rules. Compare Comment 2 to Rule 7.02.

Other older state bar opinions on this topic are mixed. Citations to these opinions, along with excerpts from digests of them as they appear in the *ABA/BNA Lawyers' Manual on Professional Conduct* follow.

Opinions that permit the use of the term include Florida Opinion 88-2 (1988) (A lawyer may use the term "Juris Doctor" on letterhead and business cards but use of the term in advertisements must be evaluated on

a case-by-case basis to determine if it is misleading in each context), New Jersey Op. 461 (1980) (The holder of a J.D. degree who is admitted to the bar of the State of New Jersey, may use that degree and the title "Doctor" since the degree indicates his training in the law), New York State—Suffolk County Opinion 87-6 (A lawyer who has earned a Juris Doctor may use the title "doctor" professionally and/or socially), South Carolina Opinion 76-02 (1976) (An attorney may use "J.D." or "Juris Doctor" on professional stationery and cards. He may also use and permit others to use the title "Doctor" in reference to himself).

State bar opinions that do not approve of the use of the term include Maine Board of Overseers of the Bar Opinion 5 (1979) (Licensed attorney who holds a Juris Doctor practices both domestic relations as a lawyer and mental health counselor. May not style himself "doctor" on the basis of a Juris Doctor. "Regular use of the title 'doctor' is almost exclusively confined to certain health professionals" and "to some extent, academics with a Ph.D. degree and clergymen." The lay person hearing an attorney referred to as doctor would assume the attorney were also qualified in one of these professions), Michigan Opinion CI-1176 (1988) (A lawyer who has received a "Juris Doctor" degree may use the title of "Doctor" as long as it is not misleading, fraudulent, or deceptive to the public or clients), North Carolina Opinion 5 (January 16, 1986) (A lawyer with a Juris Doctor may not hold himself out to the public as having a doctorate or use the title "doctor." The use of such terms without explanation could be misleading).

ABA opinions

There are older ABA ethics opinions on this topic. ABA Formal Opinion 321 (1969) prohibited lawyers from using the term, stating that to do so would violate the rule against "self laudation" as delineated in Canon 27 of the 1908 ABA Canons of Professional Ethics. Opinion 321 did however permit a lawyer to refer to himself as "doctor" in academic circles. The committee subsequently reversed its general position against the use of the term in later informal opinions. **See**, ABA Informal Opinions 1151 and 1152 (1970). Informal Opinion 1152 stated:

> You have inquired of the Committee whether under the Code of Professional Responsibility an individual possessing LL.B and LL.M. degrees is entitled to the use of the term "Doctor." DR 2-102(F) permits the use by a lawyer of "an earned degree or title derived there from indicating his training in the law." This clearly permits the use of the term "Doctor" by the holder of a J.D. degree, and as a LL.M. degree indicates a more advanced stage of training in the law than does a J.D. degree, it is the opinion of the Committee that under this language the holder of such a degree would be entitled to use and permit the use of the term "Doctor" in connection with his name. – ABA Informal Opinion 1152 ◆

SNDS Executive Director's Message

Robert Anderson

As I write this column, our 2009–2010 program year is entering the home stretch. The nomination period is open, and elections for new delegates and officers will be held at our April dinner meeting. You will also want to save the date for our Installation of Officers, set for Friday evening, May 7. Watch for details to come.

And while we have the last of our continuing education seminars this month to close out the 2009–2010 series, don't forget that our mini-seminars will be rounding out with an evening seminar on Tuesday, June 8. The mini seminars are available only for members, and are provided at no charge as a part of your dues.

Our March meeting presentation was an extended report on our 2010 Give Kids A Smile event. We invited representatives from many of the organizations and sponsors who are a part of the event, and let them speak about the impact the program has on the community. We also premiered our video report on the event; a 3-minute DVD that will be viewable on our website. Since not everyone could be there for the presentation, I want to thank the University of Southern Nevada's Orthodontic Residency program for their generous help in pre-screening almost 140 children two weeks before the main event, Sue Brooks and her crew from Helping Kids, Gene Ward Elementary School, Acelaro Learning (Head Start), Jackson Enterprises, Pizza Hut, The Wealth Consulting Group, the Southern Nevada Dental Hygienists' Association, the Hygiene School at CSN, and the residents, doctors, hygienists and assistants from the 99th Dental Squadron at Nellis Air Force Base. The UNLV Pediatric Residency and Paradise Park Children's Dental Clinic offered follow up treatment when it couldn't be completed on the day of the event.

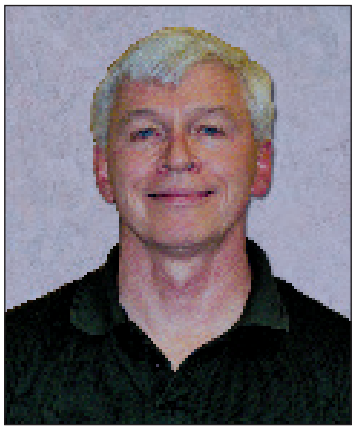
And of course, a very, *very* special thanks to our special partners at the UNLV School of Dental Medicine and Henry Schein Dental. Once again, Dean West opened the doors of the school for the event, and more than 150 dental students volunteered for the event. Faculty, administration, staff, students and the residents in their Pediatric and General Dentistry residencies all turned out to make the day our best-run Give Kids A Smile. This year we had 92 chairs all working at the same time. And thanks to the number of patients pre-screened, every one of those chairs was busy right off the bat!

For their part, Henry Schein—already a national sponsor—worked miracles in providing support for our event in Las Vegas. They provided materials, equipment, technology, volunteers, and even brought Pact One on board as a sponsor to help with the technical end of things. From portable radiology units to disposable exam kits and everything in between, they met every challenge. It's important for everyone to know that without UNLV and Henry Schein on the team, our event would be far, far different.

We also cannot forget the generous gift of time given by our members, more than 70 of whom stepped up and helped make a difference. Dentists who volunteer their time and talent are the core of Give Kids A Smile, and it has been for each of the program's eight years.

This year, thanks to the boost given by the pre-screening day held at USN, we were able to provide exams, radiology, hygiene and restorative treatment for 174 children in just under five hours. The value of this work is still be tabulated but already greatly exceeds $100,000 and is greatly appreciated by the families of these young patients, who have no insurance, no Medicaid, and no ability to pay for oral health care.

