PUBLISHED BY THE AMERICAN ACADEMY OF IMPLANT DENTISTRY / FALL 2016

AAID NEWS

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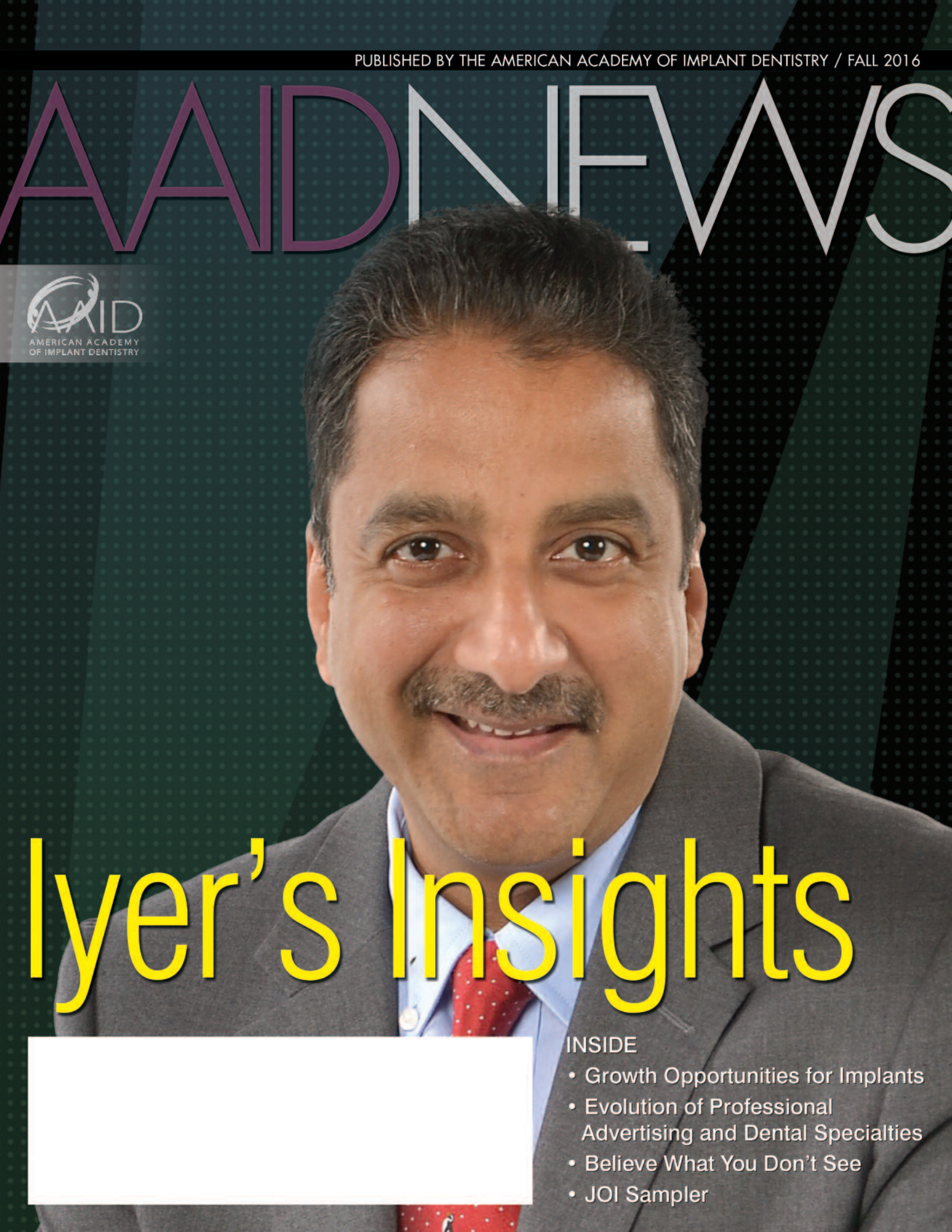

Iyer's Insights

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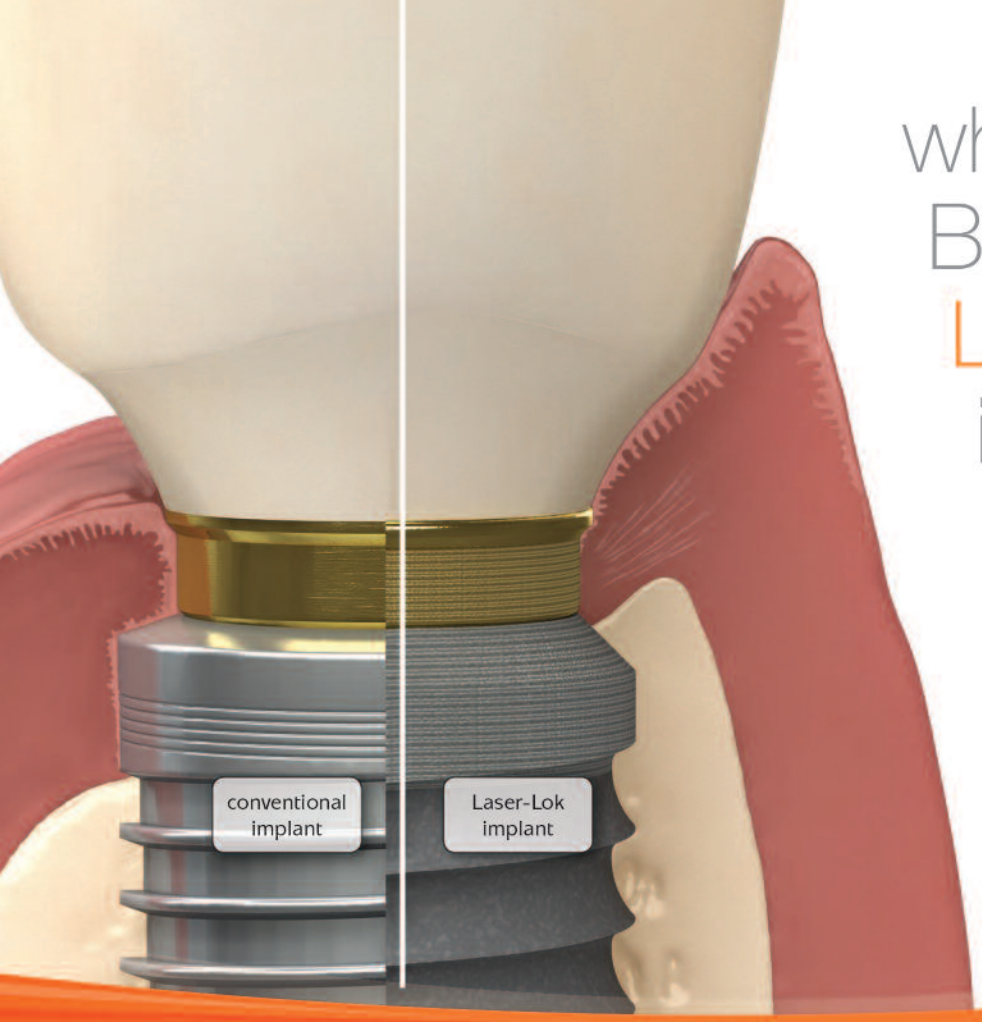

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1. M Nevins et al. *Int J Periodontics Restorative Dent*. Vol. 28, No. 2, 2008.
2. S Botos et al. *Int J Oral Maxillofac Implants*. 2011; 26:492–498.

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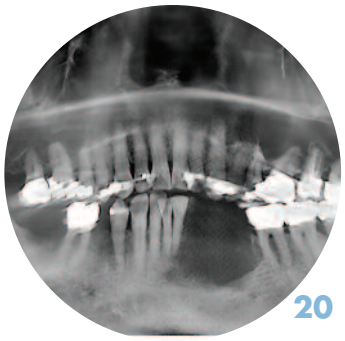
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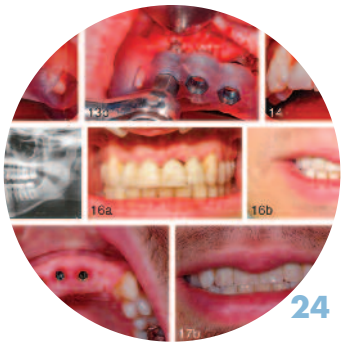
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AMERICAN ACADEMY OF IMPLANT DENTISTRY

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aaid.com

Lead Stories

AAID News

By James E. Ference,
DMD, MBA, AFAAID, DABOI/ID
Editor, *AAID News*

Just politics? Think again.

As we approach our Annual Conference, we look forward to another year of ambitious goals by a new president Dr. Shankar Iyer. I think you will find the interview where he shares his thoughts, aspirations, and plans to be quite interesting. We are blessed to have the talented crew that makes up our national and regional leadership.

It is nearly time for a major national election. Many people have strong feelings about the significance of the choices we have this time around. Many times, though, I hear people proudly describe their non-involvement believing that the political world is just not worth the investment of their time. When I hear that thought expressed, I think of a fish that considers itself independent of the water. The fish would be delusional at best. The fish may not fully appreciate it, but it is always dependent on the state of the water whether it cares or knows.

So it is with the political world. It affects us whether we invite it into our lives or not. It will dramatically affect our lifestyle, our economic standard of living, our freedom to live in the way we choose, our health, our safety, and our retirement.

[The political world] affects us whether we invite it into our lives or not.

As dentists, we are especially affected by politically-made decisions at the national, state and local level , as well as those made within the "dental world," dominated by the American Dental Association, its affiliates, and state boards.

Our world is rife with rules and regulations, most well-intended but not all well-thought-out and some with damaging unintended consequences.

Some politically-made decisions have defined the rules dictating what dental and medical insurance companies can legally do, created new categories of practitioners, such as denturists and dental therapists, and even decided what constitutes a "specialist" in dentistry. As we all know, there are also a myriad of other requirements and limitations determined by those operating in the political realm.

How should we respond? Do we simply adjust as our professional autonomy is crowded out by the decisions of others? As a group, dentists are well-informed and responsible citizens. Showing up to vote is a given, but, to the extent that your interest and comfort zone permit, consider stepping into the arena of political activism. Activists will make decisions about our national destiny as well as our professional future.

Maybe one of those decision-makers should be you!

Do YOU have ideas, strategies, comments, or observations that you want to share with your colleagues? Send them to me at editor@aaid.com.

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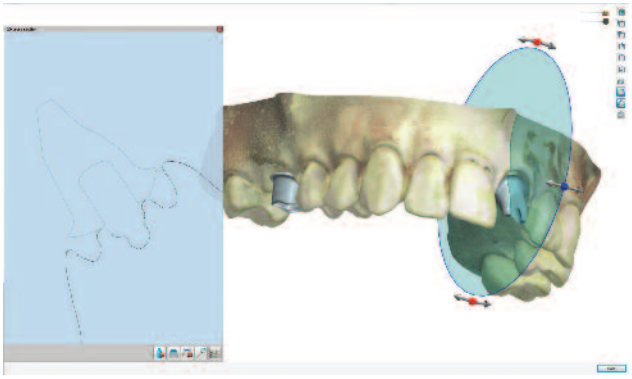
industry news

Core3daCADemy® Launches Digital Dentistry Certification Program



Core3daCADemy®, the educational arm of Core3dcentres®, announced the launch of its new Digital Dentistry Certification Webinar Program. Available to registered participants on demand, the program is organized into "Units" of three one-hour webinars focusing on a particular topic.

The program will launch with "Unit 1: A Beginner's Guide to Digital Scan and Design Success." Unit 2 will cover "Digital Crown & Bridge Techniques." Upon completion of each unit, participants will be fully-Core3daCADemy certified in the basics of digital dentistry in that area of concentration — and will receive an official Certificate of Completion. Three CE Credits are also available for each Unit as well. The cost is only $99.00 per unit.

ebradley@core3dcentres-na.com
www.core3dcentres-na.com

Digital Dental Selects Corey Tisthammer as President & CEO

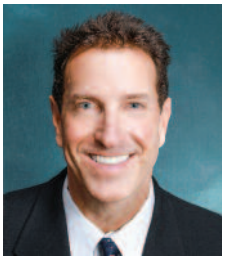
Digital Dental announced that its Board of Directors has appointed Corey Tisthammer as President and Chief Executive Officer effective July 25, 2016. Founders Scott Atkin and Kim Karpowitz will remain in their roles managing the materials and machines divisions of the company.

Earlier this year, Digital Dental was created from the merger of four leading companies manufacturing dental mills, dental lab materials, and sintering ovens, plus a state-of-the-art training lab. Digital Dental is now the leading manufacturer of dental lab milling machines in the US, with the #1 market share among America's largest traditional dental labs.

Before joining Digital Dental, Tisthammer served for 11 years as CEO of Crest Healthcare after holding strategic product and brand roles at Honeywell, Pillsbury, and Procter & Gamble. Corey also served as a naval aviator with flight duties in Operation Desert Storm.

480.948.0466
www.digitaldental.com

Top Implant Dentists Join the Teeth Tomorrow® Network



Michael Tischler

The Teeth Tomorrow® Network announces that the last available territories in the New York metropolitan market have been filled. These top-rated practices join a national network of advanced implant dentists (limited to 250 franchisees) that provide proven surgical and prosthetic solutions with the Prettau Zirconia Bridge™. The Teeth Tomorrow® Network is the only U.S. dental franchise dedicated to full-arch zirconia as the final product.

The Teeth Tomorrow® network supports its members with state-of-the-art laboratory expertise from Tischler Dental Laboratory. The Teeth Tomorrow® process is based on the concept of delivering a screw-retained provisional the next day

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Introducing Zest Dental Solutions™

ZD ZEST DENTAL SOLUTIONS™
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Zest Anchors unveiled Zest Dental Solutions as its new company name reflecting both the evolution the company has realized and its vision for the future.

For nearly 40 years, Zest Anchors has focused on improving the lives of edentulous patients throughout the world with innovative, functional products for overdenture treatment. The company's flagship product, the LOCATOR® Attachment System, continues to be recognized by the implant industry, clinicians and patients as the most trusted brand for overdenture restorations. The company set its sights on providing more patient solutions by introducing a line of narrow diameter dental implants, the CHAIRSIDE® Product Portfolio consisting of dental tools and materials for overdenture modification and processing, and the next generation LOCATOR R-Tx™ Removable Attachment System. The company will enter the fixed full arch restoration segment with its innovative LOCATOR F-Tx™ Fixed Attachment System with a commercial launch slated for the 4th quarter of 2016.

Zest Dental Solutions (zestdent.com) has moved into a new 46,000 square foot Corporate Headquarters located in Carlsbad, California. Zest Dental Solutions total facility footprint will be in excess of 75,000 square feet.

www.zestdent.com

Hahn™ Tapered Implant Named Official Implant System of the Misch International Implant Institute

MISCH INTERNATIONAL IMPLANT INSTITUTE

HAHN TAPERED IMPLANT

The Misch International Implant Institute and Glidewell Laboratories recently introduced the Hahn™ Tapered Implant as the exclusive dental implant system used in the institute's courses. As part of this collaboration, the Misch Institute is relocating its West Coast programs to the Glidewell International Technology Center in Newport Beach, California.

The Institute was founded by **Dr. Carl Misch,** renowned practitioner and educator who authored the indispensable textbook, "Contemporary Implant Dentistry."

Glidewell Laboratories launched the Hahn Tapered Implant in 2015 in cooperation with clinician and innovator **Dr. Jack Hahn.** As recently noted by Dr. Misch, "the Hahn Tapered Implant is a great fit for the institute, as its design is based on Dr. Hahn's 40-years-plus of clinical experience."

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Iyer's Insights

EDITOR'S NOTE: ***Dr. Shankar Iyer,*** *President-elect of the American Academy of Implant Dentistry, was the subject of one of AAID's recent Podcasts. The complete podcast, conducted by* ***Drs. Justin Moody*** *and* ***Danny Domingue,*** *can be heard in its entirety online at www.aaidpodcast.org. Or subscribe to AAID podcasts through your iPhone or Android podcast app. The following is an edited version of the podcast plus some additional questions posed by* ***Dr. James Ference,*** *Editor of AAID News.*

DR. DANNY DOMINGUE: Dr. Iyer, you got into implant dentistry a long time ago. Talk to us about how you got started in it.

DR. SHANKAR IYER: I graduated from dental school from Annamalai University in India in 1987. Then I did my master's in prosthodontics for a couple of years, and left India in 1990 to come to the United States for a one-year implant fellowship. After completing the fellowship, I went to New York University for two years to complete my DDS. Then I joined private practice for some time, but went back to prosthodontic residency for another three years. It was an investment of about 14 years of education.

DR. DANNY DOMINGUE: When you first started out in practice, were you doing implants?

DR. SHANKAR IYER: My Master's thesis in prosthodontics was on implants, so that's how I got excited. In 1990, I defended my Master's Thesis on dental implants under the guidance of Dr. Aruna Mehta who provided the spark in my implant career. This got me to the United States to do some additional research on bone heat generation and thermocouple measurements. In those days we were using a lot of plate/blade implants, and I was doing some research on high-speed drilling and bone heat generation. I was an associate of **Dr. Charles Weiss** for a few years, and then I moved on and started my own practice in 1995 in Elizabeth, New Jersey.

