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It has been my pleasure and honor to serve you as president of the Arkansas State Dental Association this past year. I have become better acquainted with old colleagues and have enjoyed making new friendships along the way. We all have more traits in common than differences that separate us. I can say without hesitation that the dentists within the realm of ASDA are focused on ethical and sensible dental care. I look forward to continued successes for our Association as we move forward in organized dentistry.

I want to give credit to whom it is due. We have a core membership who is dedicated to the dental profession to make our mission of promoting health for our citizens a true reality. Included in our member roster is a splendid set of new dentists who have joined ASDA for the same reasons the rest of us have retained our membership. ADA President Joe Crowley has said that the young dentists (or “new talent” as he likes to call them) are idealistic in their hopes for creating a better world for us all. And we should all strive for an idealistic outlook to keep our doors open to all who seek dental care. Even though many dental patients underutilize the entire scope of dental treatment, dentists strive to promote greater dental health to match their individual needs.

Arkansas Mission of Mercy

We gather again as an honorable profession to give forward to our fellow citizens our gifts and talents at the 2018 ArMoM to be held in Conway at the Conway Expo & Convention Center on April 26–28. Registration for dental professionals needs to occur very soon if you have not already done so. You can sign up through arkansasdentistry.org. This year for the first time we might have out of state dentists among us who have applied to our Board of Dental Examiners for a four-day charitable license, so if you see one of those “out-siders,” make them feel welcome and thank them for sacrificing their free time to give to our needy citizens. I have participated with Texas Mission of Mercy a few times, and I greatly prefer our scenario over theirs. We expect a large population of patients seeking care, and we do not want to turn anybody away because of not having enough workers. Please see to it that you become involved in 2018 ArMoM, and I promise you will be blessed in so many ways.

Helping Hands

The Helping Hands committee was formed by ASDA Executive Council in 2016 with the purpose of offering our members a temporary avenue for supplying volunteer dentists to substitute their presence in times of need to keep a dental practice opened during an emergency medical crisis. This concept was conceived arising from the medical emergency experienced by our colleague, the late Dr. Tim Chase, whereby his family and staff coordinated with several ASDA members to provide substitute dentists to care for patients in his office setting. The committee consists of Drs. Terry Fiddler(C),

Continues on page 13
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That is what dentists do. I think after DDS or DMD behind your title, we could add HO (helping others). That certainly is part of our credentials even if was earned as on the job training and not in school. Many have heard me say over the years that I truly believe that God put each of us on this earth to help others. Jesus gave the example of the ultimate servant.

We wake up every day to earn a great living but invariably during that day we get sidelined to go above your planned schedule. Perhaps you do a little extra to aid a patient when you know they can’t afford it and it becomes free of charge; perhaps you get a phone call to carry you away for a few minutes from your busy schedule to help in a community matter; perhaps you get called on to go to a nursing home or a free clinic for your expertise and not for income. Perhaps, that is why on nationwide polls concerning professions, dentists are always at the top. As people from my generation once heard actor Walter Brennan say in a popular role, “no brag, just fact.” We don’t do these things to beat our chest to be heard or seen. We just do them. Others can beat your drum, not you.

So we come to the ARKANSAS MISSION of MERCY to be held April 26–28 in Conway. We need 160 dentists. We have 60. Positions other than dental assistants are being quickly filled. WE NEED YOU. You have always come through for us and I feel certain that you will again. Please go online and register as soon as possible. We are in dire need of restorative dentists. I promise you that it will be one of the most rewarding experiences of your life. The underserved citizenry of Arkansas and surrounding states will love you! Like in other parts of your practice, we just need your expertise. We provide everything else plus 8 hours of CE credit.

HELPING HANDS is a program that has been founded in the last few years by Dr. Chuck Wood, Dr. Cindy Landry, and others. This program helps out when a dentist and their family are suffering because of illness or other family crisis that has prevented the doctor from practicing. ASDA has for years, helped those struggling for so many reasons but now we are organized in a manner to better serve. Dr. Tim Chase and his family, Dr. Tom Smith and his family, and Dr. Cindy Landry and her family were helped in some manner because of other caring dentists who helped by substituting in their offices while they were away, or by helping family members in practice sales, or just by explaining what was going on. Sometimes arms around the suffering means so much. I invite each of your reading this article to join our numbers. Our President, Dr. David Vammen, has been heavily involved in both programs. Granted both programs are physically tiring, but they are a labor of love.

Dentistry may not be solution to all the problems in the world, but to those it reaches out to help for either program, it is a godsend.
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PAST PRESIDENT
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chairman, David Cole (SW), Trevor Coffee (SW), David Vammen (SW), Alisa Hopper (SE), Stacey Swilling (SE), Chuck Wood (NE), Cindy Landry (NE), Mike Williams (NE), Tom Spivey (NW), and Mrs. Paige Chase of Monticello. During our committee meeting Mrs. Chase related her experiences with handling the coordinated effort to keep the doors open at Tim’s practice during his medical leave of absence. The Helping Hands committee members ask you, the heart and soul of ASDA, to commit your willingness to serve our colleagues as a volunteer dentist should a crisis occur. In the bible verse from Ecclesiastes 4:10, we learn “If one man falls down, his friend can help him up; but pity the man who falls and has no one to help him up.” Please search your heart and conscience and offer your name as a willing colleague to join a network as a Helping Hands volunteer. Contact a friend on the Helping Hands committee to express your willingness to serve.

ADA—Honolulu
It is time to make your plans to come to beautiful Hawaii for the 2018 ADA Convention. The dates of the meeting are October 18-22. What a fabulous destination to convene with colleagues from all over the USA and the world! Earn valuable CE hours and bask in one of the world’s loveliest island retreat. Make your plans now to attend the convention and book your lodging early at one of the many hotels so you can stay at your preferred resort. And once you have registered with the ADA, please notify the ASDA of your intentions to attend, because we want to know who’s going to join the fun at America’s Dental Meeting!

In Conclusion
I am grateful to all of you who have offered to me your kind words of encouragement during my term as president of ASDA. I really appreciate your involvement in our professional activities to perpetuate organized dentistry. We are able to provide care for God’s children through His hands in the great profession of dentistry. May God bless each and every one of you in the coming days.

Sincerely,

David Vammen, DDS
President, ASDA

P.S. If you just can’t find me, I’m probably relaxing in a chair in the cool waters of the Little Missouri River...
Volunteer Opportunities – A Chance to Give Back

Why not volunteer your dental services once or twice a year in the community that provides your livelihood? Volunteer dentists, hygienists, assistants and staff are needed.

Some of the volunteer dental clinics in central Arkansas and their times of operation are listed below. A contact person is included to answer questions and set up a time to volunteer.

Harmony Health Clinic
201 East Roosevelt Road
Little Rock, AR 72206
Contact: Eddie Pannell
501-375-4400
Hours: day and evening clinics, Monday – Saturday
www.harmonyclinicar.org

Interfaith Health Clinic
514 West Faulkner
El Dorado, AR 71730
Contact: Charlotte Ellen,
870-864-8010
Hours: 8:00 a.m. – 5:00 p.m., Monday through Friday

Northwest Arkansas Free Health Center
10 South College Avenue
Fayetteville, AR 72701
Contact: Monika Fischer-Massie,
479-444-7548 or mfischerm@arkansasusa.com
Hours: Thursdays start between 4:00 and 5:30 p.m. for about 2.5 hours; Fridays start between 8:30 and 9:00 a.m. for about 2.5 hours
Clinic makes accommodations for the volunteer dentists’ schedules.

Jonesboro Church Health Center Dental Clinic
200 West Matthews Ave.
Jonesboro, AR 72401
870-972-4777

Charitable Christian Medical Clinic
133 Arbor St.
Hot Springs, AR 71901
Contact: Millie Lopez, 501-318-1153

Shepherd’s Hope Clinic
2404 S. Tyler
Little Rock, AR 72204
Contact: Pam Ferguson
501-614-9523
Hours: 6:00 p.m. – 9:00 p.m. every Tuesday
www.shepherdshopelr.org

River City Ministries
1321 East Washington Ave.
No. Little Rock, AR
Contact: Carol Ezell
501-376-6694
Hours: 8:30 a.m. – 4:30 p.m., seven days a week
www.rivercityministries.org

Christian Community Care Clinic
2200 W. South St., Benton, AR 72015
Contact: Kae Wissler at Dr. Richard Phelan 501-778-7129
Hours: The 2nd and 4th Tuesday of every month
6:00 p.m. – 8:00 p.m.
www.bentoncareclinic.com

Arkansas Health Care Access
Little Rock, AR

Arkansas Donated Dental Services
Little Rock, AR

Eureka Christian Health Outreach, Inc. (ECHO Clinic)
4004 East Van Buren
Eureka Springs, AR 72632
Contact: Janet Arnett
479-253-5547
Clinic offers free dental extractions and other medical services.

The Harmony Health Clinic is a free medical and dental clinic that strives to meet the needs of the homeless and less fortunate in the greater Pulaski County area.

We are currently in need of dentists to volunteer on Fridays, hours ranging from 8:00 a.m. to 12:00 p.m. and can be adjusted to meet volunteers’ schedules.

An experienced dental assistant is on staff and available to assist all volunteers. If you have four hours a year to give back or more please contact Tiffany Sikes at 501-375-4400.
One of the hallmarks of being a healthcare provider in a hospital system is treating patients who have entered into a more advanced stage of the disease process. In the case of dentistry, this usually implies a severe odontogenic infection. Patients are overwhelmingly unaware of how serious a “cavity” can become, both locally and systemically. As a practitioner, part of our commission is to treat these individuals with the best care that can be provided. Ultimately, prevention and diligence on the part of the patient and the provider will largely preclude a severe odontogenic infection from arising; however, when a case inevitably presents, it is our responsibility to be equipped with the skills and the knowledge to produce a successful outcome. The intention of this paper is to educate and to offer guidance in the treatment planning options for patients with severe odontogenic infections.

Before discussing treatment options for patients presenting with odontogenic infections, it is important to first understand the source of infection as well as to fully understand the disease process. Odontogenic infections are bacterial-mediated. They occur when bacteria gain entrance into the periapical space of a tooth by way of the pulp, pericoronal tissue, or the periodontium. In terms of frequency, author Flynn, et al., explains that “the most frequent dental disease leading to severe odontogenic infection was caries (65%), followed by pericoronitis (22%), and periodontal disease (22%) (2006). The severity of the infection is multi-factorial, but is largely dependent upon the microflora present. Though it has been shown that roughly 700 different species of bacteria can be present at any given moment in the oral cavity, it is the specific compilation as well as location, which can permit such an infection to propagate (Mougeot, et al., 2015). Odontogenic infections are polymicrobial in nature and...
are predominately anaerobic gram-positive cocci and gram-negative rods. It is the virulence factors of these bacterial species that allow them to be so effective.

Stefanopoulos and Kolokotronis state that, “pathogenicity of bacterial include aerotolerance, a variety of bacterial enzymes, toxins, and metabolites detrimental to the host, possession of a capsule with antiphagocytic and abscessogenic properties, and bacterial synergism” (2004). Because odontogenic infections are mixed infections, the bacteria are able as a virulence factor by stimulating the production of inflammatory cytokines. Endotoxin, hydrogen sulfide, and other proteolytic enzymes are inherently cytotoxic. This accounts for tissue degradation resulting in the continuing spread of the infection. The addition of the beta-lactamases family of enzymes to some of these bacterial species increases their pathogenicity by inactivating two of the most commonly used antibiotic classes of drugs.

This brief introduction into the microflora of odontogenic infections has shown how these bacteria are able to be so effective in their pathogenicity. Now it is important to understand the staging of the infection and what practitioners should look for when a patient presents with symptoms of infection.