Nationally, the American Dental Association estimates that over 325,000 children will be seen by almost 13,000 dentists, assisted by 36,000 volunteers in more than 2,000 Give Kids A Smile programs. Very few of these programs provide the level of treatment we're able to deliver here in Las Vegas, making our event one of the largest of its kind in the country. This is only possible because of our great team that makes Give Kids A Smile the success that it's become here in Las Vegas. Thank you to everyone for helping us put a smile on southern Nevada! ◆



George McAlpine, DDS, MS

2009 was a difficult year in southern Nevada. Las Vegas is nationally recognized as one of the communities hardest hit by the economic downturn. This has certainly been felt by our members in their practices.

For the society, we've seen our attendance at dinner meetings grow steadily, even as our membership numbers have dropped. The SNDS has worked hard to innovate, develop and promote the value of membership, but most members who have not renewed cited the economic situation as the reason. We are confident that as the economy picks back up, we'll recover many of these members.

In spite of the poor economy, our members generously supported our Operation Dental Elf, in which our members, their families, and team members gathered toys and gifts for the families of deployed personnel at Nellis Air Force Base. This year was the third year for the event, and we broke last year's record when we turned everything over to the 99th Dental Squadron.

On the plus side, our committees are running well. Our Peer Review committee closed 45 cases last year, and currently is working on 17. Our Dentist Health and Wellbeing Committee is working with several dentists on an ongoing basis. Our membership committee is developing a dependable, sustainable system for greeting new dentists and recruiting new members.

Just last weekend we completed our 8th annual Give Kids A Smile event, and in four and a half hours treated 174 children whose families have no Medicaid, no insurance, and no ability to pay for oral health care. We were very pleased that we were able to enlist the help of the CSN Hygiene School, USN Orthodontic Residency, the Pedo, Ortho, and General Practice residencies at UNLV, and even the AEGD residency at Nellis Air Force Base in a common cause for our community. We also have to recognize the generous support we received from Henry Schein. They not only provided supplies and materials but almost 20 volunteers. Our other major partner is, of course, the UNLV School of Dental Medicine, without whom our event would not have been nearly as successful. Dean Karen West continues to generously support this important community event and this year provided students, faculty and staff in abundance. Dr. West, thank you!

We also networked with a veteran's organization and all three major dental suppliers to send care packages to 700 National Guardsmen deployed to Afghanistan. This is in addition to thousands of toothbrushes provided to southern Nevada children and veteran's homes through our network of social service and public service agencies.

Our 1 Day a Year program, or 1DAY, is currently on hold pending reorganization. Our Executive Director, Bob Anderson, is working to structure the program in a way that will be practical and self-sustaining. Essentially, once restarted, the program will function in the same way that Give Kids A Smile works, but on a daily basis. It is a totally volunteer-based program that helps our dental community make a difference in the lives of children in southern Nevada. We're looking to Bob to provide this vital program with the professional infrastructure it has needed.

Our Continuing Education series has continued to be a solid success. We have hosted nationally recognized speakers at a price that makes it very affordable for our members. We have also added a subset of four shorter seminars, two hours rather than six, held after work during the week. Our sponsors help with speaker costs, the venue, and dinner, so that we are able to offer these programs free to our members. Including our dinner meetings, this means that 15 CEUs are included in the price of our members' dues with no additional charge.

With an enviable slate of benefits, the means for communicating them to our members, and some significant accomplishments, we feel we are well placed to recapture our members and attract new members as the economy improves. ◆

Dr. Paul Homoly, certified speaker, trainer and author, has generously offered his online module, "Making it Easy for Patients to say YES!" for free to NDA members.

Send an e-mail to Dr. Homoly at nevada@paulhomoly.com and inform him that you are a member of the NDA. He will send you a link to access his online program free of charge.

Current Economic Pressure on Nevada Dental Practices and Increase in the Volume of Peer Review Complaints: *Correlation or Aberration?*

By Joseph A. Wineman, DMD

Within the last quarter, the SNDS Peer Review Committee has seen a threefold increase in the number of new complaints. Complaints are received directly at the SNDS Office while others are referred to the committee from the Nevada State Board of Dental Examiners for action. Is this upswing in activity purely happenstance or the result of current economic pressure we all face? Nevada's unemployment rate is currently 13 percent. Many laid off employees lose their benefits and drop out of our recall/recare systems. Those who are still working may have seen their dental insurance monthly premiums increase but have seen the dental annual maximum benefits decrease. Nevada dental insurance carriers and/or their administrators, with the exception of Teacher's Health Trust, are holding the line on fee schedules or decreasing their allowable fees to save money. Ask yourself these questions—are you seeing fewer patients than last year? Are more patients delaying comprehensive care? Do you have more holes in your schedule?

Ask yourself these questions—

Are you seeing fewer patients than last year?

Are more patients delaying comprehensive care?

Do you have more holes in your schedule?

For most NDA member dentists, the responses to the aforementioned questions are probably, "yes". So why is the Peer Review Committee receiving more complaints now than last year?

Possible reasons:

1. Patients who have accepted complicated, high dollar treatment plans are more demanding. Perhaps halfway through the treatment they develop buyer's remorse. They want to see a dramatic improvement in appearance or function or *both*. When their expectations are not met by the dentist, they become angry and demand their money back, frequently regretting beginning the treatment plan in the first place.
2. Dentists are doing treatment procedures that they usually referred to specialists. However with more time on their hands and overhead costs to pay, they decide to do that complicated procedure anyway. The treatment does not go as planned and the patient is unhappy.
3. Some patients just like to complain even when there is no clinical basis for their actions. Perhaps they had a friend who complained and who received some money from their dentist. Their friend encourages them to file a complaint against their dentist because that new crown is still sensitive and their dentist "must have done something wrong."
4. When switching dental offices a new patient is led to believe that their old dentist did "bad work"—cemented a crown with an open margin or left decay under the filling or used an inferior material. These "findings" are used to allow the new dentist to redo some "old" dentistry. The patient is fed some inaccurate "truths" by the dentist or his/her staff and the complaint is filed the next day.

Whatever the rationale, the number of complaints received by the SNDS Peer Review Committee has ticked upward over the past few months. Even with the increase in caseload, NDA dentists can rest assured their component Peer Review Committee is dedicated to providing a fair and objective evaluation of the complaint.