DR. DANNY DOMINGUE: In the past 26 years, what's been the biggest change for you in your practice in implant dentistry?

DR. SHANKAR IYER: The adoption of the lessons from history has taught me a lot, because I think we have a come full circle. Right now what I'm planning is all about over-engineering my cases and not to be in a position where you wish you had done something different when you first got started with a case. Not compromising biomechanics for the sake of economics. Now that I'm removing some of my own subperiosteals and blade/plate implants from the maxillae, I now wonder what's the worst case scenario for every case where implants are being placed. I create a plan "B" for the aftermath 25 years from now. After 25 years, if I have to manage these cases, would I be in a position to revise these cases? What is the next generation of implants that can circumvent or supersede what you have done in the past? I'm also very, very cautious about newer innovations and newer technologies coming into the marketplace. I'm now becoming a skeptic and not quickly adopting these technologies. For example, in the 1990s when I switched to titanium plasma

A young Shankar Iyer.

I now wonder what's the worst case scenario for every case where implants are being placed.

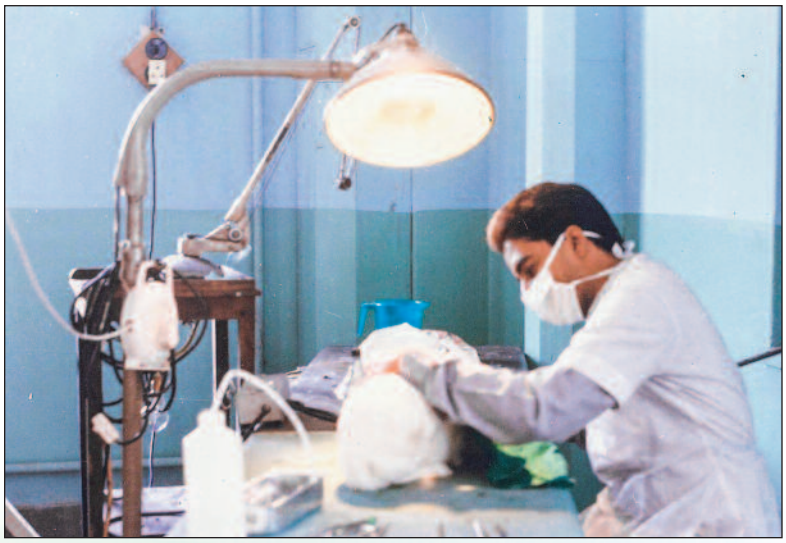
flame-sprayed and HA coated implants, they were the state of the art. Now, I'm taking out all of those plasma flame-sprayed implants. This is leading me to believe that I have to be a little more cautious and wait until the implants have gone through the test of time. Unfortunately, we don't have a crystal ball to predict how these innovations will turn out in the future. What's new is new. However, what's better, time will tell.

DR. JUSTIN MOODY: But don't you think that was the best we had at the time? We don't know what we don't know, and at the time we were doing the very best that we knew how.

DR. SHANKAR IYER: Agreed. But we need to look at some of the short-term failures and the long-term failures. It's very hard to pinpoint one technology and say this will really last a lifetime. So, it's getting increasingly difficult to pinpoint one particular area of success, because these companies are taking over the market by rapidly changing the designs and surfaces. We are not allowing for any of the innovations to be tested for long-term durability. The education's no longer with institutions, so you're relying entirely on corporate influence. I've gotten burned in the past five years on some newer technology which really has not gone through some rigorous clinical trials.

Granted, those old technologies may be dated, but you had 15-year follow-ups. None of these current implant systems have even a five-year follow-up. Before you realize it, the companies are changing to different designs, and then the components don't fit each other between the designs. For example, in 2000 a large implant manufacturer introduced a new implant design that I considered to be a good one to incorporate into my practice. I currently have about 50 or 60 of these implants. However, when I contact the manufacturer for parts that work with this particular implant design, I am told there are none. As a result, I have to custom-machine abutments. This costs me a fortune.

These are some of the things that we have to be sensitive to in terms of technology and adoption life cycle. If you want to be on the curve, want to be the innovator, developer, or the early adopter, you should be willing to take the risk, and say this is what I want to do. This is my cutting-edge practice, and that's okay. But the vast majority are looking at the early adopters to see where the trend is going. So, if you are an educator, you need to be a little more diligent about what you are propagating and not fall prey to some of these corporate influences with each presentation. That's what I'm referring to.



Dr. Iyer performed implant surgery on small animals early in his career.

What's new is new. However, what's better, time will tell.

DR. JAMES FERENCE: Implant dentistry has a lot of "players." Some are: teaching institutions, corporations that market and sell implants, state boards of dentistry, dental organizations like the ADA or AAID, and, of course, the practitioners themselves. Is there a reasonable "balance" of the numerous and individual involvements of the players, or is there any sort of imbalance that is detrimental to our professional well-being or the well-being of the profession itself?

DR. SHANKAR IYER: With the rising cost of tuition and the decreased exposure of our new graduates to comprehensive care, we are at some dangerous crossroads. New graduates are looking to augment their clinical exposure and at the same time anxious to pay off their monumental loans.

The interest in learning implants has superseded the need to excel in general dentistry because of the perceived economic impact of dental implant therapy.

Another vicious lure is corporate dentistry which is attracting new dentists with hefty compensation packages.

The production-based model is clouding judgment and skills. I fear we may be facing an imbalance between the extent of treatment that is rendered and the level of disease the patient presents with.

If there is one thing I would like to see happen, it would be a direct six-year dental program after high school so that the tuition can be sustained and there will be more of our own dentists taking up graduate programs.

Another change I would like to see is to lessen the importance of education that is relied upon through companies rather than institutions. Company-based certification programs are distancing evidence-based practices. We may be nearing anarchy with education especially when we see these short courses gaining popularity. Our MaxiCourses®, the flagship education program of the AAID, is by far one of the best academic exposures you can get when it comes to implant dentistry. I would like to see these being offered in every state over the next few years.

DR. JAMES FERENCE: While our focus is primarily implant-related dentistry, are there issues affecting the whole profession about which you have any special interest or concerns? For example, are there threats that may negatively impact patient care?

DR. SHANKAR IYER: I am concerned that vocabularies like "edentulate," or "prosthetically necessary ostectomies" are creeping into our profession. There seems to be a connotation that it is almost a nuisance to hold onto natural teeth. While dental implants are the best to replace MISSING TEETH, I don't agree that they are the best to replace TEETH. Our Academy, while fostering the education in dental implants, is balanced with its practitioners who feel that they are dentists first before considering themselves as implant specialists.

DR. JAMES FERENCE: Is "organized dentistry" doing what it should be doing to guide the future of the profession?

While dental implants are the best to replace MISSING TEETH, I don't agree that they are the best to replace TEETH.

Dr. Iyer is an award-winning mime.

DR. SHANKAR IYER: "Organized dentistry" seems to be losing its focus on its goal of working together with the organizations to benefit the profession. The recent court victories of AAID is a testament to the flaws of the system. The turf needs to broaden and the agenda of special interest groups needs to be replaced with one common goal — "How can the patient be best served and how we can provide the best care?"

DR. JUSTIN MOODY: AAID MaxiCourses® are an excellent way to get a well-rounded education without the direct influence of the implant manu-

facturers. Would you agree with me on that?

DR. SHANKAR IYER: 100%. I cannot agree more with you. MaxiCourses® are where education should begin. It's not in a two-day corporate course. It's got to be something that's in a module format that gives you the entire gamut of what you can learn, from the basics all the way to the advanced techniques. Though the companies are involved peripherally, there are experts who are teaching you at these courses. The speakers are chosen based upon their prowess in the subject matter. They are usually unbiased. Course participants get a wide range of exposure to implant education. I must commend AAID for being the forerunner in implant education. I don't think there is any other academy or association that even comes close to the kind of education that we offer through these MaxiCourses®.

(l-r) Dr. Charles Weiss and Dr. Iyer prepare to fly to Nantucket Island with Dr. Angelo Chiarenza as their pilot.

The podium was primarily infiltrated with "eloquence-based" implant dentistry. Now, you're looking at an "evidence-based" model.

DR. JUSTIN MOODY: How long you've been in the AAID and what has been your involvement in the organizational side of the AAID.

DR. SHANKAR IYER: When I started with the AAID in 1991, I came in as a co-scientific chair for the annual conference in 1991. The topic was provocative issues in implant dentistry.

At that time, we used to have panels that would fight over blades, subs, HA-coated implants, and all kinds of issues. You had **Dr. Jerry Niznick** fighting with **Dr. Leonard Linkow** about their patents**,** and it was really a lot of fireworks and exchange of dogmatic arguments. People spoke with a lot of passion. The podium was primarily infiltrated with "eloquence-based" implant dentistry. People were really vociferous about their belief system, and that's the reason why we are where we are today. These people really adopted the Academy as their own, and they nurtured it. That's what makes AAID so unique. Now, you're looking at an "evidence-based" model. It's a big change over the past 25 years that I've been with the Academy.

From my initial exposure in 1991, I became an Associate Fellow in 1997. We had to defend ten cases, and that was very stringent for an entry level exam.

Back then, only Fellows were considered to be "active members." I became a Fellow in 2000 and then went on to become a Diplomate of the ABOI/ID in 2004.

This organized process of maturation is very, very important. I think AAID has done a great job in empowering the credentialed members into becoming educators and leaders in the field. That's my journey with the AAID.

DR. JUSTIN MOODY: Who were your mentors in AAID?

DR. SHANKAR IYER: I was mentored by **Drs. Charlie Weiss, Leonard Linkow,** and **Norman Cranin.** In the Northeast you had these heavy hitters who believed a lot about the blade subs, mucosal inserts, and spirals. They were all really passionate about the so-called old-fashioned concepts.

Later on, I realized blades, in fact, was a newer innovation, after I spent a lot of time with Dr. Linkow. He recently came for the inauguration of my new office. He's pushing 90, and he's sharp as a razor. God bless him.

Go to the SmileUSAcourses.com website for some of the interesting historical pictures. You'll see his picture with several of his peers. He has given me a historical perspective, and also given me all of his lifetime work for me to archive. That's when I realized root-forms were in existence prior to blade-form implants. He was doing his root-form implant years before he popularized the blades. The practice consultant and hygienist who works with me is Phyllis A. John. She was Dr. Linkow's personal hygienist and an assistant. She told me she opened up the first blade in 1968 and assisted him with his first blade surgery.

Dr. Linkow was doing root-forms beginning in 1953. So, root-forms were the norm in those days — double-helical spirals, tramonte screws, chercheve implants, and so on. In 1968, **Ralph Roberts** and Harold Roberts sent him a sample of the blades. He looked at it. He inserted the first blade in 1968, and redesigned it. At that time, blades were an innovation over the root-forms, because root-forms couldn't be performed in thin ridges.

Then along came **Dr. Hilt Tatum,** who is also one of my mentors. He taught me about ridge expansion and sinus grafts. That really opened up the entire field of implant dentistry putting the root-forms back into proper usage, not restricted by the ridges anymore. That's where I'm seeing the rapid changes taking place.

Now we are also looking at newer surfaces. The blades fail mainly, not because of the fact we use high-speed, but because all the blades were shiny with smooth surfaces. We didn't know much about the surfaces. If you looked at the older blades, they were polished, and some were plasma-flame spray-coated (this precluded the blades from being bent.) I was using a lot of textured root-forms thinking, if only we could get these same surface textures back on blades and use piezo-surgery for the osteotomies, we might end up having a superior modality to manage some of these atrophic ridges with extreme angles.

DR. JUSTIN MOODY: Isn't the Academy a great place to find a mentor or hear your mentor at the AAID Conference?

DR. SHANKAR IYER: The AAID is probably the only fountain of implant knowledge in the world. You will get to meet these mentors who will come and be there with you for no personal gain. They have no agenda, and they will welcome you with open arms. This is the kind of camaraderie that you will get with the AAID. This mentorship — one-on-one mentoring and grooming protégés — is probably one of the finest benefits that you can get. I've been very fortunate to be part of the educational team. As they say, "wealth shared is wealth halved — knowledge shared is knowledge doubled." This is very, very true when it comes to implant dentistry. I am gratified when I see dental students and residents attend our educational programs. We learn from each other.

The AAID is probably the only fountain of knowledge that you can get anywhere in the world.

DR. JUSTIN MOODY: What does it mean to you to be installed as the president of the AAID in October at our Annual Conference in New Orleans?

DR. SHANKAR IYER: I'm still in shock, even though I've been serving on the Board of Trustees for five years and another four as an officer. When I received my Associate Fellow, **Dr. Carl Misch** was standing at the podium as the president. I thought to myself, these are the giants of implant dentistry. I can't even imagine being anywhere close to that podium. Here I am, after all these years, about to stand there as well. It's a phenomenal feeling. I feel very grateful for the mentors who have groomed me. I feel very grateful to the Academy for fostering this kind of relationship with their members. I am so happy to be of service to the Academy and to all our members. This didn't happen just by my own talent or skill. It's purely through the good will and the mentorship being passed on through our predecessors who have led the Academy to where it is today. We are now fortunate to reap the benefits of the seeds that they have sown.

My long-term vision is for our Academy to be the global leader for implant education and have every state in the U.S. recognize our credentials without resorting to legal action each time.

DR. JAMES FERENCE: Pretend it is New Year's Eve in the year 2017. Your term as president of AAID came to an end just a couple months before at the Academy's 66th Annual Conference. As you look back, what are a couple of the main accomplishments you will be most proud of?

DR. SHANKAR IYER: My long-term vision for our Academy is to be the global leader for implant education and have every state in the U.S. recognize our credentials without resorting to legal action each time. This will take some time, but the path has been paved for us to prevail.

Specifically, at the end of my term as president, I would like to see an AAID MaxiCourses® in every continent.

I want to have the AAID write standards for implant residency programs around the world, and have CODA adopt these standards for recognition. I expect that state dental boards in at least ten states in the United States will have put rules and regulations in place to recognize our specialists.

DR. JAMES FERENCE: You spend more time flying across the globe each year than most people spend in a lifetime. What do you do in the little spare time you have?

DR. IYER: My priority is my family. They let me do the things that I love to pursue. My wife, Preeti, has been instrumental in my success in education and AAID activities.

Watching movies and traveling with my family augments the affection, love, and care. I have been spending time with my daughter, Easha, who is preparing for college, and it is fascinating to review her study materials. My son, Varish, who is 13, is fun to play trivia with. I love to play table tennis and teach chess to my kids. My favorite hobby is photography and video editing. I have been involved in making an independent movie for fun.

DR. JAMES FERENCE: Dr. Iyer, on behalf of the entire Academy I want to thank you for your very insightful and candid comments. Best wishes for a successful year as president of the AAID.

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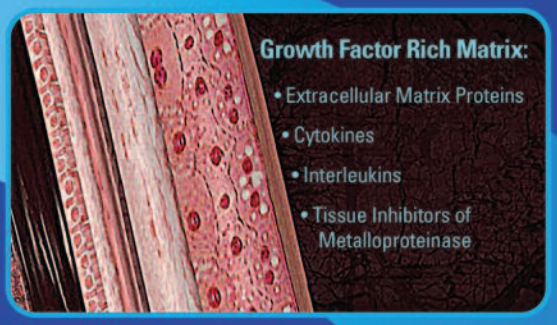

Biological Properties

- Can be left exposed
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- Allows for rapid vascular growth
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- Cellular occlusive with rapid sealing of protected space

AAID 2016 Schedule of Events

- **New Innovations Session** - Wednesday 11:00 am
  Dan Holtzclaw, DDS, MS
- **Hands on Workshop** - Thursday 8:00 am to Noon
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By Drs. Christina and Bill Blatchford

Growth Opportunities for Implants—Making Decisions

Dentists who are skilled in implants always want more implant patients. How to have more? In today's market, you can buy them. You purchase them by merging a smaller or larger practice into your own.

Dentists get stuck in the question of "how." How will I do that? How will it work? How will I staff it? Will I need to purchase their equipment, too? What if I don't like the selling doctor's work? All kinds of questions keep you from moving forward with the bigger picture of increasing your new patients for implants. In the meantime, the opportunity for you goes away as someone else purchases that practice.

A successful entrepreneur in other businesses would look at the cash flow analysis and tax returns, then make a decision and move forward without answers to the "how" questions. As dentists, we are technically trained and like everything to line up before making any decision. You can get stuck in the "how" and never recover.

A successful private practice comes on the market and is selling fast in many markets. You need to be ready to make your decision. Once you have made a decision to merge and expand, the world changes for you. Always be looking for an opportunity. Have a broker look on your behalf as well. Ask your local lab tech as they hear of moves in the community. Let your dental supply rep know of your desire to expand. Contact by phone all the dentists in your area to let them know you want to be their first contact if they are thinking of a move.