The inoculation of invading bacterial species into the tissue is the first stage of the infection process. There is an early inflammatory period at this time, due to the presence of the invading bacterial; this inflammation will ultimately cause edema. Clinically, this is significant because clinicians are able to objectively see signs of the infection. Two to five days into the infection, the edema will have progressed and cellulitis develops. The softer swelling of the initial stage will begin hardening. This infected area will be hot to the touch, quite tender, and will rapidly enlarge. From this stage to the next stage the cellulitis begins transitioning into an abscess formation. Four to seven days into the infection, the hardness will soften, and the underlying tissue will form a necrotic mass of granulation tissue, sequestered bacteria, and immunologically-active cells. Abscess formation helps by walling off the infection allowing the immune system of the host to effectively kill the invading bacteria and to stop further spread (Flynn, 2000).

Without removing the source of infection by way of endodontic therapy or exodontic therapy, this process can repeat over and over again in a patient with an odontogenic infection. This is quite common for patients to be unaware of the severity of complications that an odontogenic infection can produce. They will often admit to having a draining abscess present over the course of months to even years. In many cases, no life-threatening infection will occur.

Now that staging of a typical odontogenic infection has been fully appreciated, it is imperative to understand how an odontogenic infection becomes severe. The classic example is that of Ludwig’s angina. “Ludwig’s angina is a bilateral infection of the submandibular space that consists of two compartments in the floor of the mouth, the sublingual space and the sub mylohyoid space” (Chow, 2015). The hallmark of this disease process is airway obstruction. This occurs by the bilateral spread of the cellulitis. Mandibular second and third molars are most likely to be the source of infection resulting in Ludwig’s angina. This is due to the location of the roots of these teeth in relation to the fascial planes necessary
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to be crossed, notably beyond the attachments of the mylohyoid muscles, in order to infect the submandibular space. It should be noted “fascial layers prevent inflammatory spread, once the infection spreads into the muscle beyond the fascia, the muscle itself can transfer inflammation to the adjacent tissues” (Obayashi, et al., 2004).

The symmetrical presentation of the swelling in Ludwig’s angina is due to the aforementioned spread of infection. If the infection were instead spread through lymphatic involvement, one would note that the swelling and infection would be unilateral. This is an important finding that would rule out a diagnosis of Ludwig’s (Chow, 2015).

An established infection in the submandibular space will cause the tongue to swell and be pushed in a posterior direction towards the hypopharynx and superiorly against the palate. These factors, along with infection spread to the retropharyngeal and parapharyngeal spaces, accounts for the airway occlusion. Airway obstruction can be slightly relieved by having patients assume the “sniffing position.” This position helps to straighten the upper airway allowing for a more patent airway (Flynn, 2000). It should be noted that due to the swelling of the tongue, occlusion of the airway, and palatal involvement the patient would have a difficult time communicating verbally. This can further complicate getting necessary information from the patient for proper treatment. For a definitive diagnosis of Ludwig’s angina, “a computed tomography scan is the imaging modality of choice” at this time (Chow, 2015). In many cases magnetic resonance imaging can offer a superior image to that of a CT in regards to the initial evaluation of a patient with deep space infections; however, the authors Bali, et al., explain that this is not a practical option for many emergency cases (2015).

A severe odontogenic infection does not only present itself in the form of Ludwig’s angina, the spread of infection can follow many fascial layers. According to Jose, et al., “maxillofacial infections are known to spread intracranially by direct extension along the fascial planes or by hematogenous route into the cavernous sinus” (2014).

This route of infection is typically seen when the infraorbital space has become involved. There are angular veins that run through this space, and when a septic thrombophlebitis enters these veins it can then ascend into the cavernous sinus through valveless veins. Once present in the cavernous sinus, a thickening of the meningeal walls can produce compression of cranial nerves III-VI resulting in signs of neuropathy.

Though Ludwig’s angina and cavernous sinus involvement are two of the more severe complications associated with odontogenic infections, many other head and neck spaces can become involved. The following other spaces can be involved: buccal, infraorbital, subperiosteal, subcutaneous, submental, masticatory, submasseteric, pterygomandibular, temporal, lateral pharyngeal, and retropharyngeal. There have been cases of mediastinitis resulting from odontogenic infections. In fact, 60%-70% of cases of descending necrotizing mediastinitis have been implicated in resulting from unresolved odontogenic infections (Sakamoto, et al., 2000).

Another potential danger of odontogenic infections lies in the bacteria’s ability to gain entrance to the blood stream. This bacteremia can produce numerous distant site infections. Infective endocarditis is one such infection.

Infective endocarditis (IE) is inflammation that occurs in the endocardium of the heart. Artificial heart valves are more commonly associated with cases of IE than native heart valves. The species of bacteria that are present in the oral cavity are associated with the same infecting bacterial species as with IE. Though extracting infected teeth can help remove a source of the bacteria associated with IE, it has been shown that extractions in and of themselves can cause bacteremias, which have the potentiality to cause IE.

This discovery has prompted many to prophylactically medicate high-risk patients with antibiotics prior to extraction of diseased or even virgin teeth. Such conditions deemed high-risk include: artificial heart valves, orthopaedic joint prostheses, immunosuppressed patients, as well as patients with catheters or shunts for hemodialysis (Lockhart et al., 1999). The use of prophylactic antibiotics for the purpose of preventing distant site infections (DSI) has many opponents. Some argue that organisms that cause IE and other DSI can be found in the upper and lower digestive tract, skin, as well as the upper respiratory tract. These extraoral sites could also be the source of IE and DSI. Mougeot et al. explains “although [antibiotic prophylaxis] decreases the frequency of all oral bacterial species, both tooth brushing and single tooth extractions disrupt similar bacterial species in similar proportions” (2015). This finding suggests that, regardless of antibiotic prophylaxis, bacteremias are present in similar microbial-content as well as quantity following a common task such as brushing one’s teeth. Though the literature currently asserts that this bacteremia is

Though extracting infected teeth can help remove a source of the bacteria associated with IE, it has been shown that extractions in and of themselves can cause bacteremias, which have the potentiality to cause IE.
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caused on a daily basis through normal activities, it should be left to the discretion of the practitioner whether or not prophylactic antibiotics are prescribed. Consider the patient’s systemic conditions, history with IE, as well as other extenuating circumstances when formulating a decision. Despite acting against the literature, the litigious society in which one lives makes this decision more difficult.

A clear understanding of the cause and the process of complications resulting from severe odontogenic infections has been provided. Understanding how to manage these patients surgically is the next phase.

As one would imagine, removal of the source of infection is the primary goal for treatment of odontogenic infections. This can take many forms. Less severe infections can be primarily treated by extraction of the infected tooth and curettage of the socket. Antibiotics can be a good supplement to primary treatment; however, this is not always necessary. In more severe cases, “the establishment of gravity-dependent surgical drainage of deep space odontogenic infections is the primary treatment” (Flynn, 2000). By opening up the infected space, a significant portion of the microbial load will be removed allowing leukocytes to gain better access to the remaining infection. Not only is the infected space more accessible, but also by collapsing the avascular abscess cavity, blood is able to more effectively flow near and into the infected space increasing local leukocyte numbers.

Following incision and drainage, most surgical sites will stop producing exudate in two to three days. Complete resolution is often seen five to twelve days postoperatively. To further increase healing response time, patients are often placed on antibiotics as well as instructed to place moist heat on the infected tissue. This will trigger vasodilation in the associated area resulting in a more prompt resolution of the infection by a “rapid removal of tissue breakdown products and a greater influx of defensive cells and antibodies” (Bahl et al., 2014).

As indicated in the previous passage, antibiotic therapy is typically used in conjunction with surgical drainage or removal of the offending tooth, but not as the sole treatment. The most accurate method for choosing an antibiotic class, assuming no drug allergies, is culturing for the purpose of determining antibiotic efficacy. Though, a more pragmatic choice would be to place the patient on an antibiotic class that is statistically likely to be efficacious against bacteria that are commonly the cause of odontogenic infections. At this time, “penicillin remains the drug of choice in the management of most odontogenic infections” (Bahl et al., 2014).

Due to an increase in penicillin-resistant bacteria, it has become common practice to additionally place the patient on clavulanic acid to counter the beta-lactamase enzyme. In addition, many practitioners will add metronidazole to the antibiotic combination to aide in the reso-
As one would imagine, removal of the source of infection is the primary goal for treatment of odontogenic infections. This can take many forms.

lution of more serious anaerobic bacterial species. Regardless of the concoction of antibiotics that has been chosen, it is imperative to monitor the efficacy. If infection is not responding, one must culture and choose a more effective drug class. Tomas, et al. conclude that "clindamycin should be considered as a first-line antibiotic in the field of dentistry" (2006).

One must be aware of and consider some common complications that can arise in patients with severe odontogenic infections. As mentioned earlier, airway obstruction as seen with Ludwig’s angina can be one of the more serious complications. Ensuring that the patient has a patent airway is of upmost importance, achieving an open airway however, can be quite a challenge for the medical team. Candamourty et al. advise that a blind nasotracheal intubation can be quite dangerous in Ludwig's angina patients because there is potential for significant bleeding and abscess rupture. Options to consider can include fiberoptic intubation via nasal route, or the "gold standard" elective tracheostomy under local anesthesia (2012).

Another common complication resulting from an odontogenic infection is trismus which occurs when the infection infiltrates the masticatory space resulting in inability to open the mouth to a normal range of 40 - 60 mm. This makes extractions or access to the site of infection more difficult, or even impossible. Trismus is yet another contributing factor which can make an odontogenic infection more difficult for the practitioner to effectively treat.

Both trismus and airway management issues are objective signs that a practitioner can look for when determining whether or not a patient requires admittance into an in-patient hospital setting. Other objective signs that should alert the physician include: fever over 101°F (38.3°C), dehydration requiring intravenous fluid therapy, need for incision and drainage, possible need for general anesthesia, patients with significant systemic health conditions, as well as immunocompromised patients (Flynn, 2000).

Early recognition of these symptoms and proper diagnosing of pathology are two important tasks a physician can perform for their patient. Prevention of the initial spread of infection can spare the patient, physician, as well as the healthcare system the unwanted burdens of the aforementioned complications and treatments necessary for patients with severe odontogenic infections. Gams et al., demonstrated that the pathosis described in the above paragraphs "were associated with substantial morbidity and cost in a largely uninsured patient population." They went on to communicate to their peers that early treatment of odontogenic infections could spare unnecessary hospital admittances (2017).

The task of treating patients with severe odontogenic infections can be a daunting one; however, it is important to think logically when treatment planning, and to fully consider what has been demonstrated in this paper. Evidence-based treatment planning and problem solving that can be verified in literature will lead both the patient as well as the practitioner down a successful path.
PREVENTION/TREATMENT FOR MUSCULOSKELETAL DISORDERS IN ORAL HEALTH PROFESSIONALS

BY RACHEL R. FREYALDENHOVEN, KAYLA E. PRUITT, ANDREW D. SEYMOUR, AND RAGAN B. SNYDER
MELISSA EFURD, RDH, ED.D. (FACULTY MENTOR)
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Introduction
With a prevalence rate ranging from 64% to 93%, musculoskeletal disease (MSD) is one of the most common problems dental hygienists may encounter during their career (Gehrig, Sroda, & Saccuzzo, 2017). MSD is a combination of disorders that affect the body’s natural range of motion, including injuries to portions of the muscular, nervous, and skeletal systems.

MSD may lead to diminished productivity and patient care, while increasing medical costs, which in turn impacts quality of life and financial well-being (Kott & Lemaster, 2014). Since the 1980s, MSD, or other injuries related to repetitive motions, have increased substantially among dental professionals, with neck and shoulders being the most common areas affected. As high as 93% of hygienists have reported that their daily work activities have either caused or worsened their musculoskeletal pain (Chismark, Asher, Stein, Tavoc, & Curran, 2011).