So what are NDA dentists to do?

1. Remember your Hippocratic Oath—do no harm. If the patient needs a procedure that you do not normally do in your office or requests a service you are not licensed to provide, e.g., conscious sedation, refer to a specialist. The specialists will be happy to help you and your patient out; many will get your patient in that day to alleviate their discomfort. You may receive a referral in return.
2. Remember the Golden Rule: treat others as you would like to be treated. Treat all patients who are new to your practice the way you hope your patients who have left your practice are treated by ***their*** new dentist. If you see something that is problematic, professional courtesy goes a long way. Do not be so quick to condemn another dentist's work. Pick up the phone and call your colleague before you criticize his/her work.

3. If you are not busy, slow down and talk to your patient. With more time on your hands, this is the perfect time to improve your personal relationship with your patients of record and build their trust. Educate, teach, and share your knowledge with your patients. What is the worst thing that can happen? They might just say "yes" to your proposed treatment. Speakers at risk management seminars will tell you dentists who have strong personal relationships with their patients are sued less frequently. Call your patient after a lengthy treatment session to see how they are doing. Show them you care.
4. Probably the best thing to do when rendering treatment is to under-promise and over-deliver. Do the necessary steps to deliver predictable results. Spend the time and money doing a diagnostic wax-up prior to beginning a complex restorative case. Remember talking to a patient prior to any treatment is an explanation, talking about the case after the fact may seem like an excuse. Obtain informed consent when and where appropriate.
5. Finally, document every treatment note to the best of your ability. Treatment notes should allow anyone reading them to answer the 5 W's (who, what, when, where, why) and how of the treatment. Please remember your treatment notes are a legal document and you may have to refer to them in a court of law. While it is certainly permissible for a dentist to delegate the treatment notes to a staff member, it remains the dentist's responsibility to check and verify the treatment notes' correctness and thoroughness.

Correlation or aberration? Only you know for sure. ◆

NNDS Executive Director's Message

Lori Benvin

We thought spring had "sprung" during our very warm days in March, but it was not the case in northern Nevada. However that's not unusual; I've seen snow in May here. I hope all of you have started to show some signs of increased production this spring and that patients are coming back through your doors for needed (and possibly, postponed) dental treatment. We hope for rebounds for all our business owners.

Mario Gildone Lifetime Achievement Award for 2010

On April 8 we honored a very special person. And this year, sadly, we had to say goodbye to the namesake of this award, Dr. Mario Gildone. Losing two icons of northern Nevada in the last three months has been a tough pill to swallow, but their legacy will truly live on…in everything they have touched in our lives, the care they gave to their patients on a daily basis, the leadership and tireless hours of giving back to the dental profession, and the love we have for both Drs. Gildone and Glover.

The 8th Annual NNDS Mario Gildone Lifetime Achievement Award honors **Joel F. Glover, DDS**—*unanimously* chosen by his peers as the 2010 recipient. We also paid tribute to our friend Dr. Gildone.

NNDS History in the Making

The NNDS History Re-creation Committee and Julie Forbes have begun our interviews of identified retired dentists who are retelling the tales from yester-year and memories of dental events. The History Re-creation Committee and the NNDS Executive Board agree that these stories will be a very important archive of the dental association, the profession, and something to share with all of you when completed.

Membership Benefits

As your Executive Director for the past nine years, I truly believe that organized dentistry has some *very* important membership benefits. As the Peer Review secretary I can tell you that I believe peer review to be one of your leading benefits. Your peers work very hard to mediate the numerous complaints that come through our office and assist you and your patients by bringing together with amicable agreements that keep these issues out of court. You have many benefits as a tripartite member through the ADA, not only in continuing education, but also in resources available to you for your profession and discounts for many operations of your practice. In the past couple of months the NNDS has added a videoconferencing capability to our office. This allows us to conference with the NDA for those colleagues in Las Vegas and saves on travel costs!

One of the videoconferencing sessions created with this addition features interviews of legislative candidates running for the empty seats in the Nevada Assembly and Senate. Again, a collective legislative "voice" by your association and our incredibly, hard-working lobbyist, Jeanette Belz has certainly opened my eyes to this valuable *benefit* of membership. Your NDA Legislative Committee is certainly willing to hear from you with your concerns. Contact Dr. Bob Talley, NDA Executive Director at robert.talleydds@nvda.org to find out how you can help and get informed.

NDA Summer Meeting 2010

The NDA Annual Summer meeting is scheduled for July 8–10, 2010 at the Hotel Del Coronado in San Diego. *Wow*, what a locale, and at a great rate too! If you want to make this your family's summer vacation, this is the spot. Information about this meeting and registration is available on-line at the NDA website, www.nvda.org. *REGISTER NOW.*

If you are also interested in serving as a NNDS Delegate to the meeting, or if you are interested to know more about serving as a Delegate, Dr. Frank Caffaratti, NNDS Chief Delegate, and I would be happy to tell you more about it. Call or email us if you are planning on going to San Diego this July! ◆

New NNDS Executive Board Officers

Jason Ferguson – Secretary/Treasurer
Brandi Dupont – Member at large/ Continuing Education Chair

WELCOME NEW NNDS MEMBERS

Ali Behnoud, DMD – General Dentistry
Josh Branco, DMD – General Dentistry
Brian Evans, DDS – General Dentistry
John Kaminski, DDS – Peridontist *(returning member)*
Ah "Annie" Y. Kim, DMD – General Dentistry
Cyrus Kwong, DDS – General Dentistry
Cary Jaques, DDS – General Dentistry
Soonjin Park, DDS – General Dentistry
Seung Song, DDS – General Dentistry
Alexander S. Vaughn – DDS, General Dentistry

NNDS President's Message

Scott D. Jarrett, DDS

Well it's almost time for the sunshine to return and for me to say goodbye as your NNDS president. It has been my pleasure to serve our society this year and to help ensure that our benefits as members remain intact. After having been involved for the past five years, I am amazed at the amount of good work our local society and our state association does on our behalf. Prior to serving on the board I thought that I was joining because it was my duty to support the profession. Since then I have learned that without these organizations and the people dedicated to them we would all be in much worse shape professionally. From legislative advocacy, which is getting more important every year, to peer review and continuing education, your society and association is continuously working for you.