We love this quote from Goethe about decisions and commitment:

"Until one is committed, there is hesitancy, the chance to draw back, always ineffectiveness. Concerning all acts of initiative and creation, there is one elementary truth, the ignorance of which kills countless ideas and splendid plans: that the moment one definitely commits oneself then, providence moves, too.

All sorts of things occur to help one that would never otherwise have occurred. A whole stream of events issues from the decision, raising in one's favor all manner of unforeseen incidents, meetings and material assistance, which no man could have dreamed would come his way.

Whatever you can do or dream you can begin it. Boldness has genius, power and magic in it."

Dentists tend to put themselves in a box, thinking they could not purchase a practice larger than their existing practice. Or perhaps, they feel an older practice is too small. Be open to all possibilities. A smaller practice may be attracting denture patients. For implant practices, is that not the sweet spot:

people who are struggling to keep their teeth or have dentures now?

If there is a larger practice that interests you but has an even better facility than yours, then you consider moving. Before throwing up your hands saying it is overwhelming and too much bother, look into it. There is no commitment to purchase by just looking. Perhaps it is a deal which would be perfect for you. You are the one to make choices which are right for you at this time.

How many times have you heard people reflect on their lives about the missed opportunities in inventions, property or businesses? They were close to making decisions to go ahead but for some reason, they did not. They regret the missed opportunity. Don't let that be you.

Every practice for sale has some opportunity. Be ready to make a decision and "no" is a good decision after you have looked at the financials and it is not right for you. There is no tally in the sky for those who have looked and rejected "X" number of dental practices. If you are fee for service practice and the target practice has 10 PPO's, it is probably not the right move for you.

Each practice purchase is different. There are some set rules that work for both the buyer and seller. However, we have been involved in negotiations where the purchasing dentist pays a set amount for each new patient who shows in their office.

Be open to all possibilities. What are the geographic boundaries in your area? How far will a patient travel? Know what you want and be ready for all possibilities. Someone is going to purchase this opportunity close to you. Why someone else? Why not you?

Drs. Blatchford, both dentists, are America's leading dental business coach for private practices. They are not practice brokers but can guide, with integrity, a dentist through a practice purchase, merger or sale. Their recent book, No Nonsense Guide To Transitions, has become a must read. They can be reached at (888) 977-4600 and www.Blatchford.com.

By Frank Recker, DDS

The Evolution of Professional Advertising and Dental Specialties: Conflicting Propositions?

When I graduated from dental school in the early 1970's, one of my first tasks was to proudly join my professional association, the ADA. That affiliation continues through the present, as a Life Member. At this point the ADA was viewed as the "mother ship" to which we all looked for guidance and direction. Even during my tenure on the Ohio State Dental Board from the late 70s through the mid-80s, I continued to look to the ADA for guidance.

I don't recall much discussion about "dental specialties" during those years, other than the fact that when I graduated from dental school there were eight recognized specialties. In fact, in 1947 the ADA Council on Dental Education (CDE) declared that *"A specialty in dentistry is a field of practice which calls for intense study and extended clinical and laboratory experience by a dentist beyond the training offered as a preparation for general practice in the undergraduate curriculum. The following branches of dentistry are recognized at this time as suitable fields for the certification of specialists: Oral Surgery, Orthodontics, Pedodontia, Periodontia and Prosthodontia."*

Thus, five dental specialties were created by a simple edict from the CDE. Shortly thereafter, in 1949 Oral Pathology was added, followed by Public Health in 1950, at which time dentistry had seven dental specialties created with little fuss or fanfare. In this same year, the total number of licensed dentists in the United States was about 75,000. Endodontics was added to the specialty list in 1963. It would be another 36 years before the next and very likely the last ADA specialty was recognized, notwithstanding a span of time during which the technological advances in dentistry had skyrocketed.

The United States Department of Education began recognizing accrediting entities in 1952, at which time it recognized the Council on Dental Education as an accrediting entity in the field of dentistry. The Commission on Dental Accreditation (CODA) was formed in 1975, and it assumed the duties and policies of the CDE. So, looking back we can see that seven dental specialties were created prior to any DOE "recognition" of a dental accrediting entity.

Interestingly, prior to 1975, no dentist could lawfully advertise because such was prohibited in all states. Professional advertising was simply deemed unlawful. The only individuals aware of dental specialties were den-

tists. When I entered the practice of dentistry, I was aware of the dental specialists in my area from the local dental society and from other dentists. Consumers had no information regarding dental specialists or their respective areas of practice, unless referred by a general dentist for specific specialty care.

The laws regarding professional advertising began to change with the 1975 Supreme Court decision in ***"Virginia Pharmacy,"*** in which the Court stated that commercial free speech under the First Amendment was entitled to protection and that such information (advertising drug prices) could provide useful information to the consumer. Thus, the walls prohibiting professional advertising began to crumble. Subsequent decisions of the Supreme Court made the scope of professional advertising both more clear and broad, and logically state restrictions on professional advertising began to disappear. In the mid 1990s, the American Academy of Implant Dentistry (AAID) began successfully challenging state law restrictions on the advertising of professional credentials. It seemed oxymoronic for a dentist to spend hundreds of hours and many thousands of dollars to earn a bona fide credential, only to be forbidden from telling the public about it by a dental board regulation or statutory provision. This evolution in First Amendment law continues through today, at which time a state must be able to demonstrate how any prohibition on professional advertising prevents harm to consumers in order to justify it.

During this same time period, roughly 1980 through 2012, multiple dental organizations applied for "specialty recognition" from the ADA. But the ADA process had also evolved and changed dramatically during this same time frame. No longer was it an expedient "edict" from the Council on Dental Education, as criteria were developed — and periodically changed — relative to applying for and obtaining specialty recognition. From about 1986 through 2012, when other professional advertising began to explode, at least 15 formal applications for specialty recognition were submitted to the ADA, and almost all were denied. Only radiology succeeded in 1999, and that was likely for "esthetic" purposes because of outside influences. In May of 1999, approximately five months before the House of Delegates meeting in Hawaii, the Supreme Court of the United States declared that the Federal Trade Commission had jurisdiction and authority over the California Dental Association, and therefore by inference, over all state dental associations and the ADA itself. Many believe that, with the eyes of the FTC peering over the process, a specialty "needed" to be approved to avoid the appearance of self-interest or anticompetitive motivations. Radiology seemed to be the most innocuous and to present the least competition, and ADA counsel quietly recommended passage.

But as time evolved, the hurdles of the specialty process became more onerous, criteria for recognition changed, and the entire process became arguably more subjective. In retrospect, the reality of dental advertising transformed the dental profession into a very competitive market place, with general dentists, DSOs and specialists all advertising in competition with each other. How could a House of Delegates composed of potential competitors approve a new specialty?

As time has revealed, it apparently cannot.

> ...prior to 1975, no dentist could lawfully advertise because such was prohibited in all states.

The pivotal moment occurred during the House of Delegates Session in October 2012 when recognition of dental anesthesia as a new specialty came to the floor for a vote. Notwithstanding having been deemed to fulfill all the applicable criteria by every respective Council, Committee, reference committee and the Board of Trustees, anesthesia was again rejected by the House of Delegates. To say the decision was largely based on dental politics is a gross understatement. Nonetheless, the ultimate victims were the reputation of the ADA and the process itself. But that could have been, in retrospect, a blessing in disguise.

In response to a patently skewed and subjective method for determining specialties, in 2014 four dental organizations formed the American Board of Dental Specialties (ABDS). This entity has attempted to emulate the structure of the American Board of Medical Specialties (ABMS) in removing professional association control over the specialty recognition process. But, to its credit, the ABDS has reached out to the ADA and the Dental Specialty Group (DSG) to participate in its development. The ABDS recognizes "certifying boards" as opposed to "areas" of dentistry. Currently, it has recognized the certifying boards of the American Academy of Oral Medicine, the American Society of Dentist Anesthesiologists, the American

see Legal Bite p. 23

Believe what you don't see

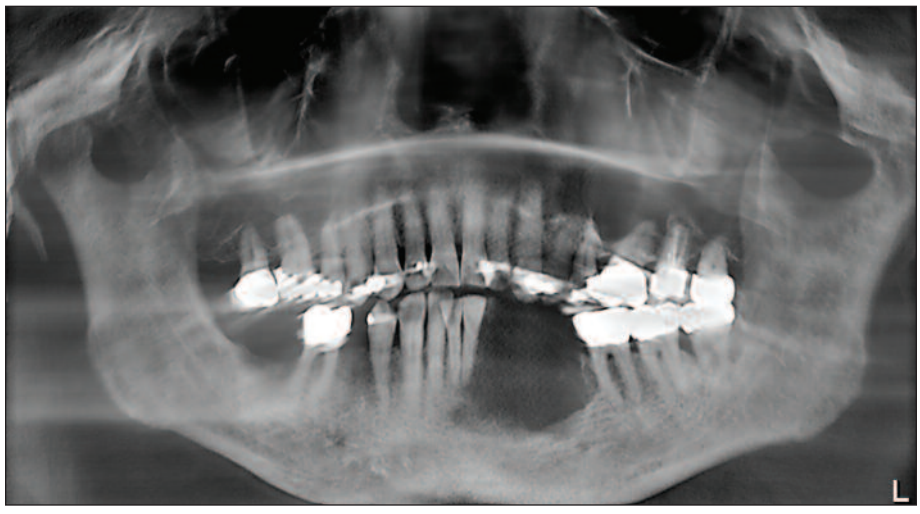
Richard Assing, DDS, FAAID, DABOI/ID

Editor's Note: We want to thank Dr. Assing for sharing an interesting case with our readers. If you have a case that you wish to share, contact Max Moses at the Headquarters' Office — max@aaid.com or by phone at 312.335.1550 ext. 227 — to discuss how to share your case with your colleagues through *AAID News.*

Have you ever seen something in a patient's mouth that made you question what you saw? Maybe it wasn't an obvious abnormality. Perhaps something just didn't look right. What if there was nothing there…when you normally expect to see something? What's your first reaction? Do you dismiss what you observe and assume it is not relevant? Or do you investigate further, appreciating the occasional important anomaly?

I faced such a situation when an 81-year old man came to my office with very loose teeth in the lower left mandible. The treatment plan that the patient wanted and agreed to involved removing the teeth and replacing them with implants.

After extracting the teeth, I questioned what I saw and took another radiograph. I thought the loose teeth were the result of periodontal disease. Because of that, I expected to see bone topography that was rough. Instead, the bone was smooth, almost as if someone had polished the bone.



I questioned why it did not follow the expected contours of normal bone loss. I suggested a biopsy and took a wedge in the 20-21-22 area to send it to a local pathology lab. Much to my surprise, Dr. Richard Jordan, Professor of Oral Pathology at University of California, San Francisco, contacted me with the results of the biopsy.

The patient had an extremely rare form of cancer: Clear cell odontogenic carcinoma (CCOC). According to a 2015 article in *World Journal of Surgical Oncology*[1] there have been only 81 cases reported in the English literature of CCOC. What makes it even rarer is that this cancer occurs predominately in women.

The patient was referred for treatment and is currently weighing his options.

Dr. Richard Assing maintains a private practice in Brandon, Florida. He is a Fellow of the American Academy of Implant Dentistry and a Diplomate of the American Board of Oral Implantology/Implant Dentistry.

1. Kwon *et al. World Journal of Surgical Oncology* (2015) 13:284

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EXPAREL is indicated for administration into the surgical site to produce postsurgical analgesia.

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EXPAREL has not been studied for use in patients younger than 18 years of age.

Non-bupivacaine-based local anesthetics, including lidocaine, may cause an immediate release of bupivacaine from EXPAREL if administered together locally. The administration of EXPAREL may follow the administration of lidocaine after a delay of 20 minutes or more. Formulations of bupivacaine other than EXPAREL should not be administered within 96 hours following administration of EXPAREL.

Monitoring of cardiovascular and neurological status as well as vital signs should be performed during and after injection of EXPAREL as with other local anesthetic products.

Because amide-type local anesthetics, such as bupivacaine, are metabolized by the liver, EXPAREL should be used cautiously in patients with hepatic disease. Patients with severe hepatic disease, because of their inability to metabolize local anesthetics normally, are at a greater risk of developing toxic plasma concentrations.

In clinical trials, the most common adverse reactions (incidence ≥10%) following EXPAREL administration were nausea, constipation, and vomiting.

References: 1. Gorfine SR, Onel E, Patou G, Krivokapic ZV. Bupivacaine extended-release liposome injection for prolonged postsurgical analgesia in patients undergoing hemorrhoidectomy: a multicenter, randomized, double-blind, placebo-controlled trial. *Dis Colon Rectum*. 2011;54(12):1552-1559. **2.** Data on file. Parsippany, NJ: Pacira Pharmaceuticals, Inc.

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Brief Summary
(For full prescribing information refer to package insert)

INDICATIONS AND USAGE

EXPAREL is indicated for administration into the surgical site to produce postsurgical analgesia.

EXPAREL has not been studied for use in patients younger than 18 years of age.

CONTRAINDICATIONS

EXPAREL is contraindicated in obstetrical paracervical block anesthesia. While EXPAREL has not been tested with this technique, the use of bupivacaine HCl with this technique has resulted in fetal bradycardia and death.

WARNINGS AND PRECAUTIONS

Warnings and Precautions Specific for EXPAREL

As there is a potential risk of severe life-threatening adverse effects associated with the administration of bupivacaine, EXPAREL should be administered in a setting where trained personnel and equipment are available to promptly treat patients who show evidence of neurological or cardiac toxicity.

Caution should be taken to avoid accidental intravascular injection of EXPAREL. Convulsions and cardiac arrest have occurred following accidental intravascular injection of bupivacaine and other amide-containing products.

Using EXPAREL followed by other bupivacaine formulations has not been studied in clinical trials. Formulations of bupivacaine other than EXPAREL should not be administered within 96 hours following administration of EXPAREL.

EXPAREL has not been evaluated for the following uses and, therefore, is not recommended for these types of analgesia or routes of administration.

- epidural
- intrathecal
- regional nerve blocks
- intravascular or intra-articular use

EXPAREL has not been evaluated for use in the following patient population and, therefore, it is not recommended for administration to these groups.

- patients younger than 18 years old
- pregnant patients

The ability of EXPAREL to achieve effective anesthesia has not been studied. Therefore, EXPAREL is not indicated for pre-incisional or pre-procedural loco-regional anesthetic techniques that require deep and complete sensory block in the area of administration.

ADVERSE REACTIONS

Clinical Trial Experience

The safety of EXPAREL was evaluated in 10 randomized, double-blind, local administration into the surgical site clinical studies involving 823 patients undergoing various surgical procedures. Patients were administered a dose ranging from 66 to 532 mg of EXPAREL. In these studies, the most common adverse reactions (incidence greater than or equal to 10%) following EXPAREL administration were nausea, constipation, and vomiting.

The common adverse reactions (incidence greater than or equal to 2% to less than 10%) following EXPAREL administration were pyrexia, dizziness, edema peripheral, anemia, hypotension, pruritus, tachycardia, headache, insomnia, anemia postoperative, muscle spasms, hemorrhagic anemia, back pain, somnolence, and procedural pain.

DRUG INTERACTIONS

EXPAREL can be administered in the ready to use suspension or diluted to a concentration of up to 0.89 mg/mL (i.e., 1:14 dilution by volume) with normal (0.9%) saline or lactated Ringer's solution. EXPAREL must not be diluted with water or other hypotonic agents as it will result in disruption of the liposomal particles.

EXPAREL should not be admixed with local anesthetics other than bupivacaine. Non-bupivacaine based local anesthetics, including lidocaine, may cause an immediate release of bupivacaine from EXPAREL if administered together locally. The administration of EXPAREL may follow the administration of lidocaine after a delay of 20 minutes or more.

Bupivacaine HCl administered together with EXPAREL may impact the pharmacokinetic and/or physicochemical properties of EXPAREL, and this effect is concentration dependent. Therefore, bupivacaine HCl and EXPAREL may be administered simultaneously in the same syringe, and bupivacaine HCl may be injected immediately before EXPAREL as long as the ratio of the milligram dose of bupivacaine HCl solution to EXPAREL does not exceed 1:2.

The toxic effects of these drugs are additive and their administration should be used with caution including monitoring for neurologic and cardiovascular effects related to toxicity.

Other than bupivacaine as noted above, EXPAREL should not be admixed with other drugs prior to administration.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no studies conducted with EXPAREL in pregnant women. In animal reproduction studies, embryo-fetal deaths were observed with subcutaneous administration of bupivacaine to rabbits during organogenesis at a dose equivalent to 1.6 times the maximum recommended human dose (MRHD) of 266 mg. Subcutaneous administration of bupivacaine to rats from implantation through weaning produced decreased pup survival at a dose equivalent to 1.5 times the MRHD [*see Data*]. Based on animal data, advise pregnant women of the potential risks to a fetus.

The background risk of major birth defects and miscarriage for the indicated population is unknown. However, the background risk in the U.S. general population of major birth defects is 2-4% and of miscarriage is 15-20% of clinically recognized pregnancies.