The main cause for the rise in MSD is due to poor ergonomics, longer workdays, and outdated dental equipment. According to Dimensions of Dental Hygiene, two out of three dental hygienists have experienced general MSD at some point in their career (Kott & Lemaster, 2014). Taking this statistic into consideration, imagine 20 or more years of chronic pain, which could lead to an early retirement or require a career change.

How important is career longevity among dental professionals? Many people endure prolonged pain without being aware of alternative treatments that are unique to a person’s injury, interests, and financial standing. These alternatives include physical therapy, yoga/Pilates, chiropractic’s/acupuncture, and home exercises (Brenman, 2007). Proactive prevention and alternative treatments are essential for quality of practice. The purpose of this paper is to educate dental hygienists regarding overall health, in order to prolong careers in this field.

MSD is a major factor connected with injury-related retirement that affects
15-50% of the dental profession (Waddell, 2006). Treatment for this disease is not difficult to find; the confusion is what treatment will offer the most benefit regarding the injury. The prevalence of musculoskeletal disease among dental hygienists has in part been linked to poor ergonomics in the workplace (Chismark et al., 2011).

In one study, participants who reported experiencing a higher level of pain also reported that they practiced correct posture less than 50% of the time (Humann & Rowe, 2015). By teaching ergonomics as part of the dental hygiene curriculum and enforcing this during clinical dental hygiene instruction, the likelihood of future work-related pain could be reduced. Continuing education courses regarding proper ergonomics will advance the hygienist’s knowledge, especially for those who did not receive ergonomics as part of their dental hygiene curriculum (Humann & Rowe, 2015).

Proper Ergonomics
Proper operator positioning includes maintaining a “neutral body position” (Gehrig et al., 2017, p. 11). The hygienist’s neck should be tilted no more than 20 degrees downward, and the head should never be angled to one side. The back should not be overly curved, but it should be flexed forward from the hips no more than 20 degrees. The hygienist’s torso should be kept straight, without leaning to one side. The shoulders should be in a straight line, not raised or rounded forward. The upper arms should be kept parallel to the body, no more than 20 degrees away from the torso, while the forearms should be parallel to the floor, optimally angled at 90 degrees.

The hygienist should take care to avoid bending the wrists up or down, as they should stay in line with the forearms (Gehrig et al., 2017, p. 12-13).

Other ergonomic principles to be enforced include proper patient positioning, so that the hygienist may see all necessary areas without forcing an awkward working position. The patient should be adjusted accordingly to what works best for the clinician, not the other way around (Gehrig et al., 2017, p. 21).

Additionally, loupes can be used to potentially reduce MSD pain in the head, neck, and back. However, wearing loupes does not assure that the hygienist will use proper posture (Humann & Rowe, 2015). As a single factor, loupes cannot be used to guarantee a reduction in work-related pain. They must be used in conjunction with optimal patient-operator positioning. Consequently, an emphasis on proper ergonomics continues to be a leading prevention in lowering the risk of developing musculoskeletal disease.

Prevention and Treatment
Yoga and specialized stretches may also help in the prevention and reduction of MSD in dental hygienists. The continuous practice of poor posture can lead to chronic discomfort in multiple parts of the body. The neck, shoulders, upper and lower back, hips, arms, wrists, and thumbs are some of the main areas in which hygienists experience aches and pains (Gupta, Ankola, & Hebbal, 2013). Along with poor posture, lack of flexibility can also lead to musculoskeletal pain in the practice of dentistry (Chismark et al., 2011).

Both yoga and certain stretching exercises have shown to improve posture, increase flexibility, and combat the pain that stems from MSD. Some yoga poses such as Bhujangasana, Salabhasana, Namaskar, Surya, Ardha, Bidalasana, Matsyendrasan, and Adho Mukha are helpful in preventing neck, shoulder, and back pain (Gupta et al., 2013).

Along with the accumulated physical stress for several parts of the body, a significant amount of stress is also concentrated on the hands of a hygienist while scaling, probing, and polishing throughout the day. This constant straining of the hand can lead to carpal tunnel syndrome (Chismark et al., 2011). The stretches found on the “Ergo-Break Poster,” (http://www2.tulane.edu/oehs/upload/Ergo-Break-Poster.pdf) demonstrate step-by-step finger and wrist flexor/extensor stretches to help prevent muscle tension that can lead to carpal tunnel (The Back School, n.d.). Allowing 30 to 45 minutes each day to practice these yoga poses and stretches may be the difference between a long career of comfort or early retirement.

Massage therapy also provides benefits for both prevention and treatment of MSD and may target the areas of the body that affect dental hygienists greatly. Massage therapy may help with both prevention and treatment of MSD and may target the areas of the body that affect dental hygienists greatly. This therapy is one of the six most commonly used complementary and alternative medicine (CAM) therapies along with yoga and chiropractic care. Massaging the muscles in the needed areas will relax the tissue. Spasms and painful contractions are reduced from the lessened compression of nerves and the proper nutrients reaching the tissues. This results in efficient operation of the muscles. Studies with the general population have shown massage therapy is an effective manipulative and body-based medicine to manage musculoskeletal pain. This therapy can lead to reductions in chronic low back pain and short-term benefits for treatment of chronic neck pain.

Relaxation of the mind and body overall is also a benefit for patients. As a treatment, massage therapy may help with pain that causes work interruptions. As a
Both yoga and certain stretching exercises have shown to improve posture, increase flexibility, and combat the pain that stems from MSD.

Cost effective alternative, compared to more extensive treatments, dental hygienists are more likely to favor these therapies (Chismark et al., 2011). The price for a one hour massage is approximately $60.00 depending on where you live and the type of treatment received (Burgan, 2016). Massage Envy, a popular massage therapy chain, offers an hour massage for $50 and 90 minutes for $75; however, the businesses are independently owned so the prices vary with location (https://locations.massageenvy.com/ar/little-rock/17200-chenal-parkway-ste-270.html). Some insurance companies provide coverage for massage therapy with a doctor’s prescription (Burgan, 2016).

Because it is a common treatment, many people use physical therapy as an ‘umbrella’ term for injury-related treatments. Physical therapists utilize exercises that require the patient to use their own body weight and strength to generate their own forces and facilitate self-care (Cherkin, Deyo, Battle, Street, & Barlow, 1998). Minor injuries may require fewer sessions compared to a detrimental injury that could require months of sessions. Prices vary from state to state, but based on this specific example, the lack of MSD preventative practices can lead to costly treatment that may otherwise have been avoided.

Another form of treatment for musculoskeletal disease is the performance of chiropractic treatment. Common treatments included stretching and strengthening exercises performed via quick, compact thrusts. In the same study, participants who underwent chiropractic care showed improvement, although it was also determined that not all people with MSD related pain should be referred to a chiropractor (Cherkin et al., 1998).

Acupuncture is an alternative to MSD that may benefit from a different method of care. Acupuncture is a method of care using needles placed specifically on the body based on the patient’s pain. The needles puncture the spinal cord and stimulate hormonal reactions that mediate pain by increasing pain tolerance and/or lessen the feeling of pain (Vickers & Zollman, 1999).

**Conclusion**

Non-surgical medication free treatments are available. Consultations are necessary to determine which treatment would be most beneficial based on the type of injury the cost incurred. Some may benefit from a combination of treatments, while others may only need one type of intervention to obtain relief from MSD. Prevention of MSD is preferred over injury and treatment. Hopefully, by practicing prevention early, less extensive treatment will be required. It is important to act early to seek help to prevent prolonged pain and chronic damage to the body. It is vital to maintain proper ergonomics which continues to be a leading prevention in lowering the risk of developing musculoskeletal disease.

Senior students at the University of Arkansas for Medical Sciences, Department of Dental Hygiene work in groups to investigate topics of interest to dentistry. The result is a written paper and a free two hour CE offering which will occur April 12, 2017. Please see the department website for details; http://healthprofessions.uams.edu/programs/dentalhygiene/

**References**


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Delta Dental of Arkansas is almost two months into the Delta Dental Smiles program. With a program of this magnitude, there are always challenges at the outset, and we appreciate the feedback offered to us from providers in the Delta Dental Smiles network. We are working diligently to act on the feedback to continually improve the Delta Dental Smiles program. Below is a Q & A which addresses the progress and/or changes we’ve made since January 1, 2018.

For clarification, Delta Dental has separate phone lines and mailing addresses for our commercial and Delta Dental Smiles business. The dedicated Delta Dental Smiles call center line is 1-866-864-2499. Delta Dental Smiles claims should be mailed to PO Box 6247, Sherwood, AR 72124 or faxed to 1-866-679-7752.

Q: Can the dentist collect the difference in cost from the Delta Dental Smiles member for posterior composites, crowns, or dentures?
A: Questions about payments for posterior composites, crowns and dentures continue going into the new managed care Medicaid dental program.

Posterior composites
Delta Dental will continue the current approach taken by DHS on posterior composites. The current DHS dental provider manual (Sec. 219.100 and 219.200) states:

“If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate.”

Under state and federal Medicaid rules, dentists cannot collect from the Delta Dental Smiles member the difference between the dentist’s charge for the posterior composite and the amount paid by Delta Dental.

Crowns
Delta Dental’s Provider Manual currently states:

D2929 --- Prefabricated porcelain/ceramic crown, primary tooth, or D2934, prefabricated esthetic coated stainless steel crown, primary tooth, may be performed and submitted but will be alternated and covered as a D2930, prefabricated stainless steel crown, primary tooth.

DHS has advised Delta Dental that a D2934 can be billed and paid at the D2930 rate. The Delta Dental Smiles member cannot be billed for the difference in cost.

However, DHS has further advised that a D2929 cannot be billed under
the current plan. Delta Dental is committed to continuing to work with DHS in the coming months to address this additional code.

Necessary modifications to reflect this change will be made to the Delta Dental Smiles Provider Manual and distributed to all participating dentists.

**Dentures**

For removable prosthetic cases started beginning January 1, 2018, the dentist will bill Delta Dental D5110 and D5120. The fee for each of these codes is $280.00. These codes apply towards the Delta Dental Smiles member’s $500 annual maximum benefit.

If both an upper and lower denture is performed at the same time, the $500 annual maximum will apply.

The dentist can collect $60 from the Delta Dental Smiles member, but only if the member has signed an agreement in advance that they will be responsible for the additional payment.

**Q.** How can a dentist identify the Delta Dental Smiles members for whom they have been assigned as the primary care dentist (PCD)?

**A.** This information is available to dentists in several ways. If the dentist is signed up for WhiteCloud, the information is available there. Delta Dental will also provide a list upon request.

**Q.** Are Delta Dental Smiles for Kids orthodontia patients required to get a cleaning every six months from their primary care dentist (PCD) or other treating dentist?

**A.** No. It is preferable so the treating dentist maintains visibility into their patient’s treatment progress and is able to monitor their oral hygiene status during orthodontic treatment.

**Q.** Can a Medicaid beneficiary change managed care organizations (MCOs) after their 90-day “switch” period expires?

**A.** Under limited circumstances, the beneficiary may be allowed to switch to another MCO after the 90-day switch period. DHS makes the decision and is currently establishing the rules for these circumstances.

**Q.** If a Medicaid beneficiary notifies DHS s/he wants to switch managed care organizations (MCOs), how long does it take for DHS’s systems and the managed care organization’s systems to reflect this change?

**A.** We understand that the effective date of a change will be the first day of the month following DHS’s completion of the switch process. While the switch process within DHS is not lengthy, the timing of the beneficiary’s decision to request the switch can affect the effective date of the switch. We encourage dentists and their offices to verify a beneficiary’s MCO via the MMIS if there are any questions or concerns at the time of treatment.