In addition to the tangible benefits aforementioned, I have found that the intangibles are even more important. The fellowship shared with other dentists at our monthly meetings is extremely valuable to all of us who tend to be locked up in the office day after day without much professional interaction. I encourage all dentists to become members of their affiliate organizations and I encourage all members to become involved in leadership. We need a continuous flow of good people running through our society to keep it fresh and to help maintain the high level of member benefits we are used to. If you have an interest in becoming involved, please contact Lori at the NNDS office, 775-337-0296 or nnds@nndental.org.

Thank You!

- NNDS Executive Board
- Dr. Mark Funke – Immediate Past President
- Dr. Mark Handelin – Vice President
- Dr. Quincy Gibbs – Secretary/Treasurer
- Dr. Bill VanPatten – Member at Large/Recruitment & Retention Co-Chair
- Dr. Jason Ferguson – Member at Large/Continuing Education Chair
- Dr. Frank Beglin for Co-Chairing our recruitment & retention efforts
- Peer Review Chair Dr. Paul Brosy and the Peer Review Committee
- Northern Nevada Dentist Health & Wellness Committee and Chair Dr. Michael Day.
- Lori Benvin – I would not have made it through this year without her.
- All pro-bono dental care providers
- All who donated their time to the Northern Nevada Dental Health Program (NNDHP); whether you treated children; volunteered on the NNDHP Advisory Board; volunteered on the Golf Tournament Committee or Golf Alliance Committee; or participated and donated to our 7th Annual Charity Golf Tournament. If you are interested in participating as an NNDHP Provider please contact Lori at NNDS, 775-337-0296 or nnds@nndental.org.
- Finally, I thank Mario Gildone for being a pillar of good on this earth. Mario lost his battle with Parkinson's in March and it was a sad day for everyone who knew him. He touched everyone he met in a positive way and always spoke of our profession with pride and honor. I would not be where I am today without his influence in my life. When I applied to dental school and asked him for a recommendation, his questions were not concerned with what kind of student I was, but rather what kind of person I was. He always told me to practice with my heart and never my wallet. I try to instill this belief in every young dentist that I meet. Thank you Mario, you will be missed.

NNDHP Update

Dr. Gilbert Trujillo was elected as the new NNDHP Secretary. This year, 358 children have been treated with pro-bono production in excess of 100k.

This year's golf tournament will be held on September 27 at Hidden Valley Country Club. The tournament has been renamed the "Joel F. Glover, DDS Memorial Golf Tournament to Benefit NNDHP" in honor of our recently departed friend and is being held at Dr. Glover's longtime country club. ◆

Have a great summer; it was an honor serving as your president this past year.

NNDS Upcoming Events

All of our events are updated on our website at www.nndental.org.

May 7: Continuing Education—OSHA, Infection Control, and CDC Guidelines

May 14: Annual NNDS Mystery Bus Trip

July 8–10: NDA Summer Meeting in San Diego, Hotel Del Coronado

August 12: NNDS Annual Open House, BBQ Bartley Ranch Park

September 27: Joel F. Glover, DDS Memorial Golf Tournament to Benefit NNDHP, Hidden Valley Country Club

NDA Mid-Winter Meeting

Silverado Resort, Napa, CA
February 12–13, 2010

Business or Hobby?

By Quinn Dufurrena, DDS, JD

Dentistry is a great profession. It affords many opportunities for a family to enjoy a nice lifestyle. Dentistry can also be stressful. As such, it's important to have the ability to get away from the busy practice. One way to do this is to get a hobby. Whether gardening, fishing, or skydiving; your escape is important.

Is there any other reason to have a hobby? Maybe. Many dentists make significant income. Wouldn't it make sense to be able to deduct part of that income while enjoying the benefits of your hobby?

I have a friend, with a background in legal accounting, that feels a dentist should always have a second business; a business that is clearly enjoyed, just like a hobby. He taught a course, for dentists, on how to enjoy their second business while reducing taxes on their dental practice.

Psychologically, with the ability to "get away" from the stresses of being a health care professional, an added benefit is increasing the doctor's longevity. Also, hand in hand with longevity, goes the ability to treat more patients, in a quality fashion, over a doctor's lifetime.

Anytime somebody is making money you can be sure that the IRS will be involved. Therefore, it is important to realize that the IRS has a formula used to determine whether a business is legitimate or whether the activity is a hobby. The key term is whether the activity, being engaged in is "for profit"? If your object is to make a profit then this may be a business.

The IRS uses criteria to decide whether your business truly has a profit motive. One criterion is called the "three out of five" test. If your business makes a profit in any three out of five consecutive years, it is presumed to be run with the goal of making a profit. Therefore, it is presumed to be a business. However, even if you were unable to show that you made a profit, three out of five years, you still may be able to prove that your business is legitimate by providing evidence that you were "trying" to make money.

Things that show this intent are:

1. Business plans
2. Actions taken to increase profitability
3. Well-maintained books
4. Business licenses
5. Expenditures on marketing
6. Time and efforts involved in the activity

Remember, it is important to be prepared to show that your activity is an actual business. An unprofitable business can be a tax shelter, but only if you take the necessary precautions with proper documentation.

Also, even if after the third year of operation, you fail to make a profit, you have had three years of offsetting business income from your dental practice. You get to keep that money you saved on the previous year's taxes. Bottom line is that you could save money. Saving and playing are both important. They are important to you, your family and to your patients.

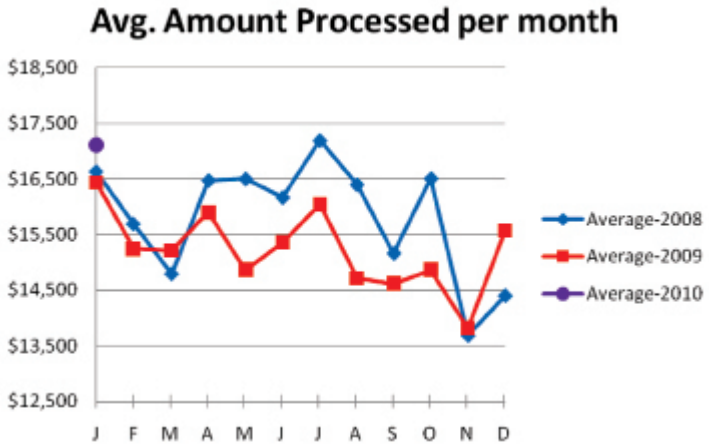
Now get creative and set up another business. ◆

Note: For more information, talk with your accountant as this is not accounting or legal advice.—Quinn Duferrena, DDS, JD

What Effect is the Economy Having on Your Dental Practice?