Clinical Considerations

Labor or Delivery

Bupivacaine is contraindicated for obstetrical paracervical block anesthesia. While EXPAREL has not been studied with this technique, the use of bupivacaine for obstetrical paracervical block anesthesia has resulted in fetal bradycardia and death.

Bupivacaine can rapidly cross the placenta, and when used for epidural, caudal, or pudendal block anesthesia, can cause varying degrees of maternal, fetal, and neonatal toxicity. The incidence and degree of toxicity depend upon the procedure performed, the type, and amount of drug used, and the technique of drug administration. Adverse reactions in the parturient, fetus, and neonate involve alterations of the central nervous system, peripheral vascular tone, and cardiac function.

Data

Animal Data

Bupivacaine hydrochloride was administered subcutaneously to rats and rabbits during the period of organogenesis (implantation to closure of the hard plate). Rat doses were 4.4, 13.3, and 40 mg/kg/day (equivalent to 0.2, 0.5 and 1.5 times the MRHD, respectively, based on the BSA comparisons and a 60 kg human weight) and rabbit doses were 1.3, 5.8, and 22.2 mg/kg/day (equivalent to 0.1, 0.4 and 1.6 times the MRHD, respectively, based on the BSA comparisons and a 60 kg human weight). No embryo-fetal effects were observed in rats at the doses tested with the high dose causing increased maternal lethality. An increase in embryo-fetal deaths was observed in rabbits at the high dose in the absence of maternal toxicity.

Decreased pup survival was noted at 1.5 times the MRHD in a rat pre- and post-natal development study when pregnant animals were administered subcutaneous doses of 4.4, 13.3, and 40 mg/kg/day buprenorphine hydrochloride (equivalent to 0.2, 0.5 and 1.5 times the MRHD, respectively, based on the BSA comparisons and a 60 kg human weight) from implantation through weaning (during pregnancy and lactation).

Lactation

Risk Summary

Limited published literature reports that bupivacaine and its' metabolite, pipecolylxylidide, are present in human milk at low levels. There is no available information on effects of the drug in the breastfed infant or effects of the drug on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for EXPAREL and any potential adverse effects on the breastfed infant from EXPAREL or from the underlying maternal condition.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

Of the total number of patients in the EXPAREL surgical site infiltration clinical studies (N=823), 171 patients were greater than or equal to 65 years of age and 47 patients were greater than or equal to 75 years of age. No overall differences in safety or effectiveness were observed between these patients and younger patients. Clinical experience with EXPAREL has not identified differences in efficacy or safety between elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Hepatic Impairment

Because amide-type local anesthetics, such as bupivacaine, are metabolized by the liver, these drugs should be used cautiously in patients with hepatic disease. Patients with severe hepatic disease, because of their inability to metabolize local anesthetics normally, are at a greater risk of developing toxic plasma concentrations.

Renal Impairment

Bupivacaine is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Care should be taken in dose selection of EXPAREL.

OVERDOSAGE

In the clinical study program, maximum plasma concentration (C_{max}) values of approximately 34,000 ng/mL were reported and likely reflected inadvertent intravascular administration of EXPAREL or systemic absorption of EXPAREL at the surgical site. The plasma bupivacaine measurements did not discern between free and liposomal-bound bupivacaine making the clinical relevance of the reported values uncertain; however, no discernible adverse events or clinical sequelae were observed in these patients.

DOSAGE AND ADMINISTRATION

EXPAREL is intended for single-dose administration only.

The recommended dose of EXPAREL is based on the following factors:

- Size of the surgical site
- Volume required to cover the area
- Individual patient factors that may impact the safety of an amide local anesthetic
- Maximum dose of 266 mg (20 mL)

As general guidance in selecting the proper dosing for the planned surgical site, two examples of dosing are provided. One example of the recommended dose comes from a study in patients undergoing bunionectomy. A total of 8 mL (106 mg) was administered as 7 mL of EXPAREL infiltrated into the tissues surrounding the osteotomy, and 1 mL infiltrated into the subcutaneous tissue.

Another example comes from a study of patients undergoing hemorrhoidectomy. A total of 20 mL (266 mg) of EXPAREL was diluted with 10 mL of saline, for a total of 30 mL, divided into six 5 mL aliquots, injected by visualizing the anal sphincter as a clock face and slowly infiltrating one aliquot to each of the even numbers to produce a field block.

Compatibility Considerations

Admixing EXPAREL with drugs other than bupivacaine HCl prior to administration is not recommended.

- Non-bupivacaine based local anesthetics, including lidocaine, may cause an immediate release of bupivacaine from EXPAREL if administered together locally. The administration of EXPAREL may follow the administration of lidocaine after a delay of 20 minutes or more.
- Bupivacaine HCl administered together with EXPAREL may impact the pharmacokinetic and/or physicochemical properties of EXPAREL, and this effect is concentration dependent. Therefore, bupivacaine HCl and EXPAREL may be administered simultaneously in the same syringe, and bupivacaine HCl may be injected immediately before EXPAREL as long as the ratio of the milligram dose of bupivacaine HCl solution to EXPAREL does not exceed 1:2.

  The toxic effects of these drugs are additive and their administration should be used with caution including monitoring for neurologic and cardiovascular effects related to toxicity.
- When a topical antiseptic such as povidone iodine (e.g., Betadine®) is applied, the site should be allowed to dry before EXPAREL is administered into the surgical site. EXPAREL should not be allowed to come into contact with antiseptics such as povidone iodine in solution.

Studies conducted with EXPAREL demonstrated that the most common implantable materials (polypropylene, PTFE, silicone, stainless steel, and titanium) are not affected by the presence of EXPAREL any more than they are by saline. None of the materials studied had an adverse effect on EXPAREL.

Non-Interchangeability with Other Formulations of Bupivacaine

Different formulations of bupivacaine are not bioequivalent even if the milligram dosage is the same. Therefore, it is not possible to convert dosing from any other formulations of bupivacaine to EXPAREL and vice versa.

CLINICAL PHARMACOLOGY

Pharmacokinetics

Local infiltration of EXPAREL results in significant systemic plasma levels of bupivacaine which can persist for 96 hours. Systemic plasma levels of bupivacaine following administration of EXPAREL are not correlated with local efficacy.

CLINICAL STUDIES

The efficacy of EXPAREL was compared to placebo in two multicenter, randomized, double-blinded clinical trials. One trial evaluated the treatments in patients undergoing bunionectomy; the other trial evaluated the treatments in patients undergoing hemorrhoidectomy.

Study 1

A multicenter, randomized, double-blind, placebo-controlled, parallel-group clinical trial evaluated the safety and efficacy of 106 mg (8 mL) EXPAREL in 193 patients undergoing bunionectomy. The mean age was 43 years (range 18 to 72).

Study medication was administered directly into the site at the conclusion of the surgery, prior to closure. There was an infiltration of 7 mL of EXPAREL into the tissues surrounding the osteotomy and 1 mL into the subcutaneous tissue.

Pain intensity was rated by the patients on a 0 to 10 numeric rating scale (NRS) out to 72 hours. Postoperatively, patients were allowed rescue medication (5 mg oxycodone/325 mg acetaminophen orally every 4 to 6 hours as needed) or, if that was insufficient within the first 24 hours, ketorolac (15 to 30 mg IV). The primary outcome measure was the area under the curve (AUC) of the NRS pain intensity scores (cumulative pain scores) collected over the first 24 hour period. There was a significant treatment effect for EXPAREL compared to placebo. EXPAREL demonstrated a significant reduction in pain intensity compared to placebo for up to 24 hours ($p<0.001$).

Study 2

A multicenter, randomized, double-blind, placebo-controlled, parallel-group clinical trial evaluated the safety and efficacy of 266 mg (20 mL) EXPAREL in 189 patients undergoing hemorrhoidectomy. The mean age was 48 years (range 18 to 86).

Study medication was administered directly into the site (greater than or equal to 3 cm) at the conclusion of the surgery. Dilution of 20 mL of EXPAREL with 10 mL of saline, for a total of 30 mL, was divided into six 5 mL aliquots. A field block was performed by visualizing the anal sphincter as a clock face and slowly infiltrating one aliquot to each of the even numbers.

Pain intensity was rated by the patients on a 0 to 10 NRS at multiple time points up to 72 hours. Postoperatively, patients were allowed rescue medication (morphine sulfate 10 mg intramuscular every 4 hours as needed).

The primary outcome measure was the AUC of the NRS pain intensity scores (cumulative pain scores) collected over the first 72 hour period. There was a significant treatment effect for EXPAREL compared to placebo.

This resulted in a decrease in opioid consumption, the clinical benefit of which was not demonstrated.

Twenty-eight percent of patients treated with EXPAREL required no rescue medication at 72 hours compared to 10% treated with placebo. For those patients who did require rescue medication, the mean amount of morphine sulfate intramuscular injections used over 72 hours was 22 mg for patients treated with EXPAREL and 29 mg for patients treated with placebo.

The median time to rescue analgesic use was for 15 hours for patients treated with EXPAREL and one hour for patients treated with placebo.

Pacira Pharmaceuticals, Inc.
San Diego, CA 92121 USA

Patent Numbers:
6,132,766 5,891,467
5,766,627 8,182,835

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For additional information call 1-855-RX-EXPAREL (1-855-793-9727)

Rx only **December 2015**

Legal Bite

continued from page 19

Academy of Oro-Facial Pain, and the American Academy of Implant Dentistry. This new entity can and will likely approve certifying boards that could never seek recognition from the ADA, and even some of which could likely never have "CODA approved" programs. Some examples might be forensic dentistry, cosmetic dentistry, special needs dentistry, geriatric dentistry, laser dentistry, and other evolving areas of practice. While the ADA model served the profession well, anticompetitive and turf influences are far too apparent to continue the traditional approach to specialty recognition. Are there any dentist members of the House of Delegates who would want to cede another portion of the practice of dentistry and create another specialty? Are there any dentist members of the House of Delegates who are immune from potentially feeling the marketplace effects of creating another specialty?

In today's world, the evolution of First Amendment law related to professional advertising and the antitrust overtones of a professional association comprised of market place competitors deciding specialty status, it has become esthetically and legally distasteful to continue the ADA specialty process. It places the ADA in an untenable position relative to criticism by antitrust forces, but also puts every dentist in the House of Delegates in a compromising position relative to a potential conflict of interest. Are there any dentists in the HOD that have no potential personal economic interest in creating a new specialty? I would suggest very few.

In January 2016, a Texas federal court concluded that board certified dentists of the ABOM (Oral Medicine), ADBA (Anesthesia), ABOP (Oro-facial pain) and ABOI/ID (implant dentistry) could lawfully advertise as "specialists" in the State of Texas. While that decision is being appealed by the State, the decision has clearly come down on the side of commercial free speech. But when a court declares such a regulation to be unconstitutional, it simply eliminates the regulation and does not create an alternative, constitutionally valid, mechanism. It simply leaves a void that the ABDS is attempting to fill. Without such an alternative mechanism, the doors are wide open for virtually any credible dental organization to declare themselves "specialists" under the protection of the First Amendment. I hope the ABDS will appropriately fill the void and be recognized as a credible, respected entity that is not controlled by any professional association or special interest group.

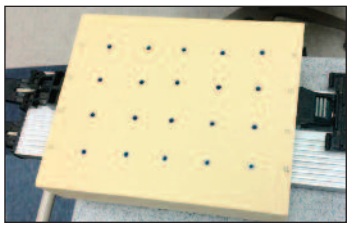
The evolution of First Amendment and antitrust law, along with the traditional specialty recognition process, are clearly intertwined. I would hope that we dentists would embrace that reality and participate in a new process that could benefit both the profession, and ultimately, the consumer.

JOISAMPLER

Editor's Note: Because of busy schedules, you may not have time to read the dozen or so articles in each issue of the Journal of Oral Implantology. In this new section of AAID News, we selected a few articles that have broad applicability to the daily practice, and provide a brief summary of key points so you can decide if you wish to read the complete article. The following articles are from Volume 42, Issue 4 (August 2016). Let us know what you think.

Research:

Comparison of Osteotome and Conventional Drilling Techniques for Primary Implant Stability: An In-Vitro Study

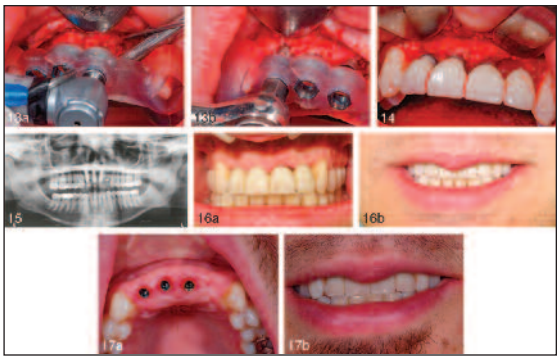


The study involved inserting 40 endosseous implant fixtures into a solid rigid polyurethane block intended to simulate low density (D3) bone. Two variables were tested: implant length (10 mm or 13 mm) and preparation of osteotomy (conventional drilling or osteotome technique). Insertion torque (IT) and resonance frequency analysis (RFA) were measured for each implant. Statistically significant higher values were for using the osteotome technique compared to conventional drilling. Also, statistically significant higher values were found for both IT and RFA with the 13 mm implants compared to 10 mm implants. The researchers concluded that the osteotome technique significantly increased primary stability.

See Ioanna N. Tsolaki, Pallavi P. Tonsekar, Babak Najafi, Howard J. Drew, Andrew J. Sullivan, Sofia D. Petrov, "Comparison of Osteotome and Conventional Drilling Techniques for Primary Implant Stability: An In Vitro Study," *Journal of Oral Implantology.* 2016;42(4):321-325.

Case Letter:

Simultaneous Virtual Planning Implant Surgical Guides and Immediate Laboratory-Fabricated Provisionals: An Impressionless Technique

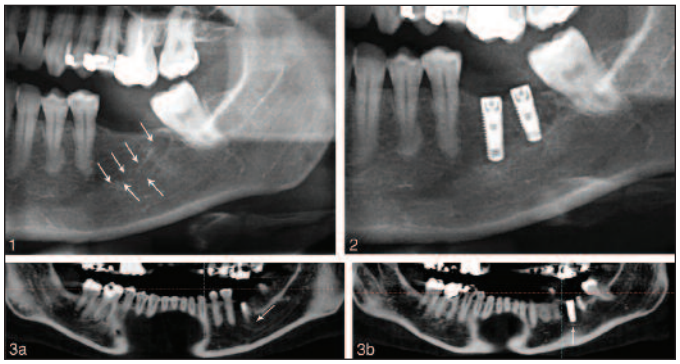


Consumers are used to demanding their products and services to be provided "faster, better, and cheaper." Patients seeking dental implants are no different. This case letter reports using intraoral digital scanning merged with CBCT data to virtually plan the site of implant placement, fabrication of the surgical guide through 3D printing, and digital design and milling of a screw-retained provisional fixed restoration to be immediately placed at the time of implant insertion, all done without the use of conventional impressions.

See George R. Deeb, Osama Soliman, Fahad Alsaad, Perry Jones, Dean Deluke, Daniel M. Laskin, "Simultaneous Virtual Planning Implant Surgical Guides and Immediate Laboratory-Fabricated Provisionals: An Impressionless Technique," *Journal of Oral Implantology.* 2016;42(4):363-369.

Case Report:

The Management of Persistent Pain from a Branch of the Trifid Mandibular Canal Due to Implant Impingement

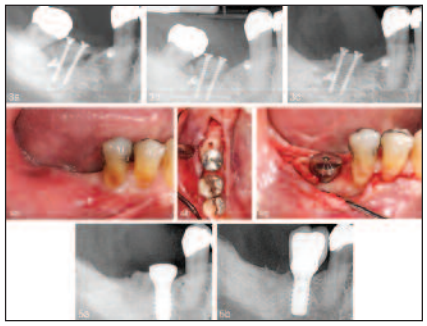


It is well known that care must be taken not to injure the mandibular canal because it is a conduit that allows the inferior alveolar nerve, artery, and vein to transverse the mandible to supply the dentition, jawbone, and soft tissue around the lower lip. However, care must also be taken to avoid injury to any of the multiple branches of the mandibular canal. This case report details the situation faced by a 42-year-old woman who continued to have pain following the replacement of her missing mandibular left first molar, which had been extracted several years earlier. For several weeks after the implant was placed, the patient experienced severe, sharp paid from the implant site. Eventually a CBCT scan was done and it appeared that the patient had three corresponding accessory buccal foramina, suggesting 3 (trifid) canals. One obvious foramen was adjacent to the medial implant. The mesial implant was removed and replaced with a shorter implant. The patient reported immediate and significant reduction in the intensity of the pain. Within one week the patient described the pain as mild and there was no paresthesia at the lower left jaw. Within 3 months, the symptoms completely resolved.

See Sharifah Aljunid, Saif AlSiweedi, Phrabhakaran Nambiar, Wen-Lin Chai, Wei-Cheong Ngeow, "The Management of Persistent Pain From a Branch of the Trifid Mandibular Canal due to Implant Impingement," *Journal of Oral Implantology.* 2016;42(4):349-352.

