2017 has been a fantastic year for NYCDS. We’ve seen many changes, the foremost being our successful move to our new facility. If you have not already seen it, please join us for some of the many functions and classes we hold here. Once again I would like to thank Diane Laurenzo, our executive director, and the members of our re-location committee for both extricating us from our previous, more burdensome lease, and for helping to create such a modern, efficient, and forward-thinking new headquarters.

Here in NYC, our society has a lot of exciting events right around the corner. First, by the time you read this we will have just held the Greater New York Dental Meeting, the largest dental meeting in our nation. We exist as a component because of the funds we receive from this event; we are already looking forward to next year’s meeting!

Next, we will have our Give Kids A Smile event on February 2nd, 2018. This is one of our must fun and fulfilling volunteer opportunities. We are expecting to screen even more underserved New York City children than ever, and this year we anticipate that we will be applying fluoride varnish for the first time. What a wonderful way to give back to our community, and to have some fun as well.

We have also been representing our NYC dentists on the national level. In October, the NYCDS leadership helped voice the concerns of our component at the ADA House of Delegates meeting in Atlanta. The increased prominence of corporate dentistry across the country, and the increasing presence of (continued on page 3)
I am pleased to report that over 250 dentists attended four, all-day Speed Learning programs in 2017. In light of the success of these programs, three all-new Speed Learning events will be scheduled for 2018.

Each symposium provides six, one-hour educational sessions in one day from a diverse group of highly respected instructors. It is a wonderful way to get exposure to new speakers and topics that pique your interest without having to invest several hours on a particular lecture.

**Speed Learning Symposia in 2018**

- **Friday, March 2**
- **Friday, May 11**
- **Wednesday, July 18**

New, returning, and core Continuing Education programs are also planned for the new year. There will be courses for recertification of the anesthesia certificate and new topics including dentistry in the digital age. You will find courses for the first quarter of 2018 on the back of this newsletter. Be sure to check our website (and your inbox) regularly as new courses get added regularly.

**Congratulations...**

After serving as Continuing Education Director for the past two years, this will be Dr. Jackson’s final column. Dr. Jackson was elected to serve as NYCDs secretary in 2018. You can read a brief biography of Dr. Jackson on page 7. Congratulations to Dr. Jackson on her new role. We thank her for her leadership and many contributions to the Henry Spenadel Continuing Education Program.

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**Introducing...**

Mitchell Rubinstein, DMD will be taking over as CE Director in 2018. Dr. Rubinstein served on the NYCDs Board of Directors from 2011–2017, chaired the Communications Committee from 2011–13 and held several other posts at NYCDs. He is currently the Program Committee chair for the New York Academy of Dentistry, and a member of the New York State Dental Association’s Information Technology Committee. He serves on the American Dental Association’s Standards Committee for Informatics, and recently lectured at the ADA annual meeting on the subjects of E-Prescribing and HIPAA compliance. As a member of the Dental Practice Based Research Network, he participates in public health research through the University of Rochester’s Eastman Dental Institute.
Candid Conversations about Ethics at Young Professionals’ Event

It was another special night for our Young Professional dentists and several dental students from Columbia University College of Dental Medicine as they listened to a stellar panel address a variety of ethical dilemmas posed to them by Ethics Committee Chair Julie Connolly. The topic was “Insights and Candor on Ethics Issues” and we were fortunate to be able to award 1.5 CE credits for this program held on November 15. The various perspectives of the panelists were informative and the feedback on this program was very enthusiastic. In fact, the program lasted longer than expected!

These are just some of the thought provoking questions the panel addressed: What would you do if you are a specialist and are asked by a frequent referring dentist to do a procedure that you feel is not the correct procedure or an unnecessary one? If you have a new CT Scan in your office, you are taking “additional” images in the name of dentistry or is to help offset the cost of the machine? How do you manage a senior partner who is pressuring you to produce more and dictating treatment plans?

The discussion was lively and could have gone on for at least another hour, but all of the panelists agreed on several themes. Clear communication with patients and colleagues is essential, as is through documentation of the situation.

Several panelists stated, “you have to be able to sleep at night.” It’s about having a moral compass and doing what is in the best interest of the patient that should be your guiding principle over and above your own financial concerns, or the directive of an employer.

Special thanks to Dr. Connolly for moderating and to our distinguished panelists: American College of Dentists Regent Mark Bauman, NYCDS Board Member Suchie Chawla, NYS Board for Dentistry Member Steven Cho, 2018 ADA Council on Ethics, Bylaws and Judicial Affairs Representative Guenter Jonke, and Peer Review & Quality Assurance Chair Barry Sporer.

The Young Professionals’ ethics program was impactful and engaging.

PRESIDENT’S MESSAGE
(continued from page 1)

dental therapists and mid-level providers were high on the agenda. There was also discussion of the growth of Do-It-Yourself orthodontic aligner use and the risks associated with unsupervised orthodontic tooth movement. These are all issues of great importance to both our national community and to our local practitioners; we were proud to be able to participate!