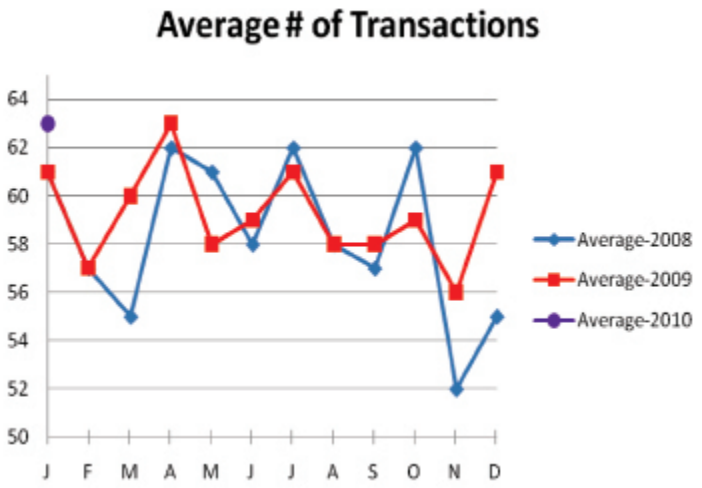
2009 was one of the most difficult years for the economy in recent memory. However, "The Great Recession," as it has come to be called, did not affect all industries uniformly. Best Card is the NDA's endorsed credit card processor who services over 1,300 dental practices primarily in six Midwest/Western states and provides the following data on their dental practices.

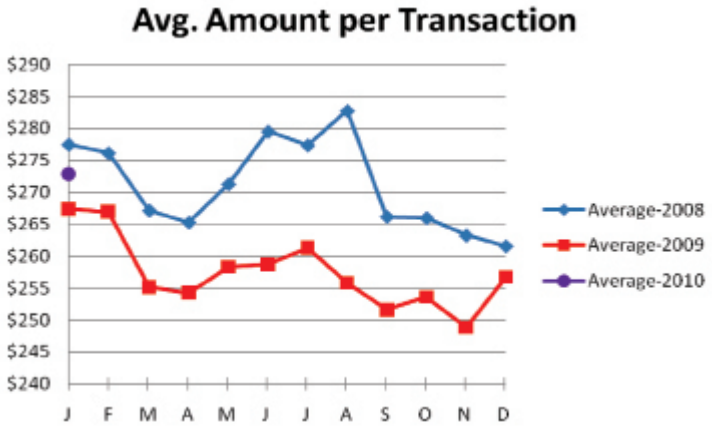
In 2009 the average monthly amount of credit cards processed of $15,221 for Best Card's 1,300+ dental practices reflects a 3.68% decrease from the $15,803 average in 2008. The 2009 average for NDA dentists was $14,146. This is only one indicator, however, for most practices approximately 25% to 33% of dental payments are made with credit cards. From our data it would seem that dentistry has been hit slightly harder than the rest of the economy; a 3.68% decline is greater than the overall 2.4% decline in the national GDP in 2009.



Overall there has actually been a slight increase in the total amount of credit card transactions for dental offices. Dental practices ran an average of 59.3 credit card transactions per month in 2009 (NDA average was 53.6) compared to 58.3 transactions per month in 2008. This increase may seem counterintuitive given the condition of the economy. The reasons for this could be attributed to more people relying on credit to pay medical bills or more people paying for their own dental procedures instead of paying for dental insurance. Still this data does not indicate a significant change in the number of patients seen.

The most significant change in credit card processing in dental offices has been the 5.09% decrease in the average amount per transaction. In 2008 the average amount per credit card transaction was $271.20 compared to $257.40 dollars in 2009. The 2009 NDA average was $263.15.





Considering the number of transactions and the drop in the amount of the average ticket, this could imply that dental offices are still maintaining much of their business but that customers are declining or postponing certain procedures.

While you can always do marketing to increase revenues, you also want to make sure that you're effectively managing

costs to maximize your net profit margins. A simple method to see if your credit card processing fees are too high would be to divide your monthly processing fees by your dollar volume processed (i.e. fees $262.12/ processed $9,973.14=2.63% effective rate charged). If you are paying more than 2.2% we strongly recommend that you reassess your rates—now is a great time since most processors are increasing rates in April.

Best Card, the Oregon Dental Association's partner for credit card processing, has saved dental practices an average of $1,066 annually (or 23%) over previous processors. If you would like to see how much your practice can save, they can be reached at 877-739-3952 or you may fax a recent credit card processing statement to them at 866-717-7247. ◆

Dedicated Insurance Agent for NDA Members

Insurance is necessary, but does not need to be complicated. NDA members have a dedicated agent to identify needs, perform research and make recommendations, saving the time and effort associated with looking for insurance. **Rhonda Wright, TDIC Insurance Solutions'** sales agent, will simplify the insurance process for members with insurance reviews and plans inspected and approved by a committee of dentists.

Rhonda Wright is based in Las Vegas and can be contacted at 800-733-0633 with questions or to schedule an insurance review.

Insurance reviews analyze existing insurance and compares it to your current needs. Wright uses the insurance review to check for gaps or overlapping coverage and suggests changes based on what she finds.

As NDA's endorsed insurance broker, TDIC Insurance Solutions partners with the best-in-class carriers to provide workers' compensation, long-term care and life, health and disability plans. It is the only broker offering TDIC's professional liability and office property insurance.

"Helping NDA member-dentists is my top priority. I want to make sure they have the protection they need," Wright said. ◆

Chondrosarcoma of the Left Mandibular Condyle

By Matthew J. Madsen DMD; Juan F. Yepes DDS, MD; Larry L. Cunningham DDS, MD

Abstract

Neoplastic diseases of the Temporomandibular Joint (TMJ) complex are rare. Diagnosis of TMJ neoplasms is made difficult due to the relatively common complaints in the general population of TMJ pain or inflammation as well as the common complaints of clicking, popping, or subluxation. This article presents a case report of a patient with a rare chondrosarcoma of the TMJ. The patient, a 54-year-old male first presented with the chief complaint of pain in the preauricular and TMJ area. This case report emphasizes the importance of the need for thorough clinical examination as well as proper radiographic diagnosis.