Case Letter:

Vertical Ridge Augmentation with Mandibular Lingual Torus Block Graft

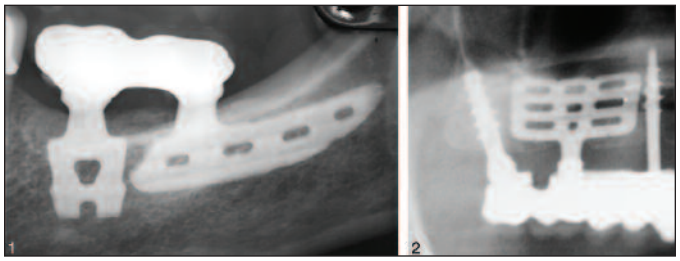


Tori, also known as intraoral exostoses, are benign bony protuberances that are covered with a thin and poorly vascularized mucosa. Found in approximately 42% of dentate Americans, tori are mostly asymptomatic and removal is unnecessary unless causing pain, prohibit proper seating of dental appliances, or preclude proper speech articulation. Although using tori as donor tissue for autogenous grafting materials is not novel, particularly for horizontal ridge augmentation and sinus lifting, the authors appear to be the first to report using torus block graft for vertical ridge augmentation.

See Chin-Wei (Jeff) Wang, Chung-Hsun (Bruce) Huang, Stephen H. Grossman, Jacob Pourati, "Vertical Ridge Augmentation with Mandibular Lingual Torus Block Graft," *Journal of Oral Implantology.* 2016;42(4):369-372.

Case Letter:

A New Look at the Blade Implant



Created to address the need for implants when most of the depth and width of bone needed for support has been lost, Blade Implants use the height and length of the implant's body within the bone for support. Large openings in the implant's body allow surrounding bone to grown into and around the implant's body. The authors of the Case Letter not only describe the advantages of blade implants but also provide guidance on blade insertion, making the implant socket, seating the blade, and closing the wound. They also discuss differences in using blade implants in the maxillary arch, completely edentulous maxilla, and mandibular arch.

See Leonard I. Linkow, Sheldon Winkler, Mike Shulman, Luca Dal Carlo, Marco E. Pasqualini, Franco Rossi, Michele Nardone, "A New Look at the Blade Implant," *Journal of Oral Implantology.* 2016;42(4):373-380.

soundbites

The AAID Annual Conference is, for some members, the highlight of their year. They look forward to everything from the cocktail parties to the cadaver heads. We sat down with five members to see what they are most excited about for this year's Annual Conference in New Orleans, LA.

Natalia Evans, DMD, from North Vancouver, BC

Olinga Hargreaves, DDS, from Denver, CO

What are you looking forward to most about this year's Annual Conference?

It is a great time to reconnect with colleagues from all over the world that I have met and developed friendships with. We catch up and discuss our working experiences. I am also looking forward to the new scientific discoveries, new techniques and products.

I always look forward to learning about the latest and greatest trends in implant dentistry but the best part is the camaraderie and catching up with friendships that have developed over the years!

What was your first AAID Annual Conference experience like?

It was a while ago, but it was very exciting. It was a new avenue in dentistry for me. It made me want to learn more and challenge myself.

I remember it very clearly in 2002- Los Angeles. It was so touching the number of members who went out of their way to make me feel welcomed and introduced me to others when they noticed that it was my first conference. I definitely felt the graciousness and the genuine warmth.

What makes AAID's Annual Conference different than other events?

There is a great diversity of people that come to AAID meetings. Also, there are a lot of learning modes from main podium lectures to hands-on workshops. The main podium lectures are nice as they don't seem "sponsored" like a commercial for product placement like a lot of conferences. Also, the social events are always a lot of fun and great networking.

AAID has always set the bar for me to challenge myself and achieve the highest standard in implant dentistry. The quality of the speakers and hands-on workshops is by far the best amongst all other organizations. As a matter of fact, it doesn't even begin to compare. Over the years at the AAID Annual Conferences, it is amazing to me how many renowned national and international legends I have had the privilege of meeting and getting to know on a personal level!

What new programs or offerings would you like to see added in the future?

I would like to see more development in programs for my staff. It would be nice if there were hands-on workshops that involve the doctor and team to enhance "team" learning.

I am always fascinated with genetic recombinants and genetic engineering, but I can definitely benefit from learning more regarding business management.

Terry Hunt, DDS, from Rocky River, OH

The location is great, of course, but I look forward to going to it because when I walk out of there after a few days, it's almost like I recharged my implant treatment "battery." When I get back to the office on Monday, I start looking at things differently again.

I had no idea what to expect. I was kind of overwhelmed and I was on my own. I didn't realize what it was going into it. Some of the lectures were way over my head, but then some others I followed along. That was ten years ago and I've been to almost every meeting since!

The fact that the meeting is focused on just implants. As a general dentist, I always have to pick and choose from a lot of different programs that are out there. AAID's meeting covers a lot of topics, but they are always related to implants. I always, always, walk out of there going "wow, I never knew you could do that."

I think we should introduce new members attending the Annual Conference from the podium. They don't know anyone yet, and it would really make them feel welcome.

Kaz Newman, DMD, MS, from Poway, CA

Believe it or not, year after year I look forward to joining my peers and friends for learning and much fun. I love AAID conferences. The congeniality is really unique. That's very important to me.

Whenever that was, it was a while ago. But I know that I felt the warmth and was welcomed right away, so I've been coming back all these years.

As an orthodontist for 30 years, I have attended many conventions for general dentistry and specialty conventions such as orthodontics for quite a long time. While I loved all conventions, especially conventions in my own specialty, I tell you that I have been impressed by AAID conventions.

None really. I look forward to it every year.

John Strawman, DDS, from Bowling Green, OH

I am looking forward to learning about newborn heart transplantation. [Last year in Vegas] I was awed by hearing about the first human face transplant along with films of the procedure.

I don't remember what my first meeting was like, but my daughter, Brittany Strawman, a recent University of Michigan College of Dentistry graduate, is attending for the first time and is taking the all-day cadaver course. We are very excited.

AAID's quality of speakers is way above any other national meeting. More live surgery broadcasts to the main podium.

I think if AAID found a way to increase the capacity for hands-on courses, it would be really valuable to me. I am a GP, and having more hands-on opportunities would help me get my credits for the Academy of General Dentistry.

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❑ AAID provides exhibitors with a list of registrants prior to and after the meeting. Check here if you want to be excluded from that list.

A. Meeting Registration

	By 9/20/16	After 9/20/16
_____ AAID Associate Fellow/Fellow/Diplomate*	$1145	$1245
_____ AAID General Member*	$1195	$1295
_____ AGD or AACD Member* (Member # required)	$1195	$1295
_____ NonMember PLUS! Dentist* [2016 AAID Membership PLUS Registration]	$1345	N/A
_____ Nonmember*	$1545	$1645
_____ Recent Dental School Graduate (2015)	$595	$595
_____ Technician	$395	$445
_____ Life Member or Retired Member	$295	$295
_____ Office Staff	$395	$445
Doctor's Name _____		
_____ Student (Current or 2016 Graduate)	$150	$150
_____ Spouse/Guest Name _____	$295	$295
_____ Spouse/Guest Name _____	$490*	$490*

** Includes one (1) President's Celebration ticket*

A. Meeting Registration subtotal _____

B. Hands-on Workshops

Each Workshop is $199 (unless otherwise noted) if registration received by 9/20/16 ($219 after 9/20/16)

____ W1: Surgical Techniques Including Suturing (Stuart Orton-Jones, BDS)
____ W2: Digital Photography and Radiography: Optimal Case Presentations for AAID Credentialing and Beyond (Cheryl A. Pearson, DMD, FAAID, DABOI/ID) (No Charge)
____ W3: Predictable Ridge Preservation: The Soft Tissue Perspective (Ziv Simon, DMD, MSc)
____ W4: Advanced Barrier Membrane Technology: Clinical Applications (Sponsored by Snoasiis Medical; Mark Lucas, DDS, MS; Dan Holtzclaw, DDS, MS)
____ W5: Program to be announced (Sponsored by Neodent)
____ W6: PRF-BLOCK…A Consistent Protocol for Inlay/Onlay Grafts (Sponsored by Intra-Lock; Nelson Pinto, DDS)
____ W7: Hands-on Implant Placement and Bone Grafting on Cadavers FEE: $1,495 or $1,695
____ W8: Dental Malpractice & Beyond: What Implant Dentists Need to Know Now (Olivia Calhoun Palmer, DDS, JD, FAAID, DABOI/ID)
____ W9: Sinus Augmentation: Current and Future Trends (Ziv Mazor, DMD)
____ W10: Soft Tissue Management for Health and Esthetics Around Teeth and Implants (Michael Sonick, DMD)
____ W11: Guided Implant Surgery: Introduction and Workflow (Bradley DeGroot, DDS, MS)
____ W12: Implant Overdentures: Thought-Provoking Treatment Planning for the Edentulous Patient (Brian J. Jackson, DDS, FAAID, DABOI/ID)
____ W13: History and Application: Short Implants (Sponsored by Bicon Dental Implants; Drauseo Speratti, DDS)

B. Workshops subtotal _____

C. Seminars

Unless otherwise noted, each seminar is priced at $99 ($119 after 9/20/16)

____ S1: Management of Medication-Induced ONJ (James L. Rutkowski, DMD, PhD, FAAID, DBAOI/ID)
____ S2: Tunneling Procedures and Options for Root and Implant Coverage (Edward Gottesman, DDS)
____ S3: Demystifying the Oral and Written Exams: Increase Your Chances for Success (David Resnick, DDS, FAAID, DABOI/ID) (No Charge)
____ S4: Management of the Anxious Patient and Sedation Complications (Richard Nagy, DDS)
____ S5: Comprehensive Digital Workflow for the Treatment of Terminal Dentition and Edentulous Patients (Siamak Abai, DDS)
____ S6: A Systematic Approach to Simplifying Full-Arch Fixed Reconstruction (Howard Chasolen, DMD, FAAID)
____ S7: Managing Dental Implant Occlusion with Computerized Occlusal Analysis Technology (Robert Kerstein, DDS)
____ S8: The Full-Arch Zirconia, Screw-Retained Bridge: Guided and Non-guided Surgical Options (Michael Tischler, DDS)
____ S9: Creating the Ultimate Internet Presence NO CHARGE (Sponsored by Advice Media; Chad Erickson)
____ S10: Multi-Media Strategies for Practice Development: A Sneak Peek Behind the Scenes of Single-Provider Implant Practices Producing $1-4 Million in Annual Revenue (Daniel Holtzclaw, DDS, MS)
____ S11: Improvement of Soft and Hard Tissue Healing with New Protocols of Smart Blood Concentrates (Joseph Choukroun, MD)
____ S12: Ethics and Law in Implant Dentistry (Arthur W. Curley, JD)

C. Seminars subtotal _____

D. Special Events

____ First-Time Attendee/Student Reception, NO CHARGE
____ Demystifying the Oral and Written Exams, NO CHARGE
____ ABOI/ID Certification Process Explained, NO CHARGE
____ ABOI/ID Case Requirements Explained, NO CHARGE
____ ABOI/ID Lunch, $100
____ Women Dentists Wine & Cheese, NO CHARGE
____ President's Celebration, $195
____ Application of Microsurgical Principles in Plastic Periodontal and Implant Surgeries $695 AAID members and non-members who register for 2016 Annual Conference ($795 all others)

D. Special Events subtotal _____

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Registrations received by October 14, 2016, will be processed prior to the meeting.

All refunds are subject to a $50 administrative fee regardless of when requested or the reason. Requests for refunds must be made in writing and received by September 26, 2016 for a full refund (less the $50 administrative fee). Between September 27, 2016 and October 3, 2016, a 50% refund (less the $50 administrative fee) will be given. Due to advance commitments to the hotel, no refunds will be made after October 3, 2016.

Hyatt Regency New Orleans puts you just an elevator ride away from all the action of NOLA as well as AAID's Annual Conference. Call the toll-free reservation line at (888) 421-1442 or the hotel directly at 504-561-1234. Or make your reservation online at www.aaid.com. Take advantage of the special group rate of $249 single or $264 double per night plus tax.

Richard Mercurio,
DDS, FAAID, DABOI/ID
President, American Academy
of Implant Dentistry

Time Flies

I can't believe that my year as president of the American Academy of Implant Dentistry is nearly over. It feels like only yesterday that I addressed my colleagues at the annual business meeting. I gave my vision for the Academy to be the leader in unbiased, dental implant education. I proudly encouraged you to participate in the AAID Foundation's Wish a Smile program by both volunteering and encouraging eligible patients to seek the free treatment from the program. I strongly supported our efforts to achieve specialty status for implant dentistry through the efforts of the American Board of Dental Specialties and AAID's own pursuit of legal challenges in strategic states.

[Our credentialing program] shows that our organization strives to maintain the highest standards for our credentialed members.

Our credentialing program is second to none. It shows that our organization strives to maintain the highest standards for our credentialed members. The profession and the public see the AAID name and appreciate the education, experience, and integrity of their AAID Credentialed implant dentist.

We achieved a major victory in Texas, when a judge in the U.S. District Court entered a decision and order eliminating the ADA as the sole source of specialty recognition for dentists in that state. This is significant for so many reasons. It was a team effort involving the efforts of so many in the AAID and from other dental organizations. This victory has had far reaching consequences within organized dentistry for AAID, implant dentists, and ultimately our patients. We are well on the way to achieving our goal of specialty recognition for implant dentistry.

In our pursuit to be the leader in world-wide dental implant education, we increased the number of MaxiCourses®, our comprehensive continuum of implant education, from 11 to 15 and more are on the drawing board. This year we also launched our "Clinical Classroom," an online set of implant-specific courses, videos, and case studies. Any member of the Academy can access that education anywhere and at any time from their computer or even mobile device. Our newest offering is the MaxiCourse® Clinical Classroom. This will allow attendees at MaxiCourses® to complete important pre-requisite courses online before showing up at their respective MaxiCourse® sites. This is a major step forward and will save everyone money, but more importantly, improve the quality of education they receive.

The strength of our Academy is in the number of implant dentists who choose to join. That number increased an amazing 11% this year. This results in part from programs and services that

the Academy offers. However, much of the credit goes to the reputation you, our members, have for being the most accomplished implant dentists in the world. Others want to be a part of the leading organization of dental implant experts.

We must continue to bring the message — the good news, if you will — about the Academy to the profession. We have started to do so but there is much more than can be done. We conducted the very first comprehensive study of the implant practice and shared it with the profession. I am proud that the AAID is the first and only organization to deliver this valuable resource. While we have started down the path, there is much more we can do to let dentists know about the Academy and the necessary role that we play in the profession.

One new program that is particularly exciting on many levels is just beginning. AAID Podcasts officially launched right after Labor Day weekend. I was privileged to be the first guest of Dr. Danny Domingue and Dr. Justin Moody. The entire podcast concept for the Academy came about from our volunteers. They took it upon themselves to develop the idea, identify guests, and record the conversations. AAID staff helped get the podcasts out to the membership and rest of the profession. This is an excellent example of the strength of our organization — involved members and capable staff.

We want patients to know about the AAID, as well. Our ultimate goal is to have patients ask their implant dentist, "Are you credentialed by the AAID?" We brought the message directly to patients this year in a way never done before. AAID's Dental Implant Month, celebrated in August, included a grass-roots effort by our own members to share their affiliation with the Academy, the value of dental implants, their expertise, and that of the AAID, with patients throughout the country. I am very pleased that more than 400 members — a completely unexpected number — participated to spread the word. Hundreds of thousands of patients became aware of the AAID as the best source for their dental implant treatment.

I want to remind you of the importance of our Foundation's Wish a Smile program. We have had a good response from our members who wish to volunteer the time and skills. However, we need more patients who are eligible

see President's Message p. 58

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First AAID MaxiCourse® in Europe

The American Academy of Implant Dentistry's first MaxiCourse® on the European continent has been approved and has commenced its first module. The Ludes University – American Academy of Implant Dentistry MaxiCourse® is under the directorship of **Dr. Dennis Flanagan,** an Honored Fellow of the AAID and Diplomate of the American Board of Oral Implantology/Implant Dentistry. His Co-director is AAID President-elect, **Dr. Shankar Iyer.**

LUDES Higher Education Institute is the affiliated institution, and the courses will be taught in Ricasoli, Malta. This is a non-commercial, non-sponsored MaxiCourse®.

The program includes the placement of ten implants with all surgical and prosthetic components. All materials plus a complete surgical instrument kit are provided to each student.

The instruction will be offered in five different modules presented over ten months. Each session is presented over a weekend. Fifteen distinguished implant dentists from throughout the world will be presenters.

To register or obtain further information, contact **Dr. Shankar Iyer** at Drsiyer@aol.com.