This brings me to the importance of advocacy. It has become increasingly clear, as my tenure as NYCDS president draws to a close, that the primary function of organized dentistry is—and must be—the protection of our interests as dentists. There are so many special interest groups who are conspiring to whittle away our abilities to practice the way we choose. These special interest groups would shackle our independence as dental practitioners and would insidiously (or sometimes overtly) siphon away our patients, our practices, and our livelihoods. The only organizations which can help defend us against these incursions are our tripartite: the ADA, NYSDA, and NYCDS. Specifically, donating money to our political action committee gives us the ability and the access to make our opinions known to our elected officials. There has been a lot of volatility over the last months (and years), but one unfortunate reality that remains unchanged is this: financial contributions to those with power can increase access. It’s the only way that we can get the ear of our elected officials, to make them aware of issues affecting our profession. I therefore encourage each and every one of you to donate to our political action committee, to empower them to advocate on the behalf of dentistry!

I would like to thank everyone for making this past year one of the most challenging, thought provoking and fulfilling of my professional life! Without the stalwart efforts of our Executive Board, our Executive Director, and our spectacular staff it would have been impossible. Thank you all for your selfless hard work!

What an honor to have served you! I am deeply grateful.

The Young Professionals’ ethics program was impactful and engaging.
The September 11 membership meeting offered a terrific opportunity for members to catch up after summer. Michael D. Turner, DDS, MD, FACS, a Diplomate of the American Board of Oral & Maxillofacial Surgery and a Fellow of the American College of Surgeons was the evening’s speaker. His topic, “Computer Assisted Planning in Orthognathic Surgery,” captivated attendees. Dr. Turner reviewed several cases and noted that with virtual surgical planning the hard work is done virtually—surgery is comparatively easy. He demonstrated the latest technology and showed how patients can get a real sense of how they will look after surgery using a patient’s own photo and manipulating it to illustrate surgical changes.

Dr. Turner is considered a thought leader and a national expert in the field of minimally invasive salivary gland surgery as well as having a considerable interest in maxillofacial trauma and orthognathic surgery. Currently Dr. Turner is the Chief of the Division of Oral and Maxillofacial Surgery at the Jacobi Medical Center and the North Central Bronx Hospital. He is a member of the Institute for Head and Neck and Thyroid Cancer within the Department of Otolaryngology-Head and Neck Surgery at the Mount Sinai Beth Israel Medical Center, and functions as the associate director of the postgraduate training program in Oral and Maxillofacial Surgery.

Prior to the lecture Dr. Lawrence Bailey paid tribute to the passing of former NYCDS president and avid GNYDM volunteer, Donna Rumberger. President Ken Cooperman thanked past and present members of the Greater New York Dental Meeting Organization Committee, noting that the Society is dependent on the GNYDM for our continued success. He encouraged members to not only attend the GNYDM, but also to volunteer. He went on to announce the slate of nominees to serve in 2018 proposed by the Nominating Committee after conducting interviews with candidates over the summer. Dr. Cooperman announced the formation of a Sesquicentennial Committee, headed by Dr. Lois Jackson, which will plan ways to celebrate and acknowledge our long heritage and the growth of organized dentistry. In addition, Golf Committee Chair Dr. David Koslovsky presented a check for $50,000 to Paul Newman’s Hole in the Wall Gang Camp. This money was raised at our highly successful Golf Outing in July.

The Hole in the Wall Gang Camp representative Andrea Keefe is presented with a remarkable donation of $50,000 from the 2017 Golf Outing. Presenting the check is Past Golf Chair David Shipper, 2017 Golf Chair David Koslovsky and NYCDS President Ken Cooperman.

Rob Malandruccolo (left) and Chad Widensky from Bank of America Practice Solutions (second from the right), a Corporate Friend, with Dr. Marcus Johnson and Dr. Bianca Frederick.

President Elect James Jacobs with Past President Maurice Edwards.

Guest lecturer Michael D. Turner, DDS, MD, FACS.
Eventful November Meeting

The membership meeting on November 6 honored two past-chairmen of the NYCDS and NYSDA Peer Review and Quality Assurance Committee and Council. The Mark Mintzer Award, which recognizes exemplary service to the Society, was presented to Egidio Farone, DMD and Richard Rausch, DDS, for their many years of valuable, behind-the-scenes work that both devoted to the Peer Review process. Dr. Farone spoke about the value of Peer Review for members in his lecture “Peer Review: Facts, Findings, and Dispelling Fears” while Dr. Rausch addressed “Everything Medico-Legal in Dentistry,” which focused on patient complaints to the Office of Professional Discipline.

The featured speaker of the evening was Henry Spenadel Award recipient Frank C. Andolino, II, DDS. The Spenadel Award is given to an individual or organization that has contributed importantly to the advancement of dentistry. Dr. Andolino, an orthodontist on the Upper East Side of Manhattan, was recognized for his more than 30 years of international humanitarian efforts. Dr. Andolino is involved with programs that bring advanced medical, dental, and orthodontic concepts to developing countries. He is the co-founder and executive director of Kageno, a multifaceted non-profit community development project whose mission is to transform impoverished communities into “places of hope and opportunity.” Kageno, which means “a place of hope” in the Kenyan dialect, helps impoverished villages build schools, health centers, pharmacies, sanitation and clean water systems and to develop programs to help protect fragile environments in two locations in Kenya and one in Rwanda. Dr. Andolino’s passion for his volunteer work was evident as he explained why he became involved and how so many of his patients have supported his work. Dr. Andolino was named the 2016 ADA Humanitarian Award recipient. He is recognized for service to the dental profession by his induction to the American College of Dentists, the International College of Dentists, and the New York Academy.