Introduction

The Temporomandibular Joint (TMJ) is a compound diarthrodial joint that is composed of the temporal bone, mandible as well as the articular disk as well as upper and lower joint spaces. The articular surfaces of the condyle and temporal bone are covered by articular fibrocartilage. This cartilage is capable of growth and regeneration, and in some cases can undergo neoplastic transformation.

There are a number of pathologies associated with the TMJ. It is estimated that TMJ related pain is experienced by approximately 5% of the general population. Approximately 2% seek treatment for TMJ related symptoms [1,2]. Disorders may result from noninflammatory causes such as osteoarthrosis, others may present as joint inflammation secondary to a bacterial infection. Neoplastic diseases of the TMJ are uncommon. Chondrosarcoma of the TMJ is a rare entity, and there are very few reported cases of TMJ chondrosarcoma [3,4]. Clinical presentation of TMJ tumors, including chondrosarcoma, often mimic those of more common disorders and are challenging to diagnose. Frequently due to the slow progression of the neoplastic growth, the initial diagnosis is related to chronic Temporomandibular Joint Disorders (TMD). Symptoms at presentation are usually nonspecific and may include: facial, preauricular, or auricular swelling; pain; limited maximal incisal opening or trismus; facial pain; discomfort in the TMJ region; persistent symptoms; and hearing loss.

Chondrosarcomas are malignancies arising from the joint fibrocartilage. Clinical observation, as well as radiographic findings, are essential in initial diagnosis. Final diagnosis is made histopathologically based on the lesions appearing as lobulated, cellular neoplasms [5]. The histologic appearance of chondrosarcomas is variable. Conventional chondrosarcoma appears as malignant hyaline and myxoid cartilage. Large bulky tumors are made up of nodules of gray-white, glistening tissue. Spotty calcifications are typically present, and central necrosis may create cystic spaces. The tumors vary in degree of cellularity, cytologic atypia, and mitotic activity [6]. Histologically, the lesions are graded from 1–3 based on degrees of hypercellularity and chondrocyte appearance. Grade I have lobular architecture; grade II have myxoid stroma with enlarged chondrocyte nuclei, grade III chondrosarcomas are markedly cellular, often with a spindle cell proliferation. Frequently lesions can have mixed areas that vary in severity of cell proliferation and malignancy.

Patients who present with chondrosarcoma are usually age 40 or older. The tumors appear to have no race predilection. This is a case presentation of chondrosarcoma in a 54-year-old patient. This case will emphasize the importance of the clinical history and the importance of correct examination and radiographic interpretation.

Case Report

A 54-year-old Caucasian male, was referred to the Division of Oral Medicine at The Hospital of the University of Pennsylvania (HUP) complaining of pain in the left temporomandibular joint and pre-auricular area. He noticed this pain approximately 5 to 6 weeks prior to the evaluation. The pain increased over the last 2 weeks. The patient reports that the pain increases when biting hard food or after sleeping on left side. At the Initial patient consult an ENT surgeon referred the patient for a dental evaluation. The ENT physical exam was reported as non-contributory for any inner or outer ear findings.

The patient's past medical history was significant for hypertension diagnosed in 1990, past surgical history was significant for a cataract in the right eye in 1991. The patient had no known drug allergies. Current medications the patient was taking included hydrochlorothiazide/triamterene and aspirin. A review of systems revealed double vision and mild joint pain in his right hip. His social and family histories were non-contributory. He denied tobacco and alcohol use.

Clinical examination revealed a well-developed and well-nourished man in no apparent distress. Extraoral examination revealed bilateral submandibular lymphadenopathy approximately 1 cm in size. The right lymphadenopathy was tender and moveable, while the left side lymphadenopathy was non-tender and moveable. The most likely reason of the lymphadenopathy was a recent cold reported by the patient. His neck was supple, and there were no lesions on his exposed facial skin. No salivary gland enlargement was noted on visual and palpation examination. Cranial nerve examination was grossly normal. Intraoral examination was within normal limits. The exam of the temporomandibular joint movements revealed a normal mouth opening with slight deviation to the right side. No sounds, clicking or crepitus were detected in the exam. The patient referred slight pain over the left temporomandibular joint especially with lateral excursions. No swelling or tenderness was noted in the exam. His major salivary glands produced clear saliva upon bidigital palpation. A Pantomograph was taken with the following interpretation: A radiolucent area near the neck of the left condyle measuring 4mm x 5mm. The lesion appears to be well defined, partially corticated, and round in shape. The rest of the interpretation was within normal limits. *(Figure 1)*

From the pantomographic film a list of differential diagnoses was compiled and included: osteosarcoma, synovial chondromatosis involving the temporomandibular joint, ameloblastoma, central giant cell granuloma, odontogentic myxoma, aneurysmal bone cyst, and keratocyst. A Computed Tomography (CT) scan was ordered showing a cartilaginous neoplasm. The CT scan was superior in defining the peripheral extent of the tumor in the region of the left condyle.

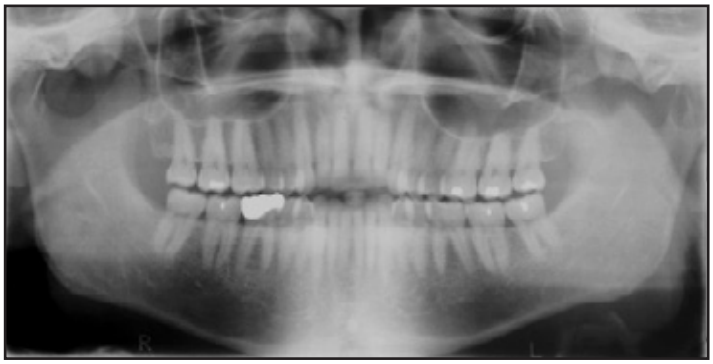


Figure 1 *Panoramic film demonstrating a well defined radiolucency within the left condylar head*

The patient was referred to the Oral and Maxillofacial Surgery service at HUP and an excisional biopsy was completed. Rich cellular stroma with multiple chondroblast and spindled-shaped mesenchymal cells. Chondroblast cells noted with multiple nuclei and hyperchromatism were present. Mononuclear cells with irregularity in cell size was seen. Gross tissue exam showed a lobular growth pattern with fibrous tissue in the middle. No calcifications were present. The peripheral areas of the lobules show immature cartilage and mesenchymal tissue. Histology grade I (low grade of malignancy). Final pathological diagnosis was interpreted as Chondrosarcoma.