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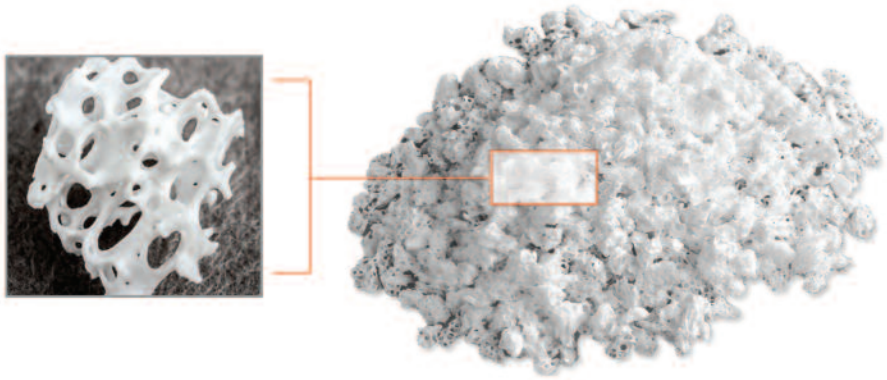

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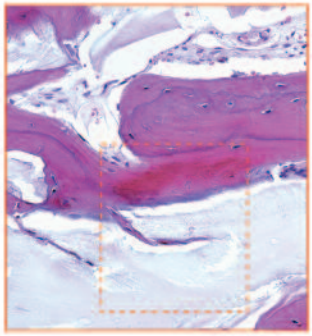
Histology of bone core harvested after 5 months of healing following ridge preservation using Zcore™ 0.25–1.0 mm particle size

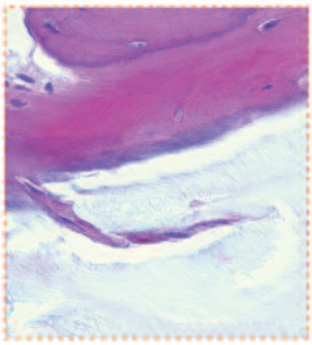
H&E staining

Magnification x4



Vital bone ingrowth into the inter-particle space of Zcore™

Magnification x20



Magnification x40

Case and histology courtesy of
Gustavo Avila-Ortîz, DDS, MS, PhD
University of Iowa College of Dentistry,
Department of Periodontics

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ART MOLZAN NAMED 2016 AARON GERSHKOFF/NORMAN GOLDBERG AWARD WINNER

Art Molzan, DDS, FAAID, DABOI/ID, was named the winner of the Academy's Aaron Gershkoff/ Norman Goldberg Memorial Award. Named after the first two presidents of the Academy, the Award recognizes outstanding contribution to AAID and the field of implant dentistry.

Dr. Molzan, of Cape Coral, Florida, currently is engaged in the private practice of dentistry with an emphasis on dental implants. An Honored Fellow of the AAID, he became a Fellow of the Academy in 1990, the same year he achieved Diplomate status in the American Board of Oral Implantology/Implant Dentistry. He served as president of the AAID in 2000. A graduate of Ohio State University College of Dentistry, Dr. Molzan received his DDS degree in 1980. He relocated to Florida to begin private practice in Cape Coral, then branched out to Naples, as well. He has been in practice in Florida for 30 years. He is a frequent speaker to the public and professional community on dentistry and is recognized by his peers for his extensive knowledge and skill level.

AAID FOUNDATION AWARDS SEVEN RESEARCH GRANTS

The American Academy of Implant Dentistry announced the recipients of the David Steflik Memorial Student Research Grant competition. This annual competition is open to dental students and those in post-graduate and residency programs. Each of the seven winners receives $2,500 to further their research. Following are the seven winning research projects:

AAIDF
AMERICAN ACADEMY OF IMPLANT DENTISTRY FOUNDATION

Dr. Sara Edmondson, Oregon Health and Science University School of Dentistry
"Implant Restorations within a Dental School Setting: A Retrospective Analysis on Success/Survival Rates and Patient Satisfaction"

Dr. Jessica Ellsperman, University of Indiana School of Dentistry
"Evaluating Implants Supported Restoration in the Pre-Doctoral Dental School Setting: A Retrospective Study"

Dr. Jian Jane Jiao, Harvard School of Dental Medicine
"Comparison of Volumetric Changes of Soft Tissue around Dental Implants and Teeth Following Connective Tissue Graft"

Dr. Andrew Lum, Tufts University School of Dental Medicine
"Association Between Lateral Window Bone Thickness and Membrane Perforation During Sinus Augmentation"

Dr. Cheryl Jonghee Park, University of Southern California
"Evaluation of Varying Thickness of Zirconia around Abutment Cylinders"

Dr. Bailey Proft, University of Connecticut School of Dental Medicine
"Comparative Evaluation of 2 CBCT Protocols for Preoperative Implant Site Evaluation"

Dr. Pooyan Refahi and Dr. Thaisa Bordin, Tufts University School of Dental Medicine
"Accuracy and Perception Evaluation of a Dynamic Navigation Implant System: a Pilot Study"

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AAID Membership Ambassadors

AAID Membership Ambassadors know first-hand how membership in the Academy helps dentists establish or expand their expertise in implant dentistry and encourage their colleagues to join the AAID. We would like to thank the Membership Ambassadors who have referred colleagues as new members between June 20, 2016, and August 9, 2016.

Thank you for referring 2 colleagues to the Academy:

Gordon J. Christensen, DDS, MSD, PhD, from Provo, UT

Bryan Hendriks, DDS, from Farmington, UT

Justin Moody, DDS, from Rapid City, SD

Thank you for referring a colleague to the Academy:

Vanja Alagic, DMD, from St. Petersburg, FL

Kathleen Casacci, DDS, from North Tonawanda, NY

G. Thomas Cloyd, DDS, from Clinton, IN

Diana Frum, DDS, from Westover, WV

Kim Gowey, DDS, from Medford, WI

Andrew Ingel, DMD, from Las Vegas, NV

Shankar Iyer, DDS, MDS, from Elizabeth, NJ

Dr. Karishma Shantanu Jaradi, from Mumbai, India

Jane Martone, DDS, from Westfield, MA

Ed Mills, DDS, from Atlanta, GA

John Minichetti, DMD, from Englewood, NJ

Peyman Raissi, DDS, from Nashville, TN

Linda M. Ribarich-Boehm, DMD, from Oneida, NY

Guy Rosenstiel, DMD, from Birmingham, AL

Cesar Tapia-Vera, DDS, from Aurora, CO

Mafaz Ullah from Dubbo, Australia

Michael Wehrle, DDS, from Hurst, TX

Matthew Young, DDS, from San Francisco, CA

Thank you Brian Jackson, DDS, from Utica, NY, for referring 3 electronic student members.

Encourage your colleagues to join the AAID and offer them a $50 discount on their first year's membership dues by letting us know you referred them. Do so by November 1, 2016, and be entered into a drawing for 2017 AAID membership dues - up to a $600 value.

If you would like to request membership applications to share with colleagues, contact the Headquarters Office at info@aaid.com or by phone at 312-335-1550.

HONORED FELLOWS ELECTED FOR 2016

The Honored Fellows Committee has selected the following individuals for the 2016 Honored Fellows:

Aladdin Al-Ardah, DDS
Loma Linda, CA

Bill Anderson, DDS
Findlay, OH

Lion Berzin, BDS
Toronto, ON, Canada

Robert Castracane, DMD
New York, NY

Jason Kim, DDS
Flushing, NY

Rodney Mayberry, DDS
Vienna, VA

The selection of new Honored Fellows includes a nomination process with final selection based on scores determined by AAID involvement (volunteer positions at the National and District levels, speaking at AAID events, study clubs, etc.) and contributions to, implant dentistry and the nominee's home communities (teaching, publishing, awards, community service, etc.).

FOLLOW DR. PHILLIPS' LEAD

Dr. Carol Phillips has come up with an innovative way to support the AAID Foundation. She has arranged to have $100 per month paid automatically and electronically to the Foundation. The Foundation thanks Dr. Phillips for her support and this innovative and easy way to support the Foundation. Consider doing this yourself. Contact Afshin Alavi at 312-335-1550 or by email at afshin@aaid.com for information on how to do this yourself.

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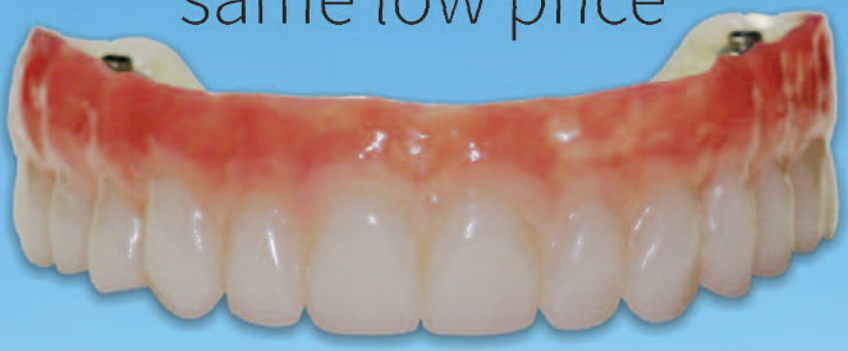

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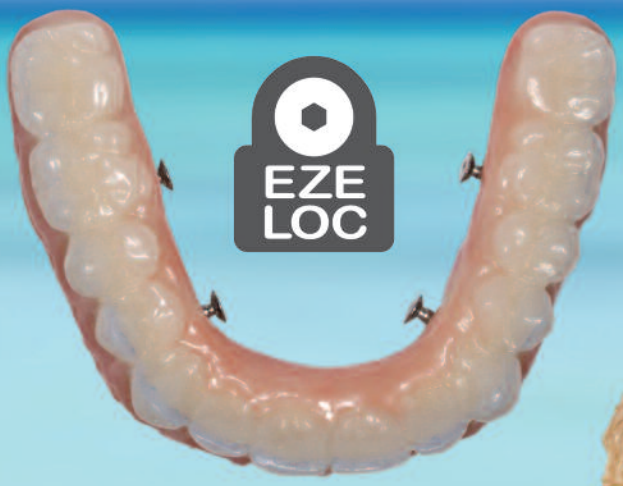

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ISAIH LEW AWARD WINNER NAMED

Sebastiano Andreana, DDS, MSc, was named the recipient of the 2016 Isaih Lew Memorial Research Award from the AAID Foundation. He will be honored in person at the President's Celebration during the Academy's 2016 Annual Conference.

Dr. Sebastiano is highly regarded in the field of laser dentistry and implants. He is Senior Associate Editor and Review for the Journal of Oral Implantology and serves on the Advisory Board of the Jouranl of Laser Dentistry. In addition to serving on the Board of Directors of the Academy of Laser Dentistry, Dr. Sebastiano also served as Co-Chair of the Academy's Science and Research Committee. He has been Principal Investigator or Co-Investigator on 60 different research projects. He holds one patent as a co-inventor. Dr. Sebastiano is currently affiliated with the Department of Restorative Dentistry at the State University of New York at Buffalo School of Dental Medicine.

OFFICER OFFSPRING

Congratulations to **Dr. Natalie Wong,** Treasurer of the AAID, on the birth of her second daughter Kyra Kao who was born on August 9, 2016, weighing in at 7 pounds.

RECIPIENT OF PAUL JOHNSON SERVICE AWARD ANNOUNCED

David Gimer, DDS, FAAID, DABOI/ID, has been named the recipient of the 2016 Paul Johnson Service Award.

The award recognizes outstanding service to AAID as exemplified by the late **Dr. Paul Johnson.** It is intended to acknowledge the work of AAID volunteers who have gone "over and above" and highlight that much of the success of AAID is due to the hard work of committed volunteers.

Any AAID member, with the exception of national officers, who volunteers for any AAID committee, task force, district, or meeting, is eligible to be considered for the award. The Board of Trustees delegated to staff the responsibility to choose the recipient.

Dr. Gimer was chosen from a half-dozen nominees. He spearheaded the creation of both the original and updated versions of the Bite of Education slides, a program that has been given in dozens of schools, and led to well over 1,000 student members joining the Academy. He also proactively contacted the University of Iowa to schedule the presentation he gave there.

Communication is crucial within any organization and Dr. Gimer always responds to requests for feedback or discussion of any kind. He is smart, yet humble, and most importantly, he truly cares about serving the Academy and improving the field of implant dentistry.

Dr. Gimer has no shortage of committee participation dating back to 2004, including a stint as Trustee member of the Board of Trustees representing the Central District.

Committees he has served on include Membership, Nominating, ABOI Liaison, Public Relations, and Bylaws.

UPCOMING KEY AAID DATES

OCTOBER 2016

26-29 **65TH ANNUAL EDUCATIONAL CONFERENCE**
Hyatt Regency New Orleans, New Orleans, LA

APRIL 2017

7-8 **MINIMALLY-INVASIVE IMPLANT DENTISTRY: LESS IS MORE**
Omni William Penn, Pittsburgh, PA

JUNE 2017

9-10 **SOLVING DENTAL IMPLANT DILEMMAS**
Chicago Marriott Downtown Magnificent Mile, Chicago, IL

Check the AAID Online Calendar using this QR Code for a complete listing of all key AAID dates.

AAID MEMBERS IN THE NEWS

Kirk Kalogiannis, DMD, AFAAID, presented a lecture entitled "Bone Loss From Implant Retained Over Dentures" at the Academy of General Dentistry's Annual Conference held in Boston. The July 2016 issue of *Dentistry Today* published articles by three members of the Academy:

"Provisionalization for Implant Dentistry" by **Michael Tischler, DDS, FAAID, DABOI/ID**

"Dental Implant Provisionalization Options" by **Justin Moody, DDS, FAAID, DABOI/ID**

"Using an Integrated Digital Approach to Treatment Planning" by David Little, DDS

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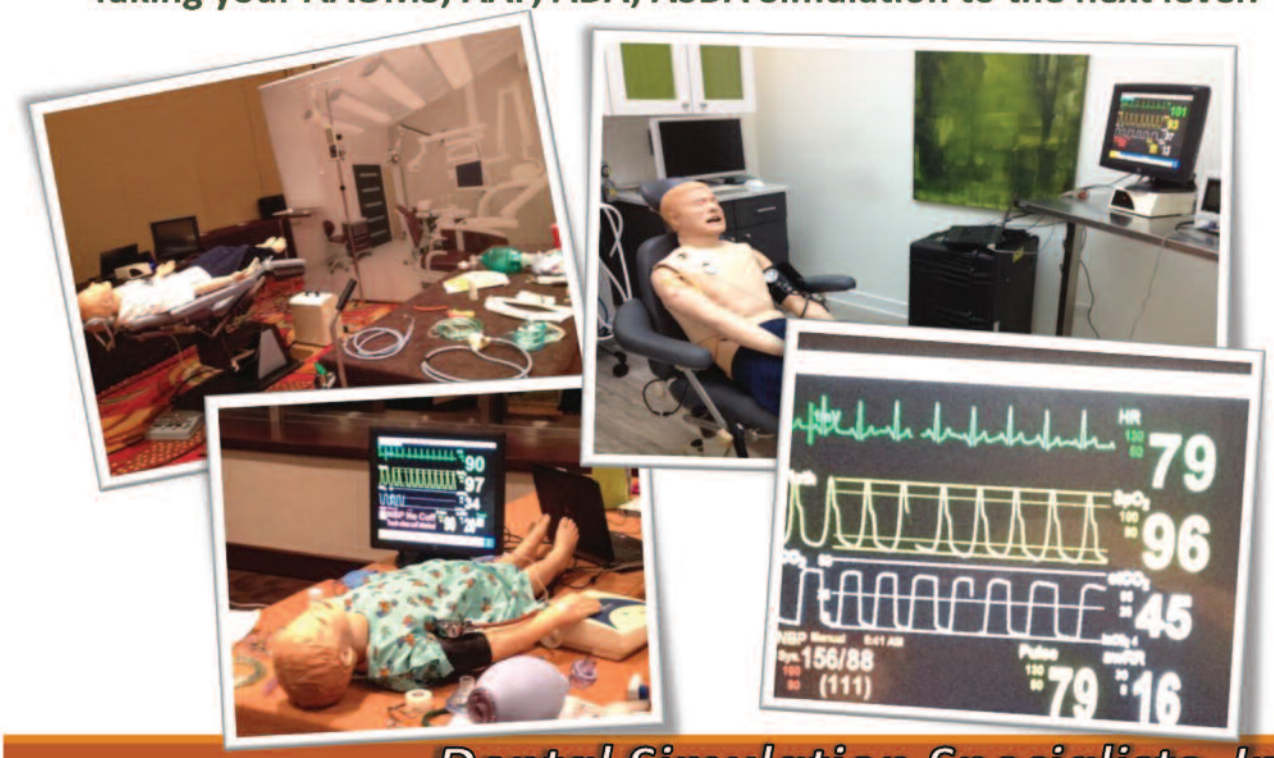

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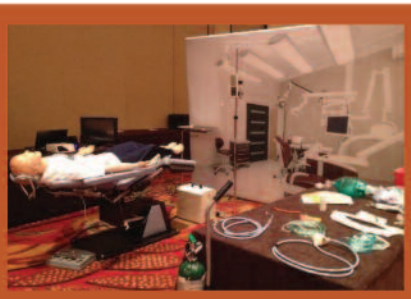

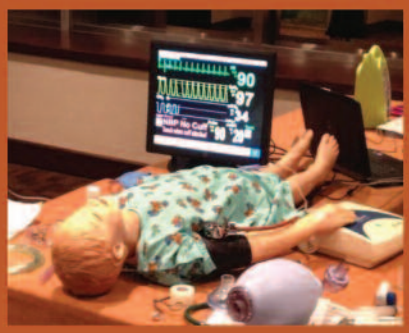

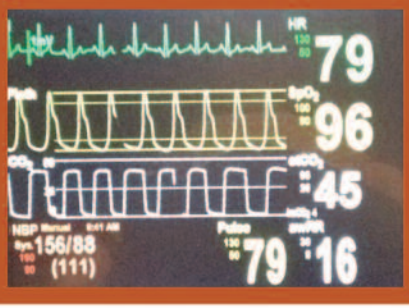

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Dental Student Awards

The 2016 AAID Dental Student Award is available to all accredited dental education programs in the United States and Canada. Sixty-one schools awarded the AAID Dental Student Award for undergraduate or graduate students this year at their graduation ceremonies.