In addition to three spectacular presentations, members approved and welcomed the slate of officers and directors to serve in 2018 with President James Jacobs: President-Elect Richard Lewenson, Vice President Luis Fujimoto, Secretary Lois Jackson and Treasurer Ioanna Mentzelopoulou (completing the second year of a two-year term); Directors-at-Large Mina Kim and Vera Tang, and Alternate Directors Michelle Lee and Layne Martin. The Society is changing its fiscal budget from a calendar year to a July 1–June 30 fiscal year to align with the GNYDM. A “stub year budget” from January to June 2018 was proposed and passed. Members approved changes proposed by the 2017 Bylaws Committee, chaired by Vice President Richard Lewenson, that streamlined our Bylaws. Dr. Robert Peracchia spoke about the importance of supporting NYSDA’s Empire Dental Political Action Committee (EDPAC), a bipartisan committee supporting policymakers dedicated to protecting the interests of dentistry and ensuring patient access to quality, affordable oral healthcare. Drs. Keren Etzion and Mina Kim spoke briefly about an exciting new program that is being developed to educate parents about early health oral intervention, which they hope to hold in partnership with the New York Public Library. Dr. Cooperman informed the membership that Dr. Roshani Patel and the Membership Committee are seeking mentors for a revamped mentoring program. Last, but not least, members were encouraged to participate in our largest community-outreach effort, Give Kids A Smile, on February 2, 2018. Special thanks to Medical Liability Mutual Insurance Company (MLMIC) for their generous support of this event.
James E. Jacobs, DMD, president, has been in private practice as a periodontist in midtown Manhattan for over 30 years. Dr. Jacobs graduated from Indiana University in 1975 and was inducted into the Phi Beta Kappa Society. He then graduated Fairleigh Dickinson Dental School in 1979 and was inducted into the national dental honor society, Omicron Kappa Upsilon and received his certificate in periodontics from the University of Pennsylvania School of Dental Medicine. Dr. Jacobs was a clinical assistant professor in periodontics at the University of Pennsylvania (1981–1985) and Columbia University (1988–92). Dr. Jacobs lectures frequently and he has been the dental editor for an internet medical website since 2006. Prior to his election as president Dr. Jacobs served as president-elect (2017) vice president (2016) and secretary (2015) of the Society. He has served on the Board of Directors since 2012 and was involved in a number of committees including Finance, Constitution and Bylaws, Nominating, and Ethics Committees. He has been a delegate to the NYSDA House of Delegates Meeting since 2013 and a delegate to the ADA House of Delegates from 2015–2017. Dr. Jacobs is a member of several other associations, including the American Academy of Periodontology, the Academy of Osseointegration, the Northeast Society of Periodontics and the Pierre Fauchard Academy.

Richard J. Lewenson, DDS, president-elect, is a retired general dentist who practiced in Manhattan for over forty years. Dr. Lewenson received his DDS from New York University College of Dentistry. He served as a lieutenant in the Navy for two years after graduation. Shortly after returning to civilian life he started his own dental practice. Dr. Lewenson was a dental consultant, serving as Tour Commander from 2001–2005, for the Office of the Chief Medical Examiner of the City of New York following 9/11. He was an assistant clinical professor in Prosthodontics at New York University College of Dentistry from 2008–2013. Prior to serving as vice president of the Society in 2017 and secretary in 2016, he served on several committees, including Finance and Legislative, and held several leadership posts with NYCDS, serving on the Board of Directors from 2002 - 2005, and again from 2014 to the present. He was on the Executive Committee in 2007 and 2008 as treasurer and secretary respectively. Dr. Lewenson was an alternate delegate to the ADA in 2016 and an ADA Delegate in 2017. Dr. Lewenson is a Fellow in the American College of Dentists and the New York Academy of Dentistry. He is also a long-time active volunteer with the Greater New York Dental Meeting.

(continued on page 7)
Luis J. Fujimoto, DMD, vice president, is a periodontist practicing in midtown Manhattan. Dr. Fujimoto is president of the American Association of Dental Boards Foundation and president-elect of the American Association of Dental Boards (AADB). Dr. Fujimoto served two terms as chair of the New York State Board of Dentistry for the New York State Department of Education. He is the past chair of the Joint Commission on National Dental Examinations for the American Dental Association. He is also the past chair of the Board of Trustees of the AADB Foundation. Dr. Fujimoto is the past president of the Osseointegration Foundation, the Northeastern Society of Periodontists and of the Eastern Dental Society. Dr. Fujimoto has served in many positions at NYCDS in addition to being secretary, and treasurer. He served two terms as a member of the Board of Directors (2009-2010, & 1999-2002), chair of the NYCDS Finance Committee (2015-2016), chair of the NYCDS/SDDS Joint Audit Committee for the GNYDM (2015), chair of the Program Committee, chair of the Henry Spenadel Award Committee, and chair of the Legislative Committee. He also served as delegate to the NYS-DA House of Delegates (2015-2017) and as an alternate delegate to the ADA House of Delegates (2015-2017 & 2001). He is the Recipient of multiple fellowships, the American Dental Association Golden Apple Award and the Leadership Award from the New York State Dental Association.