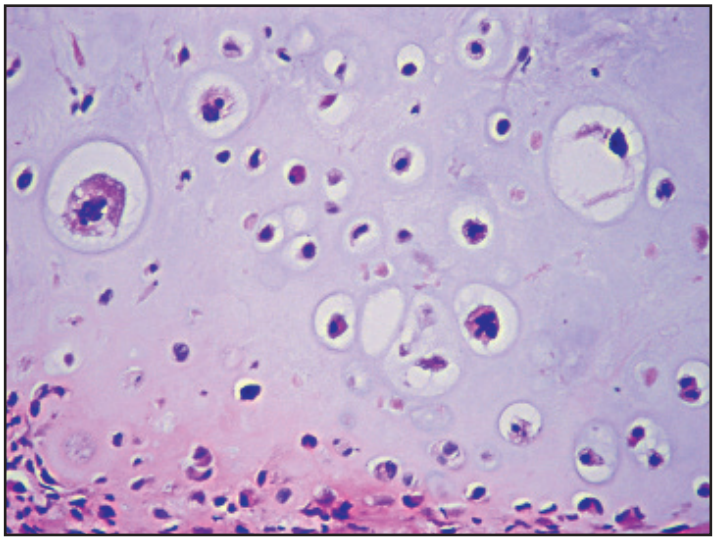


Figure 2 *Chondrosarcoma histopath*

Discussion

Chondrosarcoma of the TMJ is rare. By 1993 only five cases had been reported [7-11]. It accounts for approximately 1% of chondrosarcomas of the entire body. The lesion size of 1 cm presented here is consistent with the size of a biopsied lesion presented by Takahana dos Santos [13]. Slow presentation of clinical signs and symptoms is consistent with the gradual deterioration described by Nitzan [4]. It appears that in chondrosarcoma of the jaw, there is a slight female predominance [3].

A neoplasm that is frequently confused with chondrosarcoma is osteosarcoma of the jaw. Osteosacroma was included in the differential diagnosis of the patient described in this case report. It is the most common tumor of the TMJ constituting approximately 5–6% of osteochondromas appear in the jaws [12]. It is an aggressive malignancy that constitutes 5 to 10% of all cases of skeletal

Continues on page 34

osteosarcoma [13]. Correct diagnosis of chondrosarcoma from osteosarcoma is essential due to the treatment differences of the two malignancies. Chondrosarcoma is considered to be radioresistant and requires wide surgical excision, while osteosarcoma can be treated with surgical excision (maxillectomy or mandibulectomy), followed by radiotherapy or chemotherapy for recurrences.

Metastasis is another common source of a malignant tumor of the jaws [4]. Metastatic disease is usually the result of a distant, primary lesion. Malignancies usually appear in older patients with a history of preexisting metastatic disease. The most frequent benign bone tumors of the TMJ include osteoma and condylar enlargement or hypertrophy, and should also be considered in the diagnosis.

The difficulty of diagnosing rare neoplasms of the jaws results from the high number of patients that have been diagnosed with TMD. In all cases, further workup should be performed to eliminate the possibility of unusual causes. In addition to clinical procedures, patient's workup should include advanced radiologic examination, performed to aid in the differential diagnosis which may include joint inflammation or tumors. Tumors of the TMJ have variable presentation and can affect the osseous, cartilaginous, or muscular structures related to the joint.

The changing structures related to the neoplasm often show signs of painless swelling, expansion of the affected bones, resulting in the loosening of teeth or ill-fitting dentures. Pain, visual disturbances, nasal signs and headache may result from the extension into nearby structures [14]. Upon noting these clinical changes, along with accurate radiographic interpretation of advanced imaging modalities the clinician may obtain an accurate diagnosis in these rare cases. ◆

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Larry L. Cunningham DDS, MD is an Associate Professor in the Division of Oral and Maxillofacial Surgery, at the University of Kentucky College of Dentistry in Lexington, KY.

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NDA PAST PRESIDENTS

1922 George H. Marvin	1951 Leonard G. Jacob	1980 Duane E. Christian
1923 John V. Ducey	1952 Clifford A. Paice	1981 Dwight Meierhenry
1924 Thomas H. Suffol	1953 Walter R. Bell	1982 Clair F. Earl
1925 George A. Carr	1954 Raymond J. LaFond	1983 R. D. Hargrave
1926 Samuel T. Spann	1955 Jack E. Ahlstrom	1984 James L. Davis
1927 Bruce Saulter	1956 J.D. Smith	1985 N. Richard Frei
1928 Frederick H. Phillips	1957 Kern S. Karrash	1986 Lloyd Diedrichsen
1929 Frederick J. Rulison	1958 Vincent J. Sanner	1987 Gerald Hanson
1930 William H. Cavell	1959 Wallaxe S. Calder	1988 Gerald C. Jackson
1931 Harold E. Cafferata	1960 John B. Hirsh	1989 James C. Evans
1932 Louis M. Nelson	1961 David W. Melarkey	1990 Whit B. Hackstaff
1933 Carlton E. Rhodes	1962 David W. Melarkey	1991 William E. Ursick
1934 Pliney H. Phillips	1963 Fae T. Ahlstrom	1992 Dennis J. Arch
1935 Harold R. McNeil	1964 Morris F. Gallagher	1993 A. Ted Twesme
1936 Lawrence D. Sullivan	1965 Wayne L. Zeiger	1994 Bruce Pendelton
1937 Alexander A. Cozzalio	1966 Mario E. Gildone	1995 J. Gordon Kinard
1938 Charles A. Cozzalio	1967 William D. Berry	1996 Joel F. Glover
1939 George A. Carr	1968 James F. Archer	1997 Rick Thiriot
1940 George A. Steinmiller	1969 Philip J. Youngblood	1998 Jade Miller
1941 George A. Steinmiller	1970 Carl M. Hererra	1999 Patricia Craddock
1942 Omar M. Seifert	1971 George P. Rasqui	2000 William C. McCalla
1943 Stephen W. Comish	1972 William H. Schaefer	2001 Robert H. Talley
1944 Quannah S. McCall	1973 Robert L. Morrison	2002 Susan Jancar
1945 Oliver M. Wallace	1974 John S. McCulloch	2003 Dwyte Brooks
1946 Gilbert Eklund	1975 James M. Jones	2004 Peter DiGrazia
1947 Robert H. Gatewood	1976 Harry P. Massoth	2005 Robert Thalgott
1948 E. Ross Whitehead	1977 Leeland M. Lovaas	2006 Arnie Pitts
1949 Howard W. Woodbury	1978 Blaine R. Dunn	2007 George Rosenbaum
1950 Roy P. Rheuben	1979 Louis J. Hendrickson	2008 Joel T. Glover