Award recipients received a certificate of recognition and were provided one year free membership in the AAID and a complimentary registration at the Annual Conference. The recipients and schools that participated in order of the name of the school are:

A.T. Still University of Health Sciences Arizona School of Dentistry and Oral Health
Nicholas T. Salava

Augusta University, The Dental College of Georgia
Ryan Burroughs

Baylor College of Dentistry Component of Texas A & M Health Sci Ctr
Thomas Nichols Lawler

Boston University Goldman School of Dental Medicine
Anna Komnatnaya

Case Western Reserve Univ. School of Dental Medicine
Jeffrey Robert Evanko

Columbia University College of Dental Medicine
Lewis Chen

Creighton University School of Dentistry
Derek S. Williams

Harvard University School of Dental Medicine
Justin Michael Sheinbaum
Paul Gungwan Sonn, DDS, MMSc, Prosthodontics (Post-Doctoral)

Howard University College of Dentistry
Trevor Jamal Thomas

Indiana University School of Dentistry
Nichole Lynn Barnett

Loma Linda University School of Dentistry
Omran Bishbish

Louisiana State University School of Dentistry
Amy Simoneaux Bordelon

Marquette University School of Dentistry
Darryl Jay Banez

McGill University
Negaar Nadji

Medical University of South Carolina College of Dental Medicine
James Shawn Wood

Meharry Medical College School of Dentistry
Nneka Obi

Midwestern University College of Dental Medicine
Jonathan Krum

Midwestern University College of Dental Medicine-Illinois
Adam Gart

New York University College of Dentistry
Kumar Raghava Chowdary Annam

Nova Southeastern University College of Dental Medicine
Jillian J. Rose

Ohio State University College of Dentistry
Alexandra E. Hinkley

Oregon Health and Science University School of Dentistry
Jonathan Andrew Yih

Roseman University of Health Sciences College of Dental Medicine
Amir Nojoumi

Rutgers School of Dental Medicine
Ghata Patel

Southern Illinois University School of Dental Medicine
John E. Cairns

State University of New York at Buffalo School of Dental Medicine
Ian Thomas Mort

Stony Brook University School of Dental Medicine
Maggie W. Leung

Temple University The Maurice H. Kornberg School of Dentistry
David Matthew Ebsworth

The University of Texas School of Dentistry at Houston
Macey Brooke Cartrite

Editor's Note: One of this year's Dental Student Award winners sent Sharon Bennett, AAID Executive Director, the following note. We thought we'd share it with our readers.

Ms. Bennett,
I'm Jeri McCombs, a recent graduate of UIC College of Dentistry. I just wanted to write to say thank you for the American Academy of Implant Dentistry Award. It is a true honor, and I appreciate being recognized for my additional efforts in implant dentistry. I really enjoyed my academic, surgical and research experiences with implants and look forward to my GPR program next year at Advocate Illinois Masonic Medical Center, where I will continue to learn and grow in experience. Thank you again for the recognition of this award!

Warmest regards,
Jeri McCombs

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Dental Student Award recipient, Ian Mort. Alongside him in the photo is Dr. Joseph J. Zambon, Dean of the State University of New York at Buffalo School of Dental Medicine.

Tufts University School of Dental Medicine
Michelle Marie Garnache
Universite de Montreal
Frederique Duchesneau-Papineau
Université Laval
Catherine Crête-Belzile
University of Alabama School of Dentistry
Roger D. Miller
University of Alberta
Maryna Muzychenko
University of California at San Francisco School of Dentistry
Jonathan Jelmini
University of Colorado at Denver and Health Sciences Center
Christopher S. Carlson
University of Connecticut School of Dental Medicine
Samantha Weston
University of Florida College of Dentistry
Joana Halilaj
University of Illinois at Chicago College of Dentistry
Jeri K. McCombs
University of Iowa College of Dentistry
Andrew Richard Stevenson
University of Kentucky College of Dentistry
Rachel Riley
University of Louisville School of Dentistry
Tyler Monty Rallison
University of Michigan School of Dentistry
Derek G. Robison
University of Minnesota School of Dentistry
Melissa A. Gleason
University of Mississippi School of Dentistry
Matthew Alexander Loeb
University of Missouri-Kansas City School of Dentistry
Jordan M. Campbell
University of Nebraska Medical Center College of Dentistry
Trent R. Bauer
University of Nevada, Las Vegas School of Dental Medicine
Michael Britting
University of Nevada, Las Vegas School of Dental Medicine
Patrick Kenney
University of North Carolina School of Dentistry
William Preston Colven
University of Oklahoma College of Dentistry
Judson Seth May
University of Pennsylvania School of Dental Medicine
Jaskaran Saggu
University of Pittsburgh School of Dental Medicine
Ryan M. Orlosky
University of Puerto Rico School of Dentistry
Paola Berríos-Merced
University of Saskatchewan
Dylan Barker
University of Texas Health Science Crt-San Antonio Dental School
Christopher F. Felicetta
University of the Pacific Arthur A. Dugoni School of Dentistry
Storm Hagen
University of Washington-Health Sciences School of Dentistry
Mark T. Sundem
Virginia Commonwealth University School of Dentistry
Eric Brooks Bokinsky
West Virginia University School of Dentistry
Mona Meky
Western University of Health Sciences College of Dentistry
Parth Karia

(L to R) Dr. Jeffrey Hutter, Dean, Boston University Henry M. Goldman School of Dental Medicine; Dr. Anna Komnatnaya, Class of 2016; Dr. Bradford Towne, Clinical Assistant Professor, Department of Oral & Maxillofacial Surgery.

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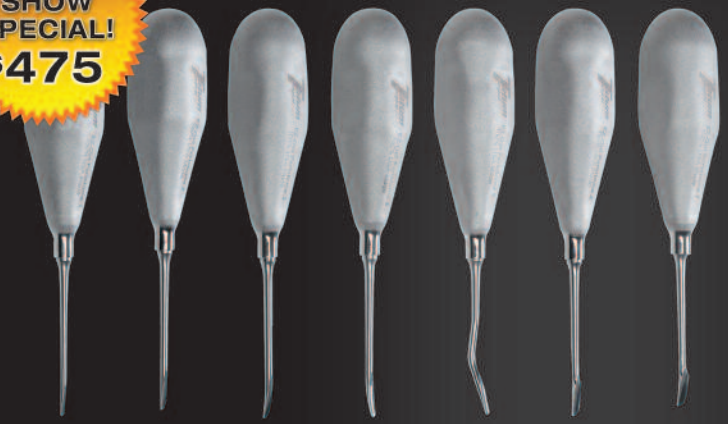
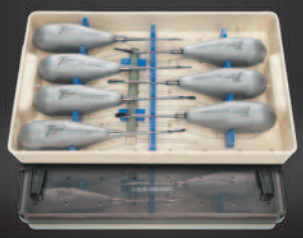


Tatum EZ-Out Periotome Kit



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AAID Announces Launch of Podcast

INTRODUCTION

AAID is proud to announce the launch of its brand new podcast. The Academy aims to foster informal discussions about the world of implant dentistry, mirroring the collaborative spirit of our members in our podcast. Hosted by **Dr. Daniel Domingue** and **Dr. Justin Moody,** the podcast will explore topics and issues encompassed in the implant practitioner's world. The podcast is available to the public to stream online, and listeners can subscribe on iTunes, Google Play, Soundcloud, and Stitcher. Visit aaidpodcast.com to listen to brand new episodes and learn more.

The AAID podcast will be setting up a mini recording studio onsite at the Annual Conference. Look for our team on the floor of the conference, who will be interviewing members and attendees for upcoming episodes.

Meet our hosts

Daniel Domingue, DDS, FAAID, DABOI/ID

Dr. Domingue was born and raised in Lafayette, LA. He received his DDS degree from the LSU School of Dentistry in New Orleans. Further training included one-year General Practice Residency and a two-year Implantology Fellowship.

Dr. Domingue is an AAID Fellow and a Diplomate of the American Board of Oral Implantology. He was recognized as the youngest ABOI/ID diplomate in the world. He is the Founder and President of Acadian Southern Society. He also serves as Chair of AAID's Membership Committee.

After being in private practice for six years (New York City and Lake Charles), Dr. Domingue moved back to his home state of Louisiana to join his uncle, Dr. Jerome Smith, in his practice in Lafayette, Louisiana. This proved to be a great opportunity for him and his family to move back home and carry on the family practice established almost 40 years ago.

Justin Moody, DDS, FAAID, DABOI/ID

Dr. Moody received his DDS degree from University of Oklahoma Health Science Center college of Dentistry in 1997. While in dental school, he was awarded the National Disaster Medical System Appreciation letter for his efforts during the Oklahoma City Bombing. He went on to attend the prestigious Misch International Implant Institute where he was awarded a fellowship and mastership. He also completed the AAID Georgia MaxiCourse®.

Episode 1	"Welcome to AAID's Podcast"	Meet our hosts
Episode 2	"Political Aspirations"	Featuring Dr. Richard Mercurio
Episode 3	"Becoming a Skeptic"	Featuring Dr. Shankar Iyer
Episode 4	"Labor of Love"	Featuring Dr. Michael Tischler
Episode 5	"Lifelong Learning"	Featuring Dr. Natalie Wong

AAID PODCAST

Dr. Moody is a Fellow in the American Academy of Implant Dentistry and is one of the youngest Diplomates in the American Board of Oral Implantology/Implant Dentistry. He serves as adjunct faculty at the University of Nebraska Medical Center and a Mentor at the Kois Center in Seattle, Washington.

Providing quality dental care to rural America is a priority of Dr. Moody's. He is the owner of Horizon West Dental group which has multiple offices in western Nebraska providing state-of-the-art dental care with the latest in technology by some of the most highly trained dentists around. In 2008, Dr. Moody limited his practice to the field of dental implants by opening the first Dental Implant Center in Rapid City, South Dakota. Dr. Moody lectures across the country and around the world as well as providing hands on training from his state-of-the-art South Dakota Dental Implant Center.

If you have feedback about the podcast, ideas for a topic, or would like to be a guest on the show, please email podcast@aaid.com.

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Fort Smith, AR

COLIN R. DIENER, DMD, BsC
St. Albert, Alberta, Canada

ISMAEL EL KHOULY CASTILLA, DDS, MS, PhD
New York, NY

JOSEPH A. FIELD, DDS
Los Altos, CA

JORGE M. HERVAS, DDS, MS
Plantation, FL

MATTHEW J. HOLTAN, DDS
Naples, FL

KWAN M. LEE, DDS
Federal Way, WA

ALAA ZOHER MAKKE, DDS, MS
Makkah, Saudi Arabia

JANE F. MARTONE, DDS
Westfield, MA

ALIREZA MOHEB, DMD
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CORY NHUT NGUYEN, DDS
Irving, TX

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Port Coquitlam, British Columbia, Canada

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2. **The impact of a modified cutting flute implant design on osseointegration** - Int J of Oral and Maxillofacial Surgery43(7) · June 2014
3. **Mechanical Evaluation of Four Narrow-Diameter Implant Systems** - Int J Prosthodont 2014 Jul-Aug;27(4):359-62

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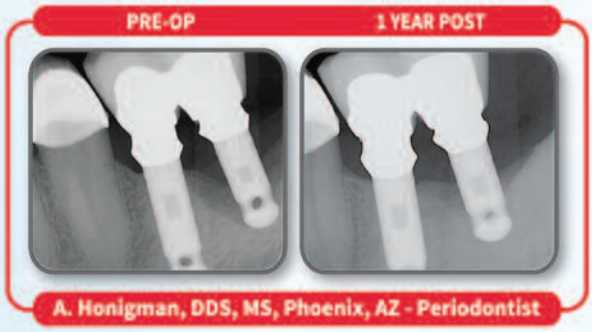
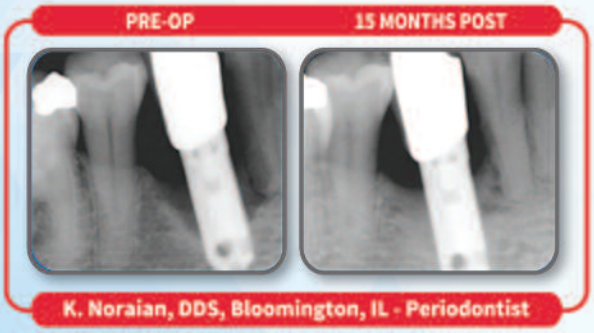
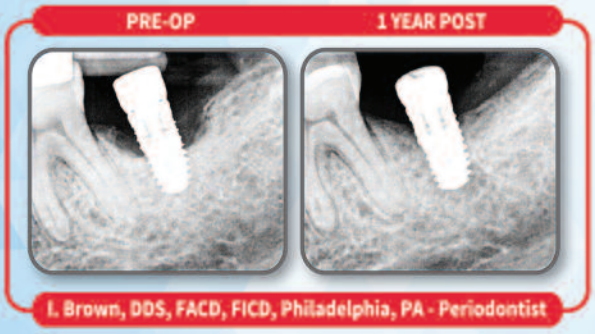


A. Honigman, DDS, MS, Phoenix, AZ - Periodontist



K. Noraian, DDS, Bloomington, IL - Periodontist



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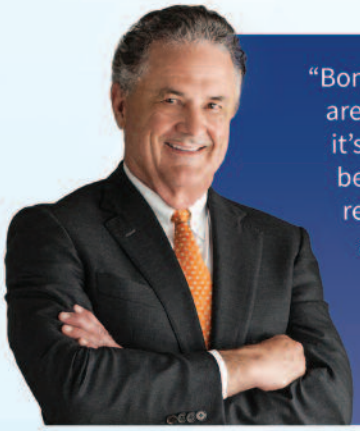

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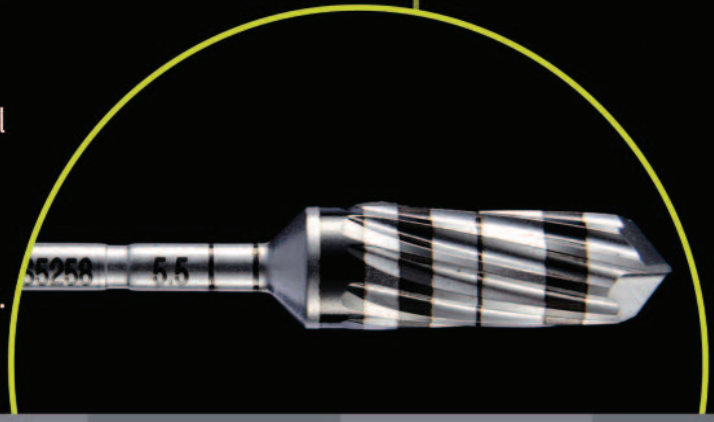

*Lahens, B., Neiva R., et. al "Biomechanical and Histological Basis of Osseodensification Drilling for Endosteal Implant Placement in Low Density Bone. An Experimental Study in Sheep." J. Mech Behav Biomed Mater, Oct; 63: 56-65, 2016

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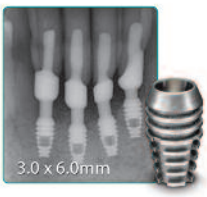

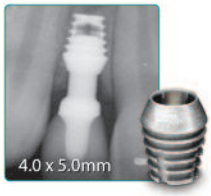

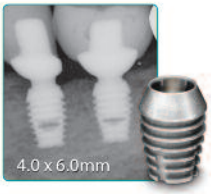

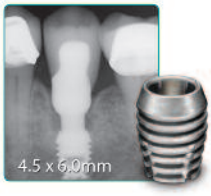

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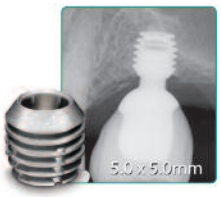