Lois A. Jackson, DDS, secretary, is a pediatric dentist with offices in lower Manhattan and Brooklyn. Dr. Jackson received her DDS and certificate in Pediatric Dentistry from Columbia University College of Dental Medicine. Dr. Jackson is an assistant clinical professor of Pediatric Dentistry and member of the Dean’s Advisory Board at Columbia University College of Dental Medicine. Dr. Jackson is a member of numerous dental societies including the Pierre Fauchard Society, Omicron Kappa Upsilon, the International College of Dentists, the American College of Dentists, and the American Academy of Pediatric Dentistry. Dr. Jackson served as a Trustee on the Board of the American Academy of Pediatric Dentistry. Dr. Jackson was chair of the New York State Board for Dentistry from 2014-2015. Dr. Jackson is the Outreach Chair of the Greater New York Dental Meeting. She is serving in 2017 as co-chair of the GNYDM Emerging Leaders Committee, chair of the GNYDM Pediatric Dental Summit, chair of New Dentist Program since 2013, and Troubleshooter since 2011. Dr. Jackson has a long history of involvement with NYCDS. Most recently she served as Continuing Education Director from 2016–2017. She served on the Board of Directors several times (2016-2017, 2006–2007, 1990–1997) and is chair of the Sesquicentennial Planning Committee (2017-2018). Dr. Jackson held other positions with NYCDS and has chaired numerous committees. She was as a NYSDA Delegate in 2017.

Ioanna Mentzelopoulou, DDS, treasurer, is a board certified pediatric dentist in private practice since 2002. Dr. Mentzelopoulou received her DDS degree from New York University College of Dentistry in 1999 and her certificate in pediatric dentistry from Interfaith Medical Center in 2002. Dr. Mentzelopoulou was active in the Second District Dental Society serving as a Board Member from 2003–2005, and as chair of the Second District’s New Dentist Committee from 2003–2009. She was a New York State representative to the ADA’s New Dentist Committee from 2005-2009. As part of her involvement with NYCDS she has served on the Member Benefits and the Children’s Dental Health Committees. She has served on the Give Kids A Smile Steering Committee since 2015. Dr. Mentzelopoulou served on the Board of Directors from 2014-2017. She was an alternate delegate to the ADA in 2016 and 2017. Dr. Mentzelopoulou is a Fellow in the American College of Dentists, and a member of the American Board of Pediatric Dentistry and the American Academy of Pediatric Dentistry. Dr. Mentzelopoulou is serving the second year of a two-year term as treasurer.
Critical Considerations for Immediate Implants
A Review of Concepts with Therapeutic Recommendations—Earn 1 CE Credit

Kara Kramer, DMD
Dr. Kramer maintains a private practice in periodontics and implant dentistry in Atlanta, GA.

Dale Rosenbach, DMD, MS
Diplomate of the American Board of Periodontology
Dr. Rosenbach is course director and clinical attending in periodontics and surgical implantology at Woodhull Medical and Mental Health Center.

Introduction
Immediate dental implant placement has become a popular alternative to conventional implant placement. If performed successfully, patients benefit from fewer surgical procedures and a faster permanent tooth solution. Historically, timing of implant placement has been controversial. Initially, it was recommended for the socket to heal for a period of 6-12 months prior to implant placement.1 With time, researchers have developed various schedules for earlier placement, including immediate (same day as extraction), early (within 4-8 weeks of extraction, allowing for soft tissue healing) and delayed (12-16 weeks following extraction, allowing for partial bony healing), assuming conditions permit.2

An abundance of literature supports the placement of immediate implants. Almost all studies report high survival rates of immediate implants from 92-100%.3 Although immediate placement has been widely endorsed in the literature, appropriate case selection is necessary. This review article will address eight critical considerations in immediate implant therapy.

Post-extraction ridge resorption
One purported advantage of immediate implants over conventional implants is maintenance of alveolar anatomy over extraction alone. Though resorption is expected following extraction, the evidence is compelling that immediate implants with socket grafting reduces horizontal bone loss.3,4 However, socket grafting alone with subsequent implant placement has been shown to achieve similarly favorable volumetric results. Furthermore, similar bone to implant contact has been observed histologically in immediate implants compared to conventional placement.5

A vertical loss of approximately 1mm can be expected whether the site is grafted alone or an immediate implant is placed in conjunction with a graft.6

However, if the socket does not possess adequate bone and requires more complex augmentation, immediate implants are often not indicated. Instead, site development is recommended to repair the volumetric defect so that implants can be placed with suitable position, angulation and depth.

Facial plate
The condition of the facial plate is a critical factor in treatment planning immediate implants. The presence of a full facial plate can provide ideal conditions for immediate placement. However, placement of an immediate implant in the presence of a partial facial plate is also acceptable if certain conditions are met, foremost of which is operator skill. With appropriate guided bone regeneration techniques and soft tissue management, predictable success can be observed. It should again be stressed that greater predictability lies within sockets that exhibit intact bony architecture. Sockets with significant facial plate deficiencies are at a higher risk for esthetic compromise, as loss of hard and soft tissue are likelier to occur potentially leading to exposure of the implant.7

The width of the facial plate is also a consideration. It has been asserted that a minimum of 2 mm of facial bone provides ideal circumstances for success. While this is often found in molar regions, it is uncommon to find such facial plate thickness in the esthetic zone. Among other rationales, this is why it is often recommended that immediate implants not be placed against the facial plate and that the ensuing gap between the implant and the facial plate be grafted.6