Calendar of Events

APRIL 2010

APR 14	SNDS Dentist Health and Well-Being Committee	6 PM	Call SNDS for details, 702-733-8700
APR 19	NDA Exec. Committee Meeting/Strategic Planning	9 AM–3 PM	8863 W Flamingo Rd, Ste 102, Las Vegas
APR 21	SNDS Peer Review Committee	6 PM	Call SNDS for details, 702-733-8700
APR 29	NNDS & 3M General Membership Dinner Meeting	6 PM	Atlantis Hotel Casino, Reno

MAY 2010

MAY 7	All Day CE Course—*presented by NNDS* OSHA, Infection Control, CDC Guidelines	9 AM–4 PM	Peppermill Hotel Casino, Reno
MAY 7	SNDS Installation of Officers		Call SNDS for details, 702-733-8700
MAY 11	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
MAY 12	SNDS Dentist Health and Well-Being Committee	6 PM	Call SNDS for details, 702-733-8700
MAY 14	NNDS Annual Mystery Bus Trip	5 PM	It's a secret!
MAY 19	SNDS Peer Review Committee	6 PM	Call SNDS for details, 702-733-8700
MAY 26	NNDS Peer Review Committee (if clinical)	5:30 PM	3575 Grant Drive, Reno

JUNE 2010

JUNE 8	SNDS Continuing Education mini seminar		Call SNDS for details, 702-733-8700
JUNE 8	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
JUNE 9	SNDS Dentist Health and Well-Being Committee	6 PM	Call SNDS for details, 702-733-8700
JUNE 16	SNDS Peer Review Committee	6 PM	Call SNDS for details, 702-733-8700
JUNE 30	NNDS Peer Review Committee (if clinical)	5:30 PM	3575 Grant Drive, Reno

JULY 2010

JULY 6	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
JULY 8–10	NDA Summer Meeting & House of Delegates	All Day	Hotel Del Coronado, San Diego
JULY 8	NDA Executive Committee Meeting	3 PM	Hotel Del Coronado, San Diego
JULY 14	SNDS Dentist Health and Well-Being Committee	6 PM	Call SNDS for details, 702-733-8700
JULY 21	SNDS Peer Review Committee	6 PM	Call SNDS for details, 702-733-8700
JULY 28	NNDS Peer Review Committee (if clinical)	5:30 PM	3575 Grant Drive, Reno

AUGUST 2010

AUG 10	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
AUG 12	Jason Eberle Memorial Concert & BBQ	5 PM	Bartley Ranch Ampitheater, Reno
AUG 19	NNDS Open House BBQ	5 PM	Bartley Ranch Park, Reno
AUG 25	NNDS Peer Review Committee (if clinical)	5:30 PM	3575 Grant Drive, Reno

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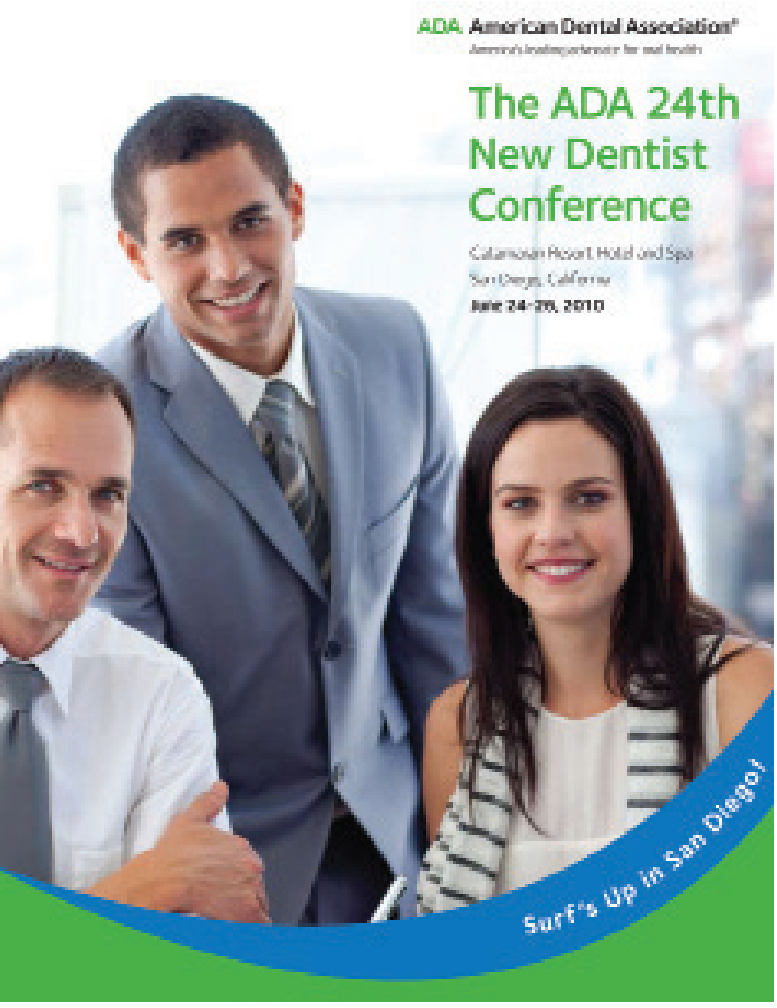

AFFILIATED PRODUCTS

The following companies are NDA affiliated products. These products have been evaluated and are recommended for use in running your practice. Please let us know if you have any feedback or would like to recommend a product or service for affiliation.

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citimortgage	*Real Estate Assistance*	**888-466-3232**
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D-Mmex	*EasyRefine Program*	**800-741-3174**
DRNA	*Waste Management*	**800-360-1001 x11**
EBESCO	*Subscription Service*	**800-527-5901 x1652**
FedEx	*Shipping Services*	**800-636-2377**
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