**Q.** Are immediate dentures a covered service?

**A.** No.

**Q.** Can a dentist bill and collect from a Delta Dental Smiles member for a service if the member has exceeded their benefit maximum?

**A.** Consistent with current DHS rules, a Delta Dental Smiles member is responsible for charges for non-covered services, including services received in excess of Medicaid benefit limitations, but only if the member has chosen to receive and agreed in writing to pay for those non-covered services in advance of the treatment.

Please do not hesitate to contact the Professional Relations Department at (501) 992-1710 if we can be of assistance.
In the course of evaluating and processing Medicaid claims, I see numerous claims that, quite possibly, are fraudulently billed. These claims appear to be submitted inaccurately out of ignorance of the law; however, considering the impending changes in the administration of Medicaid, it would seem to be an ideal time to revisit the State and Federal laws concerning fraudulent claims.

It might be of interest to trace the history of the Federal False Claims Act (FCA). This law (31 U.S.C. §§ 3729-3723), was passed March 2, 1863 and signed by Abraham Lincoln making it illegal to knowingly submit false claims for services to the government. Over the next 100 years, this law was primarily utilized for recouping monies from defense contractors. After passage of Medicare and Medicaid in 1965, health care fraud gradually increased until it represented 40% of the total lawsuits against billing entities in 1990. In 2016, $4.7 billion was recovered through the FCA. The criminal law concerning fraudulent claims in Arkansas is presented in Ark. Code Annotated §5-55-111.

In order to understand the FCA, the pertinent part will be quoted: 

“(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval, (my underline); (2) knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government: ...(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.”

The Arkansas criminal law is similar: 

“A person commits Medicaid fraud when he or she: (1) purposely makes or causes to be made any omission or false
statement or representation of a material fact in any claim, request for payment, or application for any benefit or payment under the Arkansas Medicaid Program”. Providers may be liable to the State of Arkansas, through the Attorney General, for civil penalties under the Arkansas Medicaid Fraud Claims Act, Ark. Code Ann. § 20-77-901, et seq., which states in part: “a person is liable "if he or she makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under the Arkansas Medicaid program”.

A disclaimer; the FCA and Arkansas statutes only apply to federally-funded health care programs, i.e., Medicare, Medicaid, Tri-Care, Indian Health, etc. So how does this affect your Medicaid billing? Let’s look at a few examples that could conceivably be considered fraud:

1) You have a patient that you send a prior authorization for IV conscious sedation, (D9243). As an approved Medicaid provider, you know, or should have known that this code is not covered; however, you have billed Medicaid for this procedure.

2) You submit a claim for D7310 after the extractions have been completed on another date. This does not qualify for payment under Medicaid guidelines.

3) You treatment plan a Medicaid-covered patient for implants and bill thusly.

4) You file for full mouth extractions (FMX) and code every tooth D7210 when the radiograph clearly indicates that many of these will not be surgical.

5) An adult Medicaid patient requires excision of benign lesion (D7411) and you submit this non-covered procedure for approval.

6) You submit a claim for a general anesthesia for an adult knowing that this is not a covered service under Medicaid.

7) An emergency patient is seen and you write a prescription for antibiotics and bill Medicaid for D9110.

8) You charge Medicaid D9920 (behavior management, tobacco cessation) on a three-year-old.

9) A patient is referred for extractions and possible future implants. Your treatment plan submitted to Medicaid includes D4263 (a non-covered service).

10) You perform any operative and/or surgical service that requires prior authorization and subsequently bill Medicaid.

These are just some broad examples of possible fraudulent billing. The general rule-of-thumb is:

**If it is not an approved procedure per the Medicaid manual, don’t bill for that procedure! Know the ADA CDT codes that are essential to understanding the definition of the applicable codes and how they are applied.**

Does the FCA mean that the authorities will be knocking down your door if you miscode a procedure every now and then? Probably not; nevertheless, understanding the penalties connected to the conviction of Medicaid Fraud might motivate providers to be cautious in submitting claims. If, as a provider, you “knowingly” provide information that: (1) you have actual knowledge of the inaccuracy of the claim, (2) act in deliberate ignorance of the truth or falsity of the information; or (3) you act in reckless disregard of the truth or falsity of the information; thus, no proof of intent to defraud is required for conviction.

The FCA imposes liability to the United States Government for a civil penalty of not less than $5000 and not more than $10,000, plus three (3) times the amount of damages which the Government sustains because of the act of that provider—PER CLAIM. In addition, A.C.S. §5-55-111 (3), simply having knowledge of false claims is a violation of the law.

You can’t blame the office staff for inaccurate claims submissions and the penalties only affect the Medicaid provider! Also remember, whistleblowers (qui tam relators) receive at least 15% and not more than 25% of the proceeds of the FCA action. Be careful.

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Arkansas Dentistry | Spring 2018
Being a healthcare provider for cancer stricken patients in a hospital setting can be a very arduous and psychological task. The condition of these patients during and after treatment is something that one could hardly fathom. Not only is the patient under tremendous stress, anxiety, and fear from a potentially life-threatening diagnosis but also under physical and mental stress from the treatment on board.

Being a dentist in the hospital setting, we treat many patients enduring cancer treatment, specifically head and neck cancer. These treatments often result in “significant, highly visible disfigurement and disruptions of essential functions” and overall poor quality of life.

Head and neck cancer is on the rise with approximately “650,000 new cases each year, ranking head and neck cancer the sixth most common type of cancer in the world” (Howren, Christensen, Karnell, and Funk, 2013). According to Dzebo, Mahmutovic, and Erkocevic, “cancer of the oral cavity is one of the most common cancers of the head and neck, and is one of the ten most common causes of death in the world. In the majority of cases, cancer of the oral cavity is detected in an advanced stage when therapeutic options are reduced, and the prognosis is much worse” (2017).

Despite these facts, however, head and neck cancer “remains understudied in behavioral medicine,” which focuses on an interdisciplinary field combining both medicine and psychology. Throughout this article, the psychosocial and behav-
Many head and neck cancers originate in the oral cavity such as squamous cell carcinoma, verrucous carcinoma, minor salivary gland carcinomas, and lymphomas. Over 90% of oral cancers (occurring in the lip, mouth, and tongue) are squamous cell carcinoma.

Surgical resection ranging from conservative to radical is common treatment...
These surgery sequelae can also pose issues with seeing, eating, and other daily tasks. After the cancer has been surgically resected, in some patients, the degree of deformity and disfigurement can be such that the patient is completely unrecognizable.

modality used in head and neck cancer patients. During this treatment, patients can lose portions of the palate, neck, tongue, jaws, nasal floor, eyes, cheeks, teeth, nose, and other hard and soft tissues, leading to facial disfigurement and the loss of one’s identity. The effects of cancer and treatment often cannot be concealed by head and neck cancer patients, making those who suffer from facial disfigurement vulnerable to “distress, intimacy issues, social isolation, stigma, and untoward behavior from others” (Callahan, 2005). These surgery sequelae can also pose issues with seeing, eating, and other daily tasks. After the cancer has been surgically resected, in some patients, the degree of deformity and disfigurement can be such that the patient is completely unrecognizable. Alongside the comorbidity of facial disfigurement can be chronic postsurgical pain. Many of these radical resections leave nerve endings exposed, non-keratinized tissue vulnerable to the external environment, and other nerve complications due to lack of supporting structures which leads to chronic postsurgical pain (CPSP). Chronic postsurgical pain is defined as “pain persisting for at least 3 months after surgery” (Terkawi, Tsang, Alshehri, Mulafikh, Alghulikah, and AlDahri, 2017). Risk factors such as clinical pain, surgery related, and psychological status are associated with the development of CPSP, ultimately affecting patients’ outcomes of their physical and psychological functioning and pain management. “Among head and neck cancer patients, pain was reported to be present in the majority of patients before, during, and after treatment (50%, 81%, and 70%, respectively)” (Terkawi, Tsang, Alshehri, Mulafikh, Alghulikah, and AlDahri, 2017). Chronic postsurgical pain as a result of head and neck cancer treatment affects the patients’ quality of life in many different ways. The decline in quality of life of these patients is dependent on factors such as the patients’ age, gender, stage of cancer, and treatment modality. Without proper treatment, this chronic pain can interfere with patients’ daily activities and overall physical and mental health (Terkawi, Tsang, Alshehri, Mulafikh, Alghulikah, and AlDahri, 2017).

Radiation therapy, another treatment option for head and neck cancer can cause serious side effects as well. Radiotherapy can lead to many issues such as dry skin and eyes, irritated and sensitive skin, xerostomia, and decreased salivary flow leading resulting in increased dental decay. Other side effects can include deficits in speech and swallowing, which can play a major psychosocial effect on the patient and their identity.

Another very important side effect of radiotherapy that needs to be discussed is radiation induced oral mucositis (RIOM). As dentists, one of the major side effects seen in cancer patients is radiation induced oral mucositis. RIOM is an inflammatory process of the oral mucosa, tongue, and pharynx which can last between one week and one hundred days post radiotherapy. This acute type of inflammation can become a life-threatening condition caused by a combination of severe enteral obstruction alongside weight loss and septic complication. RIOM is one of the “ionizing radiation toxicities” that results from this type of cancer therapy, making it a “major dose-limiting toxicity in head and neck cancer patients. RIOM injury makes the radiation oncologists’ job more challenging from many different aspects, such as, “radiation dose limitations, changes in dose fractionation protocol, and dramatic negative effects on patients’ quality of life” according to Muanza, Cotrim, McAuliffe, Sowers, Baum, Cook (2005).

The side effects of radiotherapy and the price the patient pays is nothing short of inevitable, unfortunately. Radiation-induced oral mucositis is a normal tissue injury as a side effect of radiation therapy, which has adverse effects on the continuity of the cancer therapy as well as the patient’s quality of life. (Maria, Eliopoulos, Manza, 2017)

Specialists in the oral cavity/head and neck experience many debilitating side effects of cancer therapy. One other side effect we see quite frequently is xerostomia or “dry mouth”. Xerostomia creates a long list of daily problems patients must deal with including “communication problems, physical problems, psychosocial problems, treatment problems, and relief strategies” (Jiang, Zhao, Jansson, Chen, and Martensson). The degree of change in the patient’s ability to eat, drink, communicate, and socialize due to xerostomia can vary from patient to patient but inevitably affects the quality of life in all cancer patients. Relief strategies for the involved symptoms can differ throughout the patient population. Some patients find relief in simple interventions such as chewing gum, doing mouth exercises, and drinking water with honey, whereas some patients have to resort to greater mea-
Regardless the remedy of choice, the majority of the xerostomic population never finds complete relief. This is yet another simple change in tissue, creating another comorbidity associated with head and neck cancer while also drastically changing the patient’s quality of life.

Chemotherapy is the third and final treatment option for head and neck cancer patients. Through this treatment option, patients can suffer fatigue, hair loss, easy bruising and bleeding, changes in appetite, weight, skin and nails, mood, and labido. The side effects of chemotherapy have many similarities with the side effects of radiation therapy. These issues contribute to the same or sometimes even additional physical and psychological problems. Many of the side effects which are marked by physical limitations, such as the ones listed above, also contribute to social and psychosocial difficulties. Patients that lose their hair, sex drive, and appetite face heavy challenges coping with the changes and differences from their past. These side effects can be the very problems that lead to loss of quality of life and poor patient survivorship.