Management of the peri-implant gap
The aforementioned gap located between the implant and the facial plate affects both hard and soft tissue healing around an immediate implant. Grafting this area has been shown to promote optimal healing and preserve horizontal bone dimensions. While some studies have shown spontaneous healing without regenerative materials in gaps <2mm,8 the data strongly suggest grafting the gap whenever possible to avoid resorption.8

Soft tissue thickness
Tissue type can play a significant role in the decision to place an immediate implant. One study showed more recession in immediately placed than conventionally placed implants due to dimensional changes in socket healing.9 Patients with thin gingival biotypes are more likely to have recession at one year than patients with a thick gingival biotype in immediate implants.7 These tissue changes occur primarily during the first 6 months of healing and can become more pronounced over time.10

Placing implants too facially often contributes to a higher incidence of recession.6 Because implants can be more readily malpositioned too facially within an extraction socket, recession is a common finding at immediate implant sites. This
Therapeutic Recommendations

Bone deficiencies exist around a socket, tooth and not the implant. For papillae between teeth and implants is provided by the same way that it does to natural teeth, the structural support sue does not attach to implants and their components in the immediate implant placement. Because supracrestal soft tis

Anatomic limitations
To achieve primary stability in an extraction socket, the implant must engage either the apical or furcal bone or the surrounding walls. However, there are many sites where anatomic limitations restrict access to apical bone. In the posterior mandible, the mandibular canal and mental foramen can provide a formidable challenge and care must be taken to avoid these structures at all costs. A safe 2mm distance is recommended from these structures, and a CBCT is frequently recommended for proper identification.

Infected sites
Early recommendations were that infection be treated prior to implant placement to avoid peri-implantitis and implant failure. While acute periapical infection is generally seen as a contraindication to immediate implant placement, the preponderance of evidence demonstrates that chronically infected sites do not compromise the healing of immediate implants when managed judiciously. Multiple systematic reviews on this procedure emphasize the importance of meticulous debridement, antimicrobial irrigation and the use of systemic antibiotics.

It is common for chronic infections to cause compromise of the facial plate. As previously noted, this may lead to compromises during the healing process if not properly managed by intervention with soft tissue flap access and/or guided bone regeneration. In immediate extraction sites adjacent to chronically infected teeth, however, the presence of periapical radiolucencies on the adjacent teeth were found to increase immediate implant failure. Therefore, caution is advised when placing immediate implants in sites adjacent to suspicious untreated radiolucencies.

Periodontal disease
As in conventional implant placement, active periodontitis is generally a contraindication for immediate implant placement. The bacteria involved in peri-implantitis are the same as those involved in periodontitis, and failure to clear infections can contribute to compromised results.

Similar to deficiencies of the facial plate, proximal bone loss as a result of periodontitis or trauma is a challenge in immediate implant placement. Because supracrestal soft tissue does not attach to implants and their components in the same way that it does to natural teeth, the structural support for papillae between teeth and implants is provided by the tooth and not the implant. Additionally, when proximal bone deficiencies exist around a socket,

<table>
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<tr>
<th>Critical Consideration</th>
<th>Therapeutic Recommendations</th>
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<tbody>
<tr>
<td>1. Ridge resorption</td>
<td>- Grafting with or without immediate implant placement reduces horizontal bone loss</td>
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<td></td>
<td>- At sites where esthetics and ridge form are priorities, sockets should be grafted even if they are pontic sites</td>
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<tr>
<td>2. Facial plate</td>
<td>- Ideal sites exhibit thick, intact facial bone</td>
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<td>- Fixtures should be placed toward the palate and not in contact with thin facial plates</td>
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<td>- Implants can be placed with minor midfacial deficiencies, but grafting is indicated</td>
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<td>- With extensive midfacial deficiencies and those that involve interproximal bone, GBR is indicated followed by implant placement 4-6 months later</td>
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<td>3. Gap management</td>
<td>- Manage all peri-implant gaps with particulate graft material</td>
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<tr>
<td>4. Soft tissue thickness</td>
<td>- At sites with minimal soft tissue thickness, soft tissue augmentation techniques should be considered</td>
</tr>
<tr>
<td>5. Anatomic limitations</td>
<td>- The mandibular canal and its mental foramen are considered inviolable and should be avoided by a margin of safety using diagnostics, planning and drill stoppers, etc.</td>
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<tr>
<td></td>
<td>- Delay implant placement with socket grafting to avoid conditions where apical bone is necessary for stability but absent in sufficient quantities</td>
</tr>
<tr>
<td>6. Infected sites</td>
<td>- Immediates in sites with active pain and/ or swelling should be avoided</td>
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</table>
|                        | - Infected sites can be prepared for immediate placement with judicious use of chemomechanical debride-
|                        | ment |
| 7. Periodontal disease | - Active periodontal defects at or near immediate sites should be treated prior to implant placement |
| 8. Immediate loading    | - Single immediately loaded implants should be out of occlusion in centric, lateral excursions and protrusive |
|                        | - Multiple splinted immediately loaded implants can be in occlusion but stability must be substantial and cross-arch stabilization is strenuously recommended |

(continued on page 10)
regeneration of lost facial bone becomes more difficult. It is therefore of paramount importance to not only assess the periodontal condition of teeth slated for extraction, but also the teeth adjacent to the immediate socket.