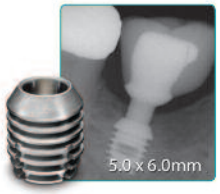

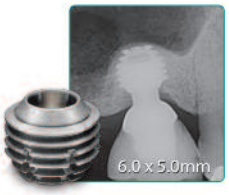

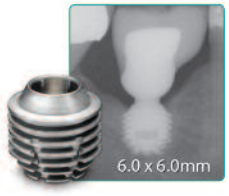

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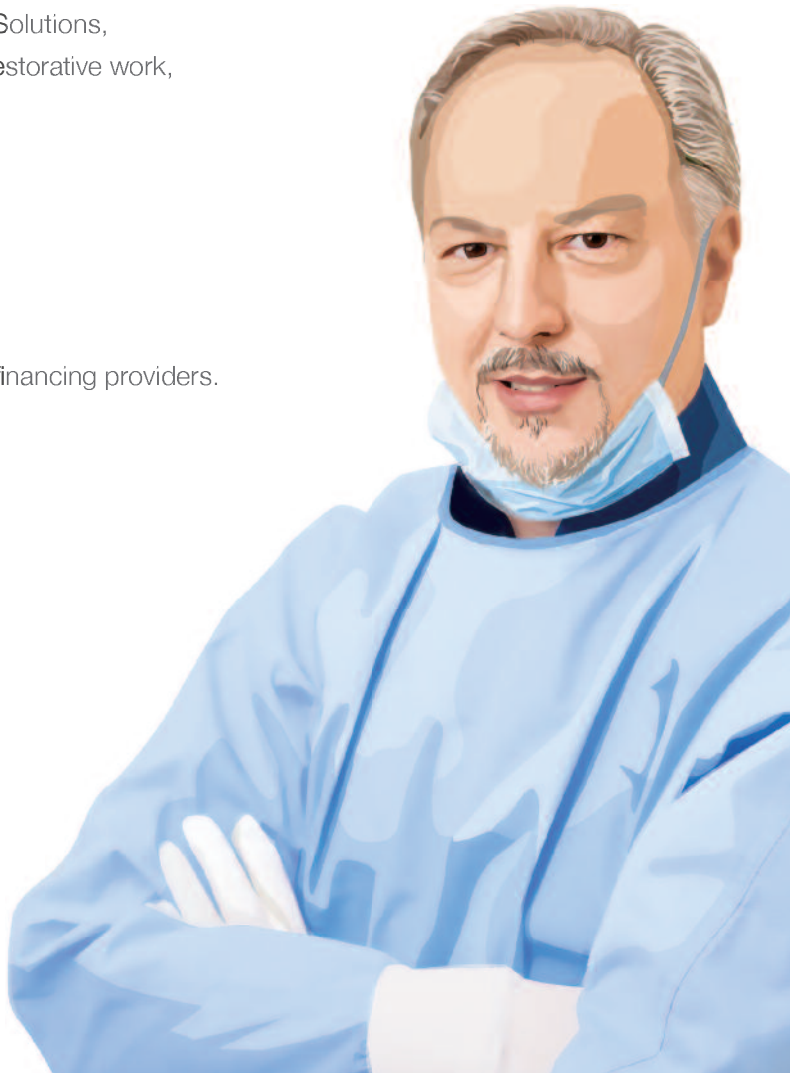

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[1] $99 monthly payment assumes a 60 month term Extended Plan loan with an amount financed of $4,250 and an APR of 13.99%. Actual monthly payment amount and APR may vary based on amount financed, term and credit history. Subject to credit approval. Amount financed is based on an average single implant procedure cost of $4,250. Source: www.dentalimplantcostguide.com.

[2] Based on data on file for approved 60-month Extended Plan loans from January 1, 2016 through June 30, 2016.

newmembers

The AAID is pleased to welcome the following new members to the Academy. The following members joined between June 16, 2016 and August 21, 2016. If you joined the Academy recently and your name does not appear, it will be listed in the next issue. The list is organized by state and then alphabetically by city. International member list is organized by country, province (if available), and city. Contact your new colleagues and welcome them to the Academy.

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Tallassee

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Allen Peyghambarian
Phoenix
Lee J. Sorcinelli, DDS
Sun City West
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Jyotsna Sundar, DMD
Santa Clara
Mireya Ortega, DDS
South Lake Tahoe

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Aurora
Jay Banez, DDS
Denver

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Yagnabala Patel
Atlantis
Miguel Scheel
Lehigh Acres
Lazaro Acosta, DDS
Naples
Tyler Monty Rallison, DMD
Niceville
Daniel R. Drake, DDS
Ormond Beach
Jason Chawla, DMD
Santa Rosa Beach
Mark P McCaughey, DMD
Santa Rosa Beach
Vanja Alagic, DMD
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James John Horan, DMD
Stuart

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Cumming
David L Settel
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ILLINOIS
Mohit Joshi
Chicago
Bradley Weiss
Evanston

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Clinton
Danny Hayes, DMD
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Indianapolis
Kyle Shank
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New Haven

IOWA
Andrew Stevenson, DDS
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Carencro
Raymond J. Steiner, DDS
Lake Charles
Cyndi Nguyen
Prairieville

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Framingham

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Douglas
Andrew B Hamilton
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Derek G. Robison, DDS
Saline
Shawn V. Nguyen, DDS
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W. Bloomfield

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Matthew Colaizy, DDS
St. Paul
Marko Kamel
Woodbury

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Columbia

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Ramsey

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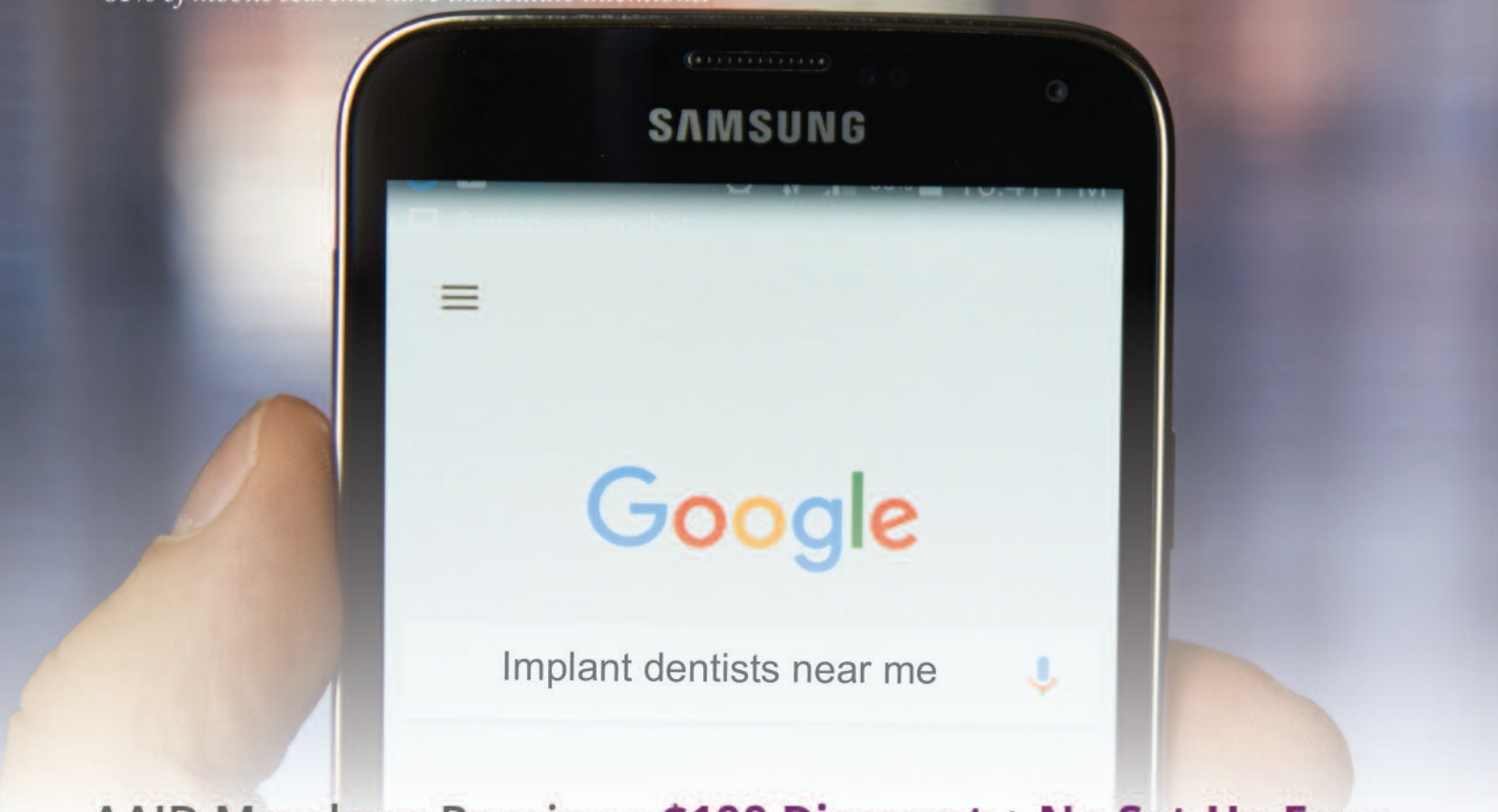

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Mark T. Armstrong, DDS
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Jonathan Jelmini, DDS
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Mini Residencies
Basic & Advanced Interactive & Hands-On MDI training
Contact: Keith Henry
Phone: 580-504-8068
E-mail: vis@sendax-minidentimpl.com
Web site: www.sendax-minidentimpl.com

Tatum Institute USA
A Hands-on Learning Series emphasizing the "Hilt Tatum" NIRISAB Philosopy
Location: Atlanta, Georgia
Instructors: Dr. Richard Borgner and Dr. Bernee Dunson
- Sinus Augmentation/Manipuulation
- Bone Expansion
- Advanced Bone Grafting
- Nerve Lateralization
- Segmental Osteotomies
- Cadaveric Specimen Course
- Each module contains both hands-on practicals and live surgeries

Contact: Rebekah Register
Phone: 727-459-4910
E-mail: tatuminfo@aol.com
Web site: tatuminstituteusa.com

University of Nevada, Las Vegas (UNLV) Division of Continuing Education Courses in Implant Dentistry
Live Implant Surgery Course (3 months)
Surgical Bone Grafting Human Cadaver Course (3 days)
Hands-on Maxillary Sinus Augmentation Course (2 days)
Pig Jaw Surgical Bone Grafting Course (2 days)
Francis Jones, DDS, PhD (Ca)
Contact: Roxane Santiago
Phone: 702-774-2822

CANADA

The D.M. Vassos Dental Implant Centre Introductory & Advanced Surgical & Prosthetic Programs
Dr. D.M. Vassos
Mentor Program – Hands-on Program over six Saturdays
Location: Edmonton, Alberta, Canada
Contact: Rosanna Frey
Phone: 780-488-1240
E-mail: rosanna@dmvassos.com
Web site: www.dmvassos.com

The BITE Club
For those not ready for the AAID Vancouver MaxiCourse®. Didactic study club to introduce you to the world of oral implantology.
Contact: Andrew Gillies, Education Coordinator
Phone: 604-330-9933
E-mail: andrew@implantconnection.ca

"Hands-on" Introductory to Advanced Surgical and Prosthetic Implant Courses with Live Surgery.
Dr. Robert E. Leigh, Director
Year-round, Custom Tailored and 5-DAY MINIRESIDENCY Courses
Location: Leigh Smile Center, Alberta, Canada
Contact: Corie Zeise
Phone: 1-888-877-0737 (Toll Free)
E-mail: coriemanager@gmail.com
Web Sites: www.rockymountainsmilecenter.com
www.leighsmilecenter.com

Implant Connect: Prosthetic Course
One-year program that will cover patient selection, treatment planning, occlusal considerations and how to incorporate implants into your practice.
E-mail: andrew@implantconnection.ca
Web site: www.cditc.ca

Pacific Implant Institute
Dr. Ron Zokol
Comprehensive Training in Implant Dentistry
September through June
Location: Vancouver, B.C., Canada
Contact: Kim
Phone: 1-800-668-2280
E-mail: kimber@piidentistry.com
Web site: www.piidentistry.com

Toronto Implant Institute
Toronto Implant Institute
Natalie Y. Wong, DDS, FAAID, DABOI/ID
Implant Prosthetic Session: Traditonal to Digital
Digital Implant Dentistry Internship
Guided Surgery and Guided Prosthetics™ for Immediate Full-Arch Implant Restorations
Contact: Linda Shouldice
Phone: 416.566.9855
Email: linda@ti2inc.com
Web site: www.ti2inc.com

Vancouver Implant Continuum
Continuing your MaxiCourse® journey
One-year program that incorporates live patient surgery on your own patients with a review of everything within the AAID Vancouver MaxiCourse®
Contact: Andrew Gillies, Education Coordinator
Phone: 604-330-9933
E-mail: andrew@implantconnection.ca
Web site: www.cditc.ca

OUTSIDE NORTH AMERICA LOCATIONS

Beirut Implant Dentistry Center
CE Courses Survey of Surgical and Prosthetic Implant Care
Drs. Jihad Abdallah & Andre Assaf
Contact: Mahia Cheblac
Phone: +961 1 747650 or +961 1 747651
Fax: +961 1 747652
E-mail: beirutidc@hotmail.com

AAID Affiliated Study Clubs*

CALIFORNIA

Bay Area Implant Synergy Study Group
San Francisco
Matthew Young, DDS, FAAID, DABOI/ID
Contact: Kimberly
Phone: 415-392-8611
E-mail: info@dentalimplantssc.com
Web site: www.drmatthewyoung.com/BayAreaImplantSynergyPage.htm

Northern California Dental Implant Continuum
Craig A. Schlie, DDS, AFAAID
Phone: 530-244-6054
E-mail: Dr.Schlie@gmail.com

FLORIDA

Central Florida Dental Implant Study Group
Altamonte Springs, FL
Don Preble, DMD
Contact: Sharon Bruneau
Phone: 407-831-4008
Fax: 407-831-8604

see Continuing Education p. 58

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Obituaries

Ebenezer Bush, DDS, Compton, CA — Associate Fellow

Terry J. Reynolds, DDS, Atlanta, GA — Honored Fellow and Past President

Dr. Terry Reynolds passed away August 7, 2016 just a month short of his 75th birthday. Dr. Reynolds was an Honored Fellow of the AAID, Diplomate of the American Board of Oral Implantology/Implant Dentistry, and served as president of the Academy in 1998. He was the recipient of the prestigious Aaron Gerschkoff/Norman Goldberg Award in 2010.

One of Dr. Reynolds most enduring achievements is the creation of the world's first dental implant curriculum called the MaxiCourse®. The first course was at the Medical College of Georgia, followed by a second program he established at Howard University. Today, there are 17 Maxicourses® located in nine countries throughout the world.

He is survived by his wife Audrey, daughter Stacy, grandson Austin and countless friends and colleagues who owe much of their success in implant dentistry to his vision.

Continuing Education

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Mid-Florida Implant Study Group
Palm Harbor, FL
Rajiv Patel, BDS, MDS
Phone: 386-738-2006
E-mail: info@delandimplants.com

NEW JERSEY

Bergen County Implant Study Club
John C. Minichetti, DMD
Contact: Esther Yang
Phone: 201-871-3555
E-mail: info@englewooddental.com
Web site: www.dentalimplantlearningcenter.com

Lincroft Village Dental Implant Study Group
Treatment planning, bonegrafting, prosthetics
Richard J. Mercurio, DDS
Contact: Martha Gatton
Phone: 732-842-5005
E-mail: lincroftimplant@aol.com

NEW YORK

CNY Implant Study Group
Brian Jackson, DDS
Contact: Melanie – Course Coordinator
Phone: 315-724-5141
E-mail: bjjddsimplant@aol.com

New York Study Club
Edgard El Chaar, DDS
John Minichetti, DMD
Phone: 212-685-5133
E-mail: info@edgardelchaar.com

NORTH CAROLINA

Clemmons North Carolina Study Club
Andrew Kelly, DDS
Clemmons, NC
Phone: 336-766-7966
E-mail: dctr2th@msn.com

* This calendar section is available to any credentialed member of the AAID to post information about implant education courses offered by the member. The member must agree to provide the list of attendees to AAID in exchange for publication of the course in the calendar. Study Club listings are available only to Affiliated AAID Study Clubs. For information about becoming an Affiliated AAID Study Club, contact Ellen Paul, Director of Professional Development at ellen@aaid.com.

President's Message

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to participate. As a reminder, patients must be between the age of 17 and 29, have congenitally missing teeth, and meet low income requirements. We are in the process of treating a handful of patients through the program, but I encourage you to identify patients who would be eligible to receive treatment.

And in a personal note, I want to acknowledge the superhuman efforts of Afshin Alavi, our CFO and the heart and soul of the AAID Foundation. If it were not for Afshin, the Foundation would not have assets of over $3 million, and be able to provide over $100,000 annually to fund implant research.

Thank you for the opportunity to serve as president of the greatest implant organization in the world.

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