Due to these side effects, consequently, head and neck cancer survivors often require extensive rehabilitative treatment including speech therapy, swallowing rehabilitation, and dental/maxillofacial rehabilitation, as well as physical and occupational therapies” (Ward and Van As-Brooks, 2006). The cost of these therapies along with the cost of the cancer treatment itself can be astronomical. The financial obligation for head and neck cancer treatment can be a serious burden on the patient and their family as well as the hospitals involved. According to Shone and Yardley, nearly 50% of patients are unable to return to work for a substantial period of time beyond treatment cessation (1991). Not only is the patient having to pay for the treatment but they are also unable to work during the time of the treatment, therefore creating a compounding effect of the treatment expense. In a New Zealand study performed by Jayakar, Choi, MacKinnon, and Tan, it was documented that on average, “oral cavity cancer, metastatic and/or locally advanced skin cancer, and skull base cancer cost $16,500/patient, $12,700/patient, and $34,500/patient respectively” (2017). Although patients pay a tremendous amount in medical expenses, remission and curing of the cancer is never a guarantee. In these cases, patients may be put into hospice. It is important that the patient’s friends, family, support system, etc. is prepared if this be the case. Education about hospice is another viable part of making sure the patient’s main-
# New Medical Insurance Premiums

## Plan #1 - Health Advantage - Point of Service

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## Plan #2 - Health Advantage HSA

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<td>$545.46 / mo</td>
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<tr>
<td>Employee + Child(ren)</td>
<td>$380.34 / mo</td>
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<tr>
<td>Employee + Family</td>
<td>$770.67 / mo</td>
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## Optional Employer-Paid Benefits

- Basic Life and AD&D
- Doctor and Executive Long-Term Disability pays 60% of earnings up to a max of $10,000 / mo.

## Benefits Paid 100% by Employees

- Dental
- Vision
- Short-Term Disability
- Long-Term Disability
- Life and AD&D
- Critical Illness

To learn more or to join the group, email ipg@axpm.com or call Josh Matthews at 501-508-2976.

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In one study regarding quality of life of patients with oral cavity cancer, physical and socio-emotional health factors were ranked by respondents involved in the study. Results showed that 52.8% of respondents had related problems to a change in mood, followed by anxiety at 42.7% of the studied population.

In one study regarding quality of life of patients with oral cavity cancer, physical and socio-emotional health factors were ranked by respondents involved in the study. Results showed that 52.8% of respondents had related problems to a change in mood, followed by anxiety at 42.7% of the studied population. Third place was reserved for recreation impossibility at 39.3% and followed by appearance in fourth place at 38.2%. Patients reported the following issues in descending order: pain (37.1%), reduced physical activity (37.1%), taste problems (31.5%), uncontrolled saliva (29.2%) speech problems (28.1%), and swallowing problems (27%).

How important is patient survival with little to no quality of life? "Quality of life is a multidimensional concept that includes evaluation of positive and negative aspects of life. Quality of life refers to “a patient’s appraisal of and satisfaction with their current level of functioning compared with what they perceive to be possible or ideal” (Cella & Cherin, 1988) (VanderWalde, Fleming, Weiss, and Chera, 2012). “Health related quality of life (HRQOL), which may be defined as the degree to which physical dysfunction, pain, and related distress limit or disrupt one’s daily behaviors, social activities, and psychological well-being (Lawton, 2001) is an important patient outcome in its own right because a cancer diagnosis is often associated with decreased life expectancy and treatment rarely affords full recovery” (Howren, Christensen, Karnell, and Funk 2013). Quality of life scores can be used to evaluate several outcomes such as treatment effectiveness, palliative care benefits, and survival (Elmqvist, Jordhoy, Bjordal, Kassa, and Jannert, 2009). “Health related quality of life has becomes a more accurate predictor of survival than some other clinical parameters such as performance status (Osoba, 2011).

Head and neck cancer is a debilitating disease that often results in unique physical and psychological sequelae along with financial burden. Treatment often requires a multidisciplinary approach involving surgeons, radiation oncologists, dentists, plastic surgeons, and rehabilitation specialists. The need for clinical health psychologists and behavioral medicine specialists is key during all phases of the patient’s disease process, from head and neck cancer diagnosis through treatment and recovery. The roles of these specialists, which were previously advocated by others, are very important to the patient’s success in overcoming their unfortunate diagnosis. There are few studies that focus on the comorbidities patients face throughout/at the end of treatment such as chronic pain, post treatment stress, disfigurement, and health related quality of life. While research continues to focus on the curative aspects of cancer treatment, the issues patients face post treatment cannot be left unnoticed.

References

THE REDNECK CHRONICLES

Chapter 6

JOHNNIE’S FIRST DEER

This story is from The Redneck Chronicles, book one, by Dr. Jim Burleson. It is available on Amazon, Zulon Press and E-books. All proceeds fund Alzheimer’s research. You may contact Jim at 501-605-3141.

Before he was a naval officer, Golden Gloves boxer and exceptional dentist, John Butler and his brother Jimmy were raised in a single-parent home; they were quite a handful for their schoolteacher mom, Elsie.

This particular story was related by John’s Uncle Warren. Warren’s middle name was Elmer, hence his nickname “Uncle Fudd.” Warren became John’s mentor after John’s father died at a young age. He introduced him to hunting and took him to his first deer camp. Against Warren’s advice, young Johnnie spent the entire night exercising his considerable skill at poker and emptying everyone else’s wallets.

Shortly before shooting light, Warren guided John to his deer stand—a piece of plywood nailed between two limbs high in an oak tree. John promptly fell asleep but not before tying a rope between his belt and the tree, as instructed. Warren took a stand nearby so he could monitor his young protégé. Sometime later, John was awakened from a deep slumber by a sound he’d never heard before. As he collected his wits he saw large buck snorting and paying the ground. Apparently, John had woken up unexpectedly and Warren ran to the brush pile at the base of the tree. In his haste, however, he forgot about the rope tethering him to the tree. As he leapt, the rope snapped tight and jerked him up, slamming him against the tree trunk and almost ripping his pants off. Dazed, John grabbed the rope and pulled himself upright with the rope pulling his pants way up, giving him a very painful wedgie.

In anguish and not thinking clearly, John whipped out his new hunting knife and severed the deer. He was in such a hurry to check out his first deer that he jumped from his stand, aiming to land on a brush pile at the base of the tree. In his haste, however, he forgot about the rope tethering him to the tree. As he leapt, the rope snapped tight and jerked him up, slamming him against the tree trunk and almost ripping his pants off. Dazed, John grabbed the rope and pulled himself upright with the rope pulling his pants way up, giving him a very painful wedgie.

In anguish and not thinking clearly, John whipped out his new hunting knife and severed the rope. He bounced off a couple of limbs like a shot-gunned squirrel and landed fortunately on the brush pile. Warren, having witnessed the entire debacle ran quickly to the brush pile and determined that there were no serious injuries. He smiled and said, “Johnnie, in all my years of hunting I’ve never seen anything like that. Are you ready for a rematch? Because right now, the deer looks considerably better than you do!” Uncle Fudd had nailed it.

Editor’s Note: I have known Jim since dental school. He has always been involved in organized dentistry and has always been one to help others. Good guy! Notice that the proceeds are going to the research program for Alzheimer’s disease. Jim’s wife Melba has been affected by this horrible disease.
The University of Arkansas for Medical Sciences General Practice Residency Program hosted the Southeast Program Director (SEPDR) annual meeting on October 5–7, 2017, in Little Rock, Arkansas.

The program directors attending were from different General Practice Residency (GPR) and Advanced Education General Dentistry Residency (AEGD) programs from around the Nation. The states represented were Alabama, Arkansas, Georgia, Kentucky, Louisiana, Ohio, Mississippi, South Carolina, Tennessee, Texas, and Virginia. The purpose of the SEPDR group is to engage in discussions, identifying issues and challenges unique in directing residency programs thereby improving the quality of the educational program.

The meeting consisted of continuing education courses titled “Management of Dental Patients on Anticoagulants,” presented by Dr. John Jones, maxillofacial surgeon and faculty of UAMS and Arkansas Children’s Hospital (ACH). Kevin Thomas, Senior Territory Representative of Arkansas of Nobel Biocare, presented “Update on Implants.” Private group tours of the Clinton Presidential Library and Heifer International Learning Center of downtown Little Rock were also provided.

Dr. John Coke from Birmingham, Alabama stated, “I found the Heifer Institute fascinating!”

The group dined Thursday evening at Cajun’s Wharf, sponsored by Arkansas Blue Cross and Blue Shield. Friday morning breakfast was sponsored by Osteomed. Lunch and tours Friday were sponsored by an anonymous donor, and dinner at Copper Grill sponsored by the Center for Dental Education completed the action packed day.

The Saturday business meeting breakfast was held at the Marriott Hotel downtown sponsored by Rock Dental Brands. A wealth of information was shared in assessing the various residency similarities and differences in management styles, didactics, rotations, curriculum, and required clinical achievements. Dr. Mark Livingston gave an update on CODA (Commission on Dental Accreditation) business. A good “working” time was had by all. AD
The International College of Dentists USA Section Board of Regents elected a local dental practitioner, Dr. Niki C. Carter, as the Regent of District 12 at its 88th Annual Meeting in Atlanta, Georgia on October 18, 2017. Her four-year term began on January 1, 2018. ICD USA Section President Charles L. Smith, DDS presented Dr. Carter with a Regent Medallion and a diamond-studded, gold FICD lapel pin symbolic of her office, and ICD’s core values of integrity, leadership and service rendered to the College.

The ICD is an honorary organization which recognizes outstanding and meritorious service to dentistry and communities throughout the world. Fellows work to improve the profession through sharing and disseminating advances in dental knowledge and seek to benefit their communities through voluntary service. The 17 USA Section Regents attend all Board of Regents meetings, as well as manage their District’s policies, programs, projects, financial affairs, and other activities.

The University of Arkansas for Medical Sciences and the Arkansas Children’s Hospital join forces to increase dental educational and research opportunities.

In January, the dentist providers at Arkansas Children’s Hospital (ACH) had their employment transferred to the University of Arkansas for Medical Sciences (UAMS), College of Health Professions’ Center for Dental Education. This merger was beneficial for both institutions. For decades, most physicians who have or had privileges at Arkansas Children’s are, or have been, employees and faculty members of the UAMS College of Medicine. This move further solidifies the relationship between the institutions and comes at a time when both dental programs have recently expanded their educational, service and research endeavors.

General practice dental residents from UAMS have rotated through ACH since the inception of the program in 2015. Recently, the University of Tennessee College of Dentistry began sending pediatric dental residents to ACH for rotations through its specialty interdisciplinary clinics. Residents from both programs interact with orthodontics, pediatric dentistry, general dentistry, oral and maxillofacial surgery, otolaryngology, plastic surgery, audiology, speech pathology, and social work in interdisciplinary teams to create tailored treatment plans and provide services to meet the patient’s individual needs.

The affiliation and faculty appointment in an academic center allows for providers at ACH to expand their research opportunities. Currently, two studies are under development. The first is to use removable orthodontic devices to treat individuals with mixed dentition who have moderate to severe sleep apnea. Another is the use of transalveolar distraction to treat individuals with large facial clefts or injuries. These studies flow seamlessly between the missions of both organizations and epitomize the interdisciplinary approach to research with dentistry and medicine.

According to the most recent Natural Wonders Study, dental disease is the number one unmet need of children in Arkansas. This agreement allows both institutions to combine resources and expertise to help community providers address the needs of the children of Arkansas. One instance of this collaboration is the James D. Koonce lecture which will occur on April 19, 2017. This full day CE program will focus on pediatric sedation in the dental office. Further information will follow concerning location and registration for this annual lecture. The mission of both institutions is to improve the health of Arkansans and this collaboration allows them to focus their efforts jointly on oral health.