**Immediate loading**
The timing of loading of immediate implants is controversial. Conventional loading is defined as waiting for a period of 3-6 months following placement, while immediate loading includes loading at the time of implant placement. In a systematic review, no statistically significant difference was found in terms of survival between conventionally loaded and immediately loaded implants. It is prudent to keep in mind, though, that the protocols for immediate loading insist on cross-arch stabilization or recommend that the restoration be free of contact in centric, lateral excursive and protrusive movements.

**Case 1:**
Apical fenestration evident at implant site #8. Intact nature of both hard and soft tissues at the coronal aspect of the socket led the clinician to decide on immediate implant placement. A submarginal incision was made on the facial to access the fenestration with minimal disturbance to both midfacial and interproximal marginal tissues.

**Conclusion**
The majority of advantages related to immediate implant placement can be realized with skillful socket grafting techniques followed by subsequent implant placement 4-6 months later. However, when the aforementioned considerations are properly monitored and managed, immediate implants can often provide comparable results with the added bonus of reducing the number of surgeries and the overall time needed for treatment to conclude.

(Photos courtesy of Dale Rosenbach, DMD, MS)
Case 2:
Apical fenestration evident at implant site #7. What was deemed as insufficient architecture for primary stability and too narrow a strap of bone at the midfacial margin led the clinician to decide on a delayed approach. A dPTFE (dense polytetrafluoroethylene, Cytoplast, Osteogenics Biomedical) membrane was used over particulate xenograft, followed by implant placement approximately 4 months later.

References:
Managing Sustainability in Dentistry

Date: July 23 – 24, 2018
Location: The Harpa Conference Centre in Reykjavík, Iceland

About the Conference
ASTM International, one of the world’s largest voluntary standards organizations, has published “Standard Practice for Managing Sustainability in Dentistry” to address the increasing desire of dental professionals to cost-effectively integrate sustainability into their organizations.

At this conference, leading experts in dentistry and sustainability will provide actionable guidance for applying this new standard and the ethic that drives it. Through presenting business case studies and by discussing diverse topics related to marketing, nutrition, and technology; attendees will gain the necessary tools to build organizations that have a greater positive impact environmentally, socially, and economically.

Book Early!
Registration is limited to 400 attendees.

Travel Note
Due to elevated tourism in Iceland during the month of July, advance reservations for hotel rooms and flights are highly encouraged.

Sponsored By
H.K. Allison projects for sustainability

For More Information/Register: hkasustainability.org/iceland2018
Immediate Implant CE Exam

Earn 1 CE Credit through the Henry Spenadel Continuing Education Program, an ADA CERP Recognized Provider, when you correctly answer seven or more of the following 10 questions. Please see below for details.

1. All of the following are true of immediate implants when compared with conventionally placed implants except:
   a. There is a similar amount of alveolar bone engaged by the immediate implant compared with those that are conventionally placed
   b. Conventional implant placement has higher success rates than immediately placed implants
   c. Immediate implant placement reduces treatment time compared with conventional placement
   d. Ideal implant position is the same in both conventionally and immediately placed implants

2. Which is an absolute contraindication for immediate implant placement?
   a. Presence of chronic infection at the site
   b. Requirement of soft or hard tissue development
   c. Presence of a fenestration in the facial plate
   d. Inability to achieve primary stability

3. Anatomic limitations such as the mandibular canal can provide a challenge to immediate implant placement. What “safe” distance is recommended to avoid damage to the mandibular canal?
   a. 1mm  
   b. 2mm
   c. 5mm  
   d. 10mm

4. According to the studies performed by Grunder and Tarnow, et al. cited in the article, papillae support adjacent to a single unit implant is achieved primarily from what structure?
   a. The adjacent tooth
   b. The abutment
   c. The restoration
   d. The coronal aspect of the implant

5. According to this article, what is the objective behind the recommendation to graft the peri-implant gap following immediate implant placement?
   a. To promote optimal healing of the bone surrounding the coronal portion of the implant
   b. To provide sufficient primary stability
   c. To prevent peri-implantitis by sealing off the middle and apical thirds to microorganisms
   d. To provide support for the papillae in case of an adjacent pontic

6. Which of the following is key for predictability in immediate implant therapy in an infected site?
   a. Sufficient debridement and irrigation of the surgical site
   b. Achieving primary closure of the soft tissue
   c. Prophylactic use of a steroid to offset inflammatory mediators
   d. Grafting the site with particulate graft material

7. Ideally, where does an anterior immediate implant typically engage to gain primary stability?
   a. Facially and the middle third
   b. Laterally and coronally
   c. Facially and apically
   d. Palatally and apically

8. An important concern related to gingival biotype in treatment planning immediate implants is
   a. Patients with thin biotypes are more likely to exhibit recession
   b. Patients with thick biotypes require immediate implants to be placed more apical
   c. The potential for implant failure is greater with patients with thick biotypes
   d. Biotype is of no consequence when treatment planning immediate implants

9. Which of the following has not been shown to contribute to an increased risk of recession on immediate implants?
   a. A thin facial plate
   b. Immediate loading
   c. A facially placed implant
   d. A thin gingival biotype

10. According to the article, why can the presence of active periodontitis pose a challenge to immediate implant placement?
    a. The microorganisms involved in periodontitis can contribute to peri-implantitis
    b. Insufficient debridement may result in compromise to the healing surgical site used for implants and/or grafting
    c. Bone loss due to periodontal disease at or near the implant site can contribute to surgical compromise
    d. All of the above

All those who achieve a passing grade of at least 70% will receive verification of completion. Credits will automatically be added to the CE Registry for NYSDA members. This at-home CE credit is available until December 31, 2018.

Name: 
Address: 
Address: 
Email: 

Please remit a check for $20 along with this page to NYCDS, 622 Third Ave., 9th Fl, NY, NY 10017
Part II: Access to Care

Q: What are the ethical considerations related to access to care?

A: The very first principle in the NYSDA Code of Ethics states: “The dentist’s primary professional obligation shall be service to the public.” The very first Advisory Opinion under that principle adds: “A dentist should strive to make her/his services accessible to all who are in need.” NYSDA members demonstrate on a daily basis that they take this ethical obligation seriously, frequently offering free dental care to many needy patients. Access to care is clearly at the forefront of ethical behavior for the profession.

Is a program like Mission of Mercy a good way of giving back or does it expose deficiencies in our present model of care for the poor? No charitable dental program should be criticized, because such programs involve volunteer dentists who are trying to do good for patients who might not otherwise receive any dental care. And it all relates back to that ethical obligation to strive to make care available to all who are in need. There are many ways to live up to that ethical obligation and many dentists do so in their private practices on a daily basis.

NYSDA, in a public-private partnership with the New York State Department of Health and a grant from the New York State Legislature, has pioneered a program of free dental care in communities throughout New York State at Article 28 facilities and Federally Qualified Health Centers. Particular focus has been on underserved rural communities and underserved populations. These smaller programs are repeatable and effective at placing patients with ongoing dental homes for regular dental care. They are part of the mix of charitable programs that can be used to provide access to care to needy patients. Rather than single out one model over another, dentistry in New York has met its access to care ethical obligations through a variety of charitable service programs to the public. This does not mean that the way government handles care for the poor is not without deficiencies, but those deficiencies would exist to an even greater extent if dentistry just sat on the sidelines and did nothing to reach out to underserved communities and populations.

Q: Should every dentist be mandated to treat Medicaid patients? Should dental therapists be allowed to treat this needy population?

A: Mandated charitable care in any field of work is not a popular idea and many of the people dentists serve through charitable care are not Medicaid patients. Medicaid was not originally designed to be a charitable care program. Like Medicare did for the elderly, Medicaid was meant to provide government insurance coverage for the needy. There was no starting premise that Medicaid fees for health care services should be reduced or deemed to be charitable in nature for either medicine, dentistry, or any other health care profession. However, over time, as government sought to cut its own costs, many government bureaucrats equated Medicaid with charitable motives and came to believe that health care providers should be willing to receive lower reimbursements for the benefit of needy Medicaid patients. But that attitude and premise, while seemingly sweetly benevolent, was never the foundation for the Medicaid program because it makes little economic sense and was financially unsustainable as a starting premise. Free dental services for everyone would be wonderful, but then there would be no dentists, or anyone else, to provide them to the public. Therefore, it really is a complete and inadvisable change of the foundation of the program to talk about mandated Medicaid participation for dentists at very low fees.

This problem is not solved by dental therapists. First, there is no reason to assume that dental therapists would find low fees and low income an attractive earnings option any more than any other provider of health care services would. Second, New York is not faced with a situation where people have a choice only between no care or cheaper care from a person with limited dental training. Access to care is not the same problem for New Yorkers as it is for people in states like Alaska, Maine, or Minnesota. Where dental therapists have arisen, it is exclusively in a very small number of vastly rural states where there are limited numbers of dentists per average square mile. Those kinds of geographic aberrations may require different solutions, but New York is not faced with that kind of dilemma. And, of course, there is always the argument that people in need should not be relegated to a lesser degree of care than a dentist could provide, but the reality is that in New York there really is no need for that argument. Nobody in New York has yet suggested that Medicaid patients should just have cheap care—and cheap care is not going to be any panacea for the many problems with Medicaid as a government insurance program.
The New York County Dental Society Welcomes Our Newest Members
August, September, October 2017

FULL ACTIVE MEMBERS
Irfan Asghar, DDS, M.D.S
225 Broadway
New York, NY 10007
UMDNJ
Endodontist

Mee Kyung Han, DMD
150 Broadway
New York, NY 10038
University of Pennsylvania
General Practitioner

Jennifer Jablow, DDS
120 East 56th Street
New York, NY 10022
New York University
General Practitioner

Herrick Lai, DDS
235 East 22nd Street
New York, NY 10010
New York University
General Practitioner

Joanna M. Pufnock, DDS
144 Chambers Street
New York, NY 10007
University of Buffalo
General Practitioner

Paolo Saggese, DMD
325 Broadway
New York, NY 10007
Temple University
General Practitioner

Tina Tong, DMD
30 East 40th Street
New York, NY 10016
Rutgers University
General Practitioner

GRADUATE STUDENT MEMBERS
Gregory Balaes, DMD
464 Stafford Avenue
Staten Island, NY 10312
Rutgers University
General Practitioner

Debbie Schub, DMD
20 East 46th Street
New York, NY 10017
University of Pennsylvania
General Practitioner