Stephen Beetsa, DDS, MHSA
Director of Dental Services
Arkansas Children’s Hospital

Gene Jines, DDS
Director of the Center for Dental Education
University of Arkansas for Medical Sciences
Dental Lifeline Network • Arkansas is pleased to announce that as of 2018, it is now operating Arkansas’s Donated Dental Services (DDS) program, which most recently was operated through ConnectCare. DLN operates DDS programs in 43 states, utilizing an experienced group of DDS coordinators, DLN program team and national strategic partnerships to efficiently deliver care.

DLN and the Arkansas State Dental Association partnered in 1997 and developed the Arkansas DDS program to provide comprehensive dental care to people with disabilities, who are elderly, or who are medically fragile and cannot afford treatment through a network of volunteer dentists and volunteer labs. Since inception, the Arkansas program has provided over $2 million in critical care to 832 patients.

Dr. Joseph Jacobi is one of many pleased DDS volunteer dentists: “My team and I were very pleased with the program,” said Dr. Jacobi. “The patients were well screened as to need and were grateful that someone was going to help them. The gratitude of the patients was a reward in itself.”

Over 100 patients are waiting for help — will you see one?

- Patients are prescreened
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- You determine your own treatment plan
- See patients in your office, on your schedule
- Never pay any lab costs
- There will be no extra paperwork for you or your staff

Arkansas DDS Program Coordinator Vivian Lovingood

Arkansas DDS Program Coordinator Vivian Lovingood ensures the program runs smoothly. She screens patients to determine eligibility, coordinates involvement with specialists and laboratories, and serves as a liaison between dentists, dental practice staff and the patient.

“I joined DLN because I wanted to work for a non-profit organization with a great mission,” Lovingood said. “The best part about working here is helping patients improve their health and their self-confidence.”

Dentists, please join the 82 dentists and 17 labs that volunteer for DLN • AR. Visit www.willyouseeONE.org to find out how!

Join the community, become a volunteer today! AD

Get involved
Volunteer: www.DentalLifeline.org/ Volunteer
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LSUSD Celebrates 50 Years!
HENRY GREMILLON, D.D.S., M.A.G.D
Dean, LSU School of Dentistry

LSU—Celebrating 50 Years!
As New Orleans celebrates its 300-year history in 2018, the LSU Health School of Dentistry (LSUSD) is celebrating its 50th anniversary. Nearly 6,000 dental professionals have been educated since the school’s inception in 1968 and today approximately 80 percent of the dental professionals in Louisiana are graduates of our school. As the only dental school in Louisiana, our mission of education, research, patient care, and service is vital to ensuring that our citizens in Louisiana and beyond receive the best oral health care possible.

LSUSD is unique among the 66 dental schools in the United States because it offers degrees in dentistry, dental hygiene, and dental laboratory technology. By educating students in all aspects of dentistry, LSUSD has earned a national reputation for offering an outstanding clinical education. I am proud to be a graduate of our school; it has afforded me the opportunity to practice a meaningful profession and enjoy a rewarding life.

One of the major highlights of my career has been the opportunity to serve in a leadership role at LSUSD. It’s a dream come true—even in light of daunting challenges that we have faced in the last decade. Fortunately a great deal has been accomplished due to the perseverance and hard work of so many. Over $80 million worth of construction and renovations have occurred on campus; nationally respected faculty members have been recruited; orofacial pain education programs are now available; and in an effort to improve the overall health of patients, interprofessional education (IPE) and collaborative care is being taught throughout the university.

It is my hope that many of our alumni and friends will join us for Alumni Day on Friday, August 24, to witness and hear firsthand about the many changes at the school. The most visible is the transformation of our campus, especially the completion of the Advanced Clinical Care and Research Building. Funded entirely by FEMA, it houses the school’s clinical and basic-science research facilities, a spacious and modern faculty practice, and the mechanical/electrical equipment for building operations. The other remarkable transformation is that of the student preclinical laboratories. The $9 million plus renovation encompasses the entire 7th floor of the E.E. Jeansonne Building. The state-of-the-art facility includes two laboratories, a classroom, and a wet lab. Other projects on campus include new parking lots, professional landscaping, renovated patient waiting areas, and the IPE clinic for low-income patients. The LSU Health Foundation, legislators, and our alumni and friends have helped to make these projects possible.

To enhance our faculty, we have

2018 Alumni Events
Thursday, May 24
NODA/LDA Welcome Reception & President’s Party
LSUSD Alumni Reception
8 Block Restaurant & Bar
7:00 – 10:00 p.m.
$30 per person, includes Buffet and Two Drink Tickets
Hyatt Regency Hotel
601 Loyola Avenue
New Orleans, LA

Friday, August 24
Alumni Day & Reunions
LSU School of Dentistry, New Orleans
8:00 a.m. to 5:00 p.m.
Reception to Follow

Reunion celebrations have historically been held in conjunction with the NODA/LDA Dental Conference. This year we will host a special complimentary celebration for those in reunion years at the LSU School of Dentistry on Alumni Day (5:00 to 7:30 p.m.) in the new Advanced Clinical Care and Research Building. All attendees of Alumni Day are invited, however, those who graduated in years that end in a three or eight will be recognized and honored. Questions? Contact Katie Kelley, MBA at (504) 941-8120 or kkell2@lsuhsc.edu.

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Dental education has a long history in Louisiana, dating as far back as 1861, with the establishment of the New Orleans Dental College (1861-1877), followed by the New Orleans College of Dentistry (1899-1909), and dental schools at Tulane (1909-1928) and Loyola (1914-1971).

When Loyola could not afford to continue its dental program, the Louisiana Legislature authorized the building of a dental school as part of the LSU System. The LSU School of Dentistry welcomed its first dental class in fiscal year 1968. Classes opened in barracks on a 22-acre tract near New Orleans City Park that originally served as World War II housing for the U.S. Navy.

In order to construct a permanent physical plant for the school, a grant was obtained from the U.S. Department of Health, Education and Welfare. The 344,000 square foot project cost $15.75 million to build. Of this total, $10.5 million came from the federal government and $5 million came from the State of Louisiana. Formal dedication of the new school took place on February 18, 1972. Over the span of four years, operations at Loyola were transferred to the new LSUSD The last class of Loyola dentists graduated in 1971; the first LSUSD dental class graduated on June 3, 1972.

In 1972 the American Dental Association Council on Dental Education approved applications for specialty programs in dentistry. The new programs included general practice residency, oral pathology, orthodontics, pediatric dentistry, periodontics, and prosthodontics. However, students were only accepted that year in orthodontics, oral pathology, and oral and maxillofacial surgery (OMS). The OMS program, based at Charity Hospital, had been established in the late 1920’s and was transferred from Loyola to LSU in 1968.

Students were selected for training in pediatric dentistry and general dentistry in 1973. The first postgraduate certificate in oral pathology was presented in 1974; three students were awarded postgraduate certificates in orthodontics that same year. In 1975 students in pediatric dentistry, general practice residency, and OMS received the first postgraduate certificates in those departments.

The most devastating natural disaster that affected LSUSD in its 50-year history was Hurricane Katrina in 2005. Following the storm, LSUSD had to relocate and build a dental clinic at the South Campus of LSU in Baton Rouge. Tapping into 40 years of goodwill among the alumni, a network of 182 dentists, oral surgeons, and dental hygienists in the community agreed to supplement the clinical training of our fourth-year students and residents.

Two years after Hurricane Katrina, the students, faculty, and staff returned to our main campus in New Orleans. Shortly following the return, Henry Gremillion, DDS, MAGD, became dean in 2008.

A general practice residency satellite clinic was established in Baton Rouge following the closing of the LSU South Campus site; a partnership with Our Lady of the Lake Hospital in Baton Rouge was established following the closing of Earl K. Long Hospital; and in 2015, the $1.2 billion University Medical Center New Orleans was dedicated. Both OMS and general practice residents rotate through the above sites.

Also in 2015, the Federal Emergency Management Agency (FEMA) approved a multi-million grant to erect a new building at LSUSD to mitigate the damage caused by Hurricane Katrina. The elevated building was completed in 2018 and includes clinical and basic science research areas and a faculty dental practice. The electrical and mechanical components that operate the entire campus also reside in the new building.

Today students, residents, and faculty provide care in nearly a dozen locations statewide with an average of 100,000 patient visits annually. Each year the school also participates in community outreach events to reach the underserved and impoverished in our state. Dental screenings, sealant placement, oral health education, and direct care are among the services offered.

Deans of the LSUHSC School of Dentistry
Edmund Engler Jeansonne, DDS (1966-1974) ±
Allen Anthony Copping, DDS (1974) ±
Eric J. Hovland, DDS, MEd, MBA (1993 to 2008)
Henry A. Gremillion, DDS, MAGD (2008 to Present)

±Deceased
recruited seasoned professionals with a broad array of skills in both general dentistry and specialty areas. One fairly new area of concentration is the diagnosis and treatment of orofacial pain. Pain in the oral and craniofacial region has a fairly high prevalence rate and often, a devastating impact on quality of life. Therefore, our vision is to create a center of excellence where patients who suffer from chronic facial and neck pain can receive quality care at an affordable price. Equally important, LSUSD students and residents, as well as practicing dentists worldwide, are being afforded the opportunity to gain knowledge and clinical experiences in the treatment of orofacial pain. Plans are also underway to establish a master’s program in the field.

We are also pleased with the strides made in Interprofessional Education. The LSU Health IPE program has grown from one elective in 2012 to a new two-year experience for all first- and second-year students. In fact, on behalf of the entire university, LSUSD will receive the American Dental Education Association Gies Award for Vision in recognition of our successful programs in IPE and Collaborative Practice.

These are only a few examples of the successes experienced in the last several years. Be assured that we will continue to explore new opportunities to improve education and patient care. Know that the support of our alumni and friends has significantly contributed to our accomplishments over the years. With that in mind, thank you!

**Letter from UT College of Dentistry Interim Dean Stan Covington**

Members of the Arkansas State Dental Association, I bring you greetings from the University of Tennessee Health Science Center in Memphis. We have had a change in administration here. While I am in this position, I intend to effect a change of course back toward emphasis on basic clinical dentistry. I am most grateful for the expressions of support for these efforts. I see our primary responsibility is to provide competent practitioners to Tennessee, Arkansas, and the mid-south region. Clinical excellence has always been our hallmark and this will continue.

I don’t want to overstay my welcome but I will communicate with our many Arkansas alumni and friends as often as you’d like. While some information is confidential (especially about applicants/students), I am more than happy to listen to your concerns/opinions/thoughts by email, telephone, or personal visit. Our college’s most-valued emissary, Dean Emeritus Dr. Bill Slagle, regularly keeps me informed on Arkansas issues and thoughts. I have visited the ASDA’s leadership already and will try to make it to district meetings if you’d like.

We have a long, successful tradition of educating Arkansans and we certainly hope this will continue. At graduation within the past five years the Valedictorian and Clinical Achievement Award winners have been Arkansans. I still intend to personally actively recruit students by visits to your colleges and universities, as it allows me to establish and maintain professional contacts and friendships. I look forward to seeing everyone and getting re-acquainted at the annual ASDA meeting in March. Please know the reverse is also true—you are always welcome on campus.

Please contact me with any thoughts or concerns. AD

Sincerely,

J. Stansill Covington III, DDS, MS
Interim Dean
UT College of Dentistry

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Central District News
DR. WERNER SCHNEIDER

The Central District Dental Society conducted two meetings since the last journal publication. The first meeting was held on November 9, 2017, at the Wyndham Riverfront Steakhouse in North Little Rock. This was our election meeting as well as one to hear an invited speaker.

There were 58 members present, of which approximately 20 were new/young dentists to our district and largely there due to the efforts of Dr. Terry Fiddler through direct communication/invitation to these individuals in attendance.

Others in attendance were our ASDA President, Dr. David Vammen of Texarkana and Dr. Stan Covington, who is the interim dean for the University of Tennessee Dental School. Dr. David Rainwater of Little Rock was nominated and elected Vice President, Drs. Jordan Cooper of Jacksonville and Matt Carlisle of Little Rock were appointed President and President-Elect, respectively, and Dr. Spencer Gordy of Conway continued his position as Secretary/Treasurer. The speaker was Mr. Jonathan VanHorn who is a CPA that owns a firm that represents and conducts accounting services for dentists only. His presentation was very informative and appreciated by all of those in attendance.

The second meeting was held on January 25, 2018, again at the Wyndham Riverfront Steakhouse in North Little Rock. Approximately 30 members were in attendance and applauded the presentation of a plaque to Dr. Brad Cruse for his work and leadership as President of CDDS in 2017. A presentation was given by our guest speaker, Chip Fischner, whose firm specializes in the selling and acquisition of dental practices, especially very large and/or multiple dentist ones. The presentation was very informative and appreciated by those in attendance.

Luke Henry Webster

Dr. Werner Schneider’s hygienist, Taylor Webster, and her husband Cody welcomed their first child into the world. Luke Henry Webster was born on January 26, 2018, weighing 6 lbs. 14 ozs., and 21 inches long. All are doing well and waiting for other exciting news. Cody is a senior med student at UAMS with plans of specializing in Internal Medicine and is awaiting news on his residency placement.

Hudson Reeves Howe

The stork has been busy for members, family, and staff within the Central District. Dr. Laurence Howe of North Little Rock is proud to announce the birth of his grandson. Hudson Reeves Howe was born on December 5, 2017, weighing 6 lbs. 5ozs., and 21 and ½ inches in length. The proud first time parents are Laurence’s son Edmond and his wife Amy who reside in Little Rock.

Rob and Dr. Natalia Hodge with Julia and Nora Marie
Dr. Natalia Hodge, an Orthodontist from Little Rock, and her husband Rob are proud to announce the birth of their second child. Daughter Nora Marie was born on December 18, 2017 weighing 8 lbs. 11 ozs., and was 21 inches in length. She joins Julia Linhares (4), who according to Natalia, has become a very “doting” older sister. Congratulations to all from the Central District.

And speaking of Dr. Hodge, she joins one of many dentists/specialists that are setting up or joining practices within the Central District. As stated earlier, Natalia is an orthodontist who recently opened her own practice in the Hillcrest area of Little Rock. Natalia was born and raised in Brazil and received her first exposure to the US and Arkansas as an exchange student in the 11th grade high school in Paragould.

While there, she met and dated Rob with whom she remained in contact after her return to Brazil. Returning five years later (2007), she and Rob married and moved to Little Rock where he was completing law school. Natalia applied and was accepted to the University of Illinois at Chicago Dental School and where they lived until 2014. She completed her DDS degree in 2011 as well as masters degree in Orthodontics and Oral Health in 2014 at the same institution. Both she and Rob enjoyed the Chicago area but longed for family, friends, and Arkansas in general and returned to Little Rock to start their professional careers. Natalia practiced briefly with Westrock Orthodontics before opening the doors to her new practice in October of 2017.

Drs. Donny Quick and Hugh Burnett, Oral Surgeons from Conway and Little Rock, respectively, are proud to announce the addition of the same new associate to their offices. Dr. John Batson of Little Rock will be providing oral surgery services to both practices. John is a native of Little Rock, having graduated from the University of Arkansas at Little Rock with a degree in Biology in 2000, then a dental degree from University of Missouri at Kansas City Dental School in 2005. After dental school, he enrolled in the Health Professions Scholarship Program that helps to pay one’s health education costs through military service. So in 2005, John enrolled in the Army Dental Corps, then started and completed a GPR Program at Ft. Campbell, Kentucky.

He was deployed to Iraq to serve in Operation Enduring Freedom from 2007 to 2009. Upon his return to the states, John was sent to Womack Army Medical Center in North Carolina to complete his Oral Surgery residency from 2009 to 2013. After completing his residency, John was assigned to Ft. Stewart, Georgia, where he became the Chief of Oral Surgery at Winn Army Hospital from 2014 to 2017. After his stint at Ft. Stewart, John, his wife Rachel, and children Maggie (14), John Jr. (12) and Bobby (9) returned to Arkansas where he entered into private practice. John’s primary place of practice will be with Dr. Quick in Conway working three days a week and will “satellite” with Dr. Burnett’s office two days a week.

Dr. John Cloud of Little Rock is proud to announce the addition of a new dentist to the practice. Dr. Nathaniel Hill joined John’s practice on January 2, 2018, to form Cloud/Hill Dental Care. Nathaniel graduated from Lipscomb College in 2007 and received his dental degree from the University of Tennessee Dental School in 2011.

While in dental school he married a classmate, Jeni Hall-Hill DDS, and upon graduation, they resided and practiced in Nashville, Tennessee for three years and Conway for four years before coming to Little Rock. Dr. Hill’s joining the practice is just the latest of many changes and events that are a part of the long history of the Cloud dental family.

The practice was started by John’s dad, Dr. William Cloud, in 1952. John joined his dad in practice in 1983 and along with his dad and brother Lindsey, practiced in west Little Rock until their office burned to the ground in 2003. John and Bill built and moved into a new office (and current location) on Cantrell Road in west Little Rock in 2004 and both practiced there until Bill’s retirement in May of 2008 after 56 years of dental service.

John states that Nathaniel brings a broad range of dental experience and services that creates a “complete” practice for current and new patients alike. Dr. Hill is a member of Health Talents International which is a Christian Medical Missions group that provides care to rural Guatemala. Nathaniel and Jeni have one daughter, Olivia (3). Jeni is currently practicing as an associate at Austin Family Dentistry in Little Rock. The Central District welcomes all of those members that are new to the district and thanks all of those who have or are serving and protecting the rights and freedoms of our country.

Two dentists from the Central District have decided to retire recently. Dr. Jim Phelan, an orthodontist from Little Rock, retired in December 2017, after 43 years in private practice. Jim was raised in Donaldson, Arkansas, a small rural town between Malvern and Arkadelphia, attended and graduated from Ouachita Baptist University in 1968. He graduated and received his dental degree from the University of Tennessee Dental School in 1971, returned to Malvern and practiced general dentistry with Dr. Phillip Nix for
One year before entering Baylor Dental School in Dallas and completing his Orthodontic residency in 1974.

Upon receiving his orthodontic degree, Jim moved to Little Rock and became an associate for one year in the orthodontic practice of Dr. James Shuffield, then moved into the old Doctors Hospital to start his own practice. Jim then moved his practice to west Little Rock and set up his office in the same building as the late Dr. Doug Shirey. He practiced there until 1984 and then moved down the street into the Breckenridge Professional Building and is the current location of Phelan Orthodontics.

Jim was joined by his son Tom in 2002 and both practiced together until his retirement and as Tom states, his dad has not stepped back into their office since doing so! Jim was married to the late Francie Phelan for 32 years and had 3 children together. Kristi, a stay at home mom, lives in Dallas; Tom, who has taken over the orthodontic practice; and Patrick who works in the software marketing business and who also lives in Little Rock. Jim and his wife Paula plan to spend retirement enjoying time in the outdoors on Lake Ouachita, some of that with their nine grandchildren and other traveling as well.

And as Tom states, one of Jim's proudest accomplishments is that of his family's service in profession on dentistry. Jim's brother Richard is a general dentist practicing in Benton, nephew Todd Phelan (Richard's son) who practices in Rogers, and of course his son Tom and his wife Wendy, who herself comes from a dental family in Dallas.

The second dentist of note that has retired in the Central District is Dr. Martin Zoldessy (aka Doctor Z) of Little Rock. Martin served as the Director of Dental Services for the State of Arkansas Correctional System and retired in December 2017 after holding that position close to 25 years.

Martin was born and raised in the Bronx, New York, and joined the Air Force in 1962. After basic training, Martin was stationed at the Little Rock Air Force Base in Jacksonville, and assigned as a medic to monitor and give any aid to the workers involved with the up keep of the surrounding 18 missile silos.

He eventually became interested in dentistry because his roommate on the base was a dental assistant at the dental clinic there. Martin left the service but remained in Arkansas to pursue a college education at LRU (now the University of Arkansas at Little Rock) and graduated in 1969. He was accepted to and obtained his dental degree from the University of Tennessee in 1973.

After graduation, he did a stint with the Public Health Department in North Carolina before returning to Arkansas to do the same thing with our Department of Health and their Children's Health Clinic. In 1977, he entered private practice opening an office near the intersection of Rodney and Green Mountain Drive in west Little Rock as well as working part time at the Arkansas Children's Hospital in Little Rock.

Then in the early '80s, Martin moved his office and practice into a building/off ice space complex next door to the old Kroger's store located on Cantrell Road in west Little Rock. Some of his reasoning for moving the practice into that area was due to a growing interest in wines that led him to purchase space for a liquor store next to his office and to make it easier to run and keep “tabs” on both.

As if he didn't have enough on his plate, Martin also worked part time at the St. Vincent's East End Dental Clinic and that is where he met a fellow dentist who was working at the clinic and introduced him to correctional dentistry at the Dental Services Division for the Arkansas Correctional System.

In 1993, he began working two days a week at the Varner prison unit in southeast Arkansas. By 1997, Martin was offered the director's position and accepted, but still maintained the liquor store as well as his private practice. He soon realized that he could not run all three, so he sold his private practice and hired his daughter to manage the liquor store which she did for six years until getting married and moving to Germany. Martin attempted to run the liquor store and maintain his director duties within the Correctional System but soon realized as he did in 1997 that “something had to give”, so he sold the store and devoted his full energies to the director's job until his recent retirement from that position.

Martin is only the third person to hold that position since its inception and his replacement to follow will have some big shoes to fill. When he entered the department some 25 years ago, it had three dentists and one hygienist to provide dental services to approximately 8,500 inmates at the time and now the department has approximately 20 dentists and six hygienists that provide services to nearly 20,000 inmates!

Martin and his wife of 38 years, Aurian, have three daughters, two of whom live in Texas and one in Little Rock—all are school teachers as well. They also have one grandson. As far as retirement, Martin is not completely done with dentistry for he plans to do some part time work in dental clinics at a few selected prison sites. He and Aurian plan to do some traveling especially to vineyards and wine producing areas (go figure!) as well as learning to become an actual Master Gardener and also return to teaching wine classes which is something he did and enjoyed when he owned the liquor store.

Congratulations and good luck to these two individuals and any other dental professionals that have chosen to retire from our profession within the Central District as well as across our state.
Northeast District News

DR. ROBERT KALOGHIROU

The Northeast District held its 2018 annual session at Arkansas State University Centennial Hall on January 26 and 27. The meeting was a huge success with over 150 dentists and hygienists attending. Dr. Douglas Damm an Oral Pathologist from the University of Kentucky was the keynote speaker. Dr. Herb Blumenthal also spoke on the second day of the meeting about TMJ Disorders. Both lectures were very well received by all in attendance.

The Northeast district would also like to welcome Dr. Sarah Yarnell. She is a Northeast Arkansas native and is now practicing in Jonesboro. Dr. Yarnell purchased Dr. Bill Panneck’s office. Dr. Panneck has recently retired and we would like to wish him well. Dr. Yarnell will be serving on the Executive Council for our district.

Dr. Alan Ainley has also recently retired from his family practice in Paragould. Both Dr. Panneck and Dr. Ainley were valuable members to our district over the last three decades. They will be dearly missed and we would like to wish them happy retirements.

Northwest District News

DR. DUNCAN JOHNSON

The Northwest District meeting will be held on Friday, June 8, 8 a.m. – 4 p.m. at the Fayetteville Town Center. Gordon Christensen will be the speaker.

This spring the Academy for Interdisciplinary Therapy study group will host another great speaker in European Lecture series. The speaker will be Renato Cocconi, MD, MS, who is an orthodontist from Parma, Italy. The title of the lecture is Interdisciplinary Treatment to the Face. This will be held on Monday April 9, 2018, in Fayetteville, Arkansas at the University of Arkansas Sam Walton Conference Room.

Annual group CE trip of NWA Spear

Spring 2018 | Arkansas Dentistry
Study Club. We attended the 2018 AAO/AAPD Joint Winter Conference in sunny Scottsdale, Arizona, where they enjoyed learning more about Early Orthodontic Treatment in children!

Dr. Mark and Janet Bailey celebrated their 35th anniversary and granddaughter Reese’s fifth birthday on a seven-day Disney Cruise with ports of call at Port Canaveral, St. Maarten, St. Thomas, and Castaway Key.

Dr. Liggett and a team of dentists, hygienists, doctors, nurses, and lab technicians in St. Elizabeth Parish, Jamaica

Southeast District News

DR. KEITH JONES

Hello from the Southeast District! We have some exciting news to share in this part of the state.

Greetings from Monticello and Yvonne Shelton at Dr. Alissa Hopper’s office! Yvonne is celebrating her 22nd year with Dr. Alisa Hopper’s office. Yvonne’s family is growing, and she is expecting her fourth grandson at the end of the month! Happy New Year to ALL!

Dr. Kelli Grubbs and her husband Clay are excited to announce that they are expecting their third child in February 2018. This is the first girl for the family.

Dr. Jim Moore’s wife, Connie, is glad hunting season has finally come to an end so Dr. Moore can return to completing his honey-do list. She says he is an excellent handy man and happy to loan him out if anyone should ever need some help.

Southwest District News

Dr. Trevoer Coffee, Darby Kate, and Jody enjoy the snow and each other in Red River, New Mexico.

Dr. Garrett continues to struggle. Please remember him in your thoughts and prayers. AD

(L-R) Assistant Cruise Director, Mark Bailey, Janet Bailey, Cruise Director, and Reese Ann Anglin in front.

Shelton Family—Joseph, Amanda, Braxton, Kipton, Rick and Yvonne, Richard, Holley, Whittman, and Baby Will Henry on the way!
Greetings from the Arkansas Dental Hygienists’ Association! ArDHA ended 2017 by hosting our bi-annual Strategic Planning Session in November. At this meeting we developed new goals for our association that will be implemented over the next two years. We are very excited about many new ideas and participants.

In January 2018, ArDHA hosted the 3rd Annual Student Board Review in Russellville at Shiloh Missionary Baptist Church. This event is to help UAFS and UAMS senior dental hygiene students prepare for the National Board Dental Hygiene Examination this spring. We want to give a big thanks to all our sponsors and volunteers that made this fun event possible! Sponsors include Vondran Orthodontics, Parkway Dental, Philips, Hu-Friedy, American Eagle Instruments, Dental Decks and Dental Hygiene Nation.

In February ArDHA hosted a Smile Drive at Walmart in Little Rock to collect oral hygiene products for foster children in Arkansas. We also participated in Delta Dental’s Toothapalooza at the Museum of Discovery in Little Rock to provide oral health screenings and oral hygiene instructions for children. ArDHA had the fantastic opportunity to participate with the Arkansas Oral Health Coalition in the proclamation signing declaring February as Children's Dental Health Month by Governor Asa Hutchinson. These events were a great way to celebrate National Children’s Dental Health Month!

ArDHA will be participating in many different events with a number of organizations in April! We are thrilled to participate another year in the Arkansas Mission of Mercy in Conway! We will also be participating in the Children's Advocacy Alliance’s Heroes for Hope in Conway. ArDHA is partnering with the Arkansas Cancer Coalition to host a continuing education course in Northwest Arkansas on Friday, April 6 from 1–4 p.m. The course is Motivational Interviewing for Dental Professionals.

In June ArDHA is looking forward to the Governor's Oral Health Summit hosted by the Arkansas Oral Health Coalition at Pulaski Tech in North Little Rock. We are greatly anticipating a fun and productive time at the American Dental Hygienists’ Association Annual Conference in Columbus, Ohio, as well! As June approaches, our state and delegates will be preparing with the four other states in District VI for the House of Delegates at the ADHA Annual Conference.

This spring and summer are full of opportunities for all dental professionals to give back to our communities and to earn CE units. ArDHA is looking forward to seeing each of you there!
Spring semester began on January 8 with 33 students in each class. All students are in clinic during the spring semester. Senior students are completing various community outreach projects in Community Dentistry II. All students attend an interprofessional rotation at the 12th Street Health and Wellness Clinic on Monday and Wednesday nights under the supervision of Dr. Marcia Wheeler and dental hygiene faculty Jennifer Stane. Graduation for the senior class will be May 19 at Verizon Arena.

Applicants are applying for the fall 2018 class. Interviews for the incoming fall class will be conducted in June. The AS Degree option will no longer be offered beginning with the fall 2018 semester. Local Anesthesia will be offered in May 2018. Please see the website for all CE offerings; http://healthprofessions.uams.edu/programs/dentalhygiene/

UA-Pulaski Technical College Dental Assisting Program

BY DEANNA DAVIS, CDA, RDA, MED
Dental Assisting Program Director

Wow, this school year has passed quickly. Our students began their first clinical rotation on February 13. Two days of the campus being closed put us a little behind. Teaching is kind of like dentistry—you have to roll with the flow.

A huge thank you to Dr. James Penney. He comes each year to talk about endodontics and gives the students some good information about a career in assisting with endodontics. Every year he comes and students see how quickly a root canal can be done and ask to change their specialty.

Our students do four different clinical rotations and one of those four is in a specialty of their choice. Sometimes so many want to do one specialty field that we have to go to their second choice. The other three rotations are general dentistry.

Our students have the opportunity to rotate three weeks through the Little Rock Air Force Base, the VA Dental Clinic in North Little Rock, UAMS Dental Clinic, and Arkansas Children’s Dental Clinic. Our students are very fortunate for the opportunities given to them at the above clinics and most importantly, the individual dental practices that work with them.

We are continuing to make the changes necessary to align with the University of Arkansas system. Who was to know of all of the policies that needed to be changed? We are slowly rebranding because of the cost that is involved with it. We will get it all done in time.

Our students will be participating in ARMOM this year. We are excited for them to see what need there is for adult patients. They volunteer to do fluoride varnish for two Little Rock schools so they see the need for the children early on. There was only one year that our students were able to volunteer at ARMOM.

MOMs are usually in May and our students have already graduated. This year in April we will have them there on Friday and some might return on Saturday.

Weeda, Jackie, Floy, and I are proud of our 21 graduates this year. Congratulations!

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Specialty</th>
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<tbody>
<tr>
<td>Kristen Anger</td>
<td>Little Rock</td>
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<tr>
<td>Grace Barefoot</td>
<td>Bryant</td>
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<td>Tabitha Basinger</td>
<td>North Little Rock</td>
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<tr>
<td>Alexia Beza</td>
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<td>Briley Brazear</td>
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<td>Laticia Crittenden</td>
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<td>AJ Deshazer</td>
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<tr>
<td>Autumn Draper</td>
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<td>Brianna Fowler</td>
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<td>Alexis Harris</td>
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<td>Nathaniel Hunter</td>
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<td>Bailey Kirby</td>
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<td>Francisco Reta</td>
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<td>Telisha Sribner</td>
<td>Lonoke</td>
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<td>Carlin Wheeler</td>
<td>Little Rock</td>
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Arkansas Dentistry | Spring 2018
Dr. John L. Bost  
SEPT. 24, 1924–FEB. 10, 2018

Dr. John L. Bost (Jay), age 93, of Paris, Texas, and Hot Springs, Arkansas, departed this world on Saturday, February 10, 2018. By his side to the very end was the love of his life and best friend, his beloved wife, Sarah Jane. Dr. Bost was a member of Holy Cross Episcopal Church in Paris, Texas.

Dr. Bost was preceded in death by his parents, C.J. and Hattie Bost, two sisters, Dorothy Bost Wells and Kitty Bost Evans, and his stepson, Dr. Danny Glasgow. He is survived by his wife of 58 years, Sarah Jane Hightower Bost, four sisters, Bettye Bost Bollen, Pat Bost Finley, Reba Bost Hobson and Shanie Bost Martin, three brothers, Claud Bost, John Bost, and Jerry Bost.

Dr. Bost was born, reared and received his early education in Plum Bayou (Wright, Arkansas). He started life in a very humble rural household growing up during the Great Depression. From those humble beginnings he created and enjoyed a very successful life. He joined the U. S. Navy at age 18 during World War II as a B-25 bomber crew member and endured many dangerous missions in the Pacific. After the war he earned a B.S. degree in chemistry and later did chemical research for Dow Chemical Co. After a few years he resigned and was admitted to Baylor University Dental School and received his Doctor Dental Surgery (DDS) degree. Later through additional training and education he became an Orthodontist having a successful practice in North Little Rock, AR for many years.

In addition to a successful professional career, Dr. Bost also enjoyed a successful personal life. He was a gifted golfer, playing many courses over the U.S. and Europe. During his playing days he accomplished an astonishing 17 holes in one. He and his wife also enjoyed the passion of thoroughbred horse racing in Hot Springs. To those who knew him personally, all would say his greatest talent was that of an engaging and spellbinding storyteller with stories coming from his colorful, exciting, and entertaining life of 93 years. His stories and his zest for life will continue to live in our hearts and minds forever.

Donations may be made to Hospice Home Care, 4332 Central Ave., Suite J, Hot Springs, AR, 71913.

Dr. Doffie Jarvis  
JULY 25, 1934—FEB. 22, 2018

Dr. Doffie Neal Jarvis, 83, of Jonesboro went home to be with the Lord Thursday, February 22, 2018, at Lexington Place Nursing and Rehab. He was born on July 25, 1934, to the late Noble and Ethel Jarvis in Jacksonport.

In addition to his parents, Doffie is preceded in death by his sister, Alice Edgin. Dr. Jarvis is survived by his loving wife, Pat, of the home; daughters, Linda (Harold) Wilson of Jonesboro and Suzanne (Tommy) Ames of Bentonville; brother, Charles (Joyce) Jarvis of Newport; brother-in-law, Bill Chmelar of Washington, Iowa; grandchildren, Brandon (Cari) Cooper, Brett (Lindsey) Cooper, Brooke (Matt) Love, Whitney (Timothy) Welch, and Tanner Wilson as well as six great-grandchildren.

A visitation service and a funeral service were held on Sunday, February 25, 2018, in the Emerson Memorial Chapel with Larry Bailey officiating. Burial followed at Jonesboro Memorial Park Cemetery with Matt Love, Timothy Welch, Brandon Cooper, Brett Cooper, Dr. Bill Panneck, and Eric Brown serving as pallbearers. The Agape Life Group Sunday School Class of Central Baptist served as honorary pallbearers.

Donations may be made to Gideons International, P.O. Box 97251, Washington, DC 20090, to Alzheimers Foundation, 322 Eighth Avenue, 7th Floor, New York, NY 10001, or to the Central Baptist Church Mission Fund, 3707 Harrisburg Rd., Jonesboro, AR 72404.
The professionals at National Dentex Labs have the unique ability to provide specialized services and local assistance on all of our products supported by our national network that includes dedicated aesthetic and technology laboratories.
Supporting the Arkansas Mission of Mercy makes us smile.

The Delta Dental of Arkansas Foundation is proud to be a founding sponsor of ArMOM. In our 13 years of support, we have contributed more than $1.3 million to ArMOM in our work together to improve the oral health of Arkansans.

Join the Delta Dental team of volunteers in Conway April 27 - 28.

Sign up to volunteer at arkansasmissionofmercy.org