Alan J. Yee, DMD
664 Academy Street
New York, NY 10034
General Practitioner
Tufts University

ASSOCIATE MEMBERS
Anthony J. Attalienti, DDS
141 South Central Avenue
Hartford, CT 06105
New York University
General Practitioner

Ninth District Dental Society

Hernami Ajmera, DDS
425 Madison Avenue
New York, NY 10017
New York University
General Practitioner

Queens County Dental Society

Aaron Nagelblatt, DDS
1375 East 8th Street
Brooklyn, NY 11230
Columbia University
General Practitioner

Second District Dental Society

Transfered Members
Jessica Desouza, DDS
630 Fifth Avenue,
New York, NY 10111
SUNY Stony Brook
General Practitioner

John Heffernan, DDS
207 West 96th Street
New York, NY 10025
Virginia Dental Society

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Ninth District Dental Society

Marcelle Gharibe, DDS
135 West 27th Street
New York, NY 10001
University of Toronto
General Practitioner

Chicago Dental Society

Alice Golden, DDS
1760 Second Avenue
New York, NY 10128
New York University, 2016
General Practitioner

Second District Dental Society

Caitlynn Haas, DDS
515 Madison Avenue
New York, NY 10022
University of Michigan
General Practitioner

Illinois State Dental Society

Bradford McLaughlin, DDS
200 West 15th Street
New York, NY 10011
New York University
General Practitioner

Second District Dental Society

In Memoriam
Morton R. Brenner, DDS
University of Pennsylvania, 1946

Meyer Tendler, DDS
New York University College of Dentistry, 1945

CLASSIFIEDS
Members—Log onto www.nycdentalsociety.org to find additional classified ads. New online ads added regularly!

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www.dentaxsolutions.com

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Dentegra connects providers like you with stable, local patient populations that have attractive fee-for-service coverage.
For more information about Dentegra, call 866-238-1580 or email providerinfo@dentegra.com.
## Winter 2018 Continuing Education Program calendar

### January

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>9:00 AM – 1:00 PM</td>
<td>Risk Management Program</td>
<td>Frederick Wetzel, DDS</td>
</tr>
<tr>
<td>31</td>
<td>9:30 AM – 12:30 PM</td>
<td>Implant Restorative Planning</td>
<td>Isaac Hakimi, Streamline Dental Lab (new!)</td>
</tr>
</tbody>
</table>

### February

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3</td>
<td>Friday</td>
<td>Part 1, 12-Hour Sedation Certificate Renewal</td>
<td>Marc Gottlieb, DDS (new!)</td>
</tr>
<tr>
<td></td>
<td>9:00 AM – 5:30 PM</td>
<td>Part 2, 12-Hour Sedation Certificate Renewal</td>
<td>Marc Gottlieb, DDS</td>
</tr>
<tr>
<td>7</td>
<td>9:00 AM – 1:00 PM</td>
<td>Basic Life Support/CPR Certification Course</td>
<td>Marc Reilly, Rescue Resuscitation</td>
</tr>
<tr>
<td>9</td>
<td>9:30 AM – 12:30 PM</td>
<td>HIPAA Security Compliance</td>
<td>Kenneth Aschheim, DDS</td>
</tr>
<tr>
<td>14</td>
<td>9:30 AM – 12:30 PM</td>
<td>OSHA Compliance and Infection Control Made Easy</td>
<td>Lisa Miller, RDH (new!)</td>
</tr>
</tbody>
</table>

### March

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>8:30 AM – 4:30 PM</td>
<td>Speed Learning: 6 Speakers 6 Hours 6 Credits</td>
<td>6 new speakers (all new!)</td>
</tr>
<tr>
<td>9</td>
<td>9:30 AM – 12:30 PM</td>
<td>Demystifying Material Selection for All-Ceramic Restorations</td>
<td>Siamak Najafi, DDS (new!)</td>
</tr>
<tr>
<td>14</td>
<td>9:30 AM – 12:30 PM</td>
<td>My Patient Has Cancer, Now What? Dental Oncology 101</td>
<td>Lauren Levi, DMD (new!)</td>
</tr>
<tr>
<td>16</td>
<td>9:30 AM – 4:30 PM</td>
<td>Dentistry to Improve Overall Health for the Older Patient</td>
<td>Arnold Liebman, DDS (new!)</td>
</tr>
</tbody>
</table>

### April

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>9:30 AM – 12:30 PM</td>
<td>Pain Management and Restorative-Driven Endodontics</td>
<td>Marcus Johnson, DDS (new!)</td>
</tr>
<tr>
<td>18</td>
<td>9:30 AM – 4:30 PM</td>
<td>A Non-Orthodontic Approach to Restorative Dentistry</td>
<td>K. Michael Ghalili, DDS (new material!)</td>
</tr>
<tr>
<td>20</td>
<td>9:00 AM – 1:00 PM</td>
<td>Basic Life Support/CPR Certification Course</td>
<td>Marc Reilly, Rescue Resuscitation</td>
</tr>
<tr>
<td>22</td>
<td>9:30 AM – 4:30 PM</td>
<td>Advance Adhesive Dentistry &amp; The Supra-Gingival Protocol</td>
<td>Jose-Luis Ruiz, DDS (new Sunday course!)</td>
</tr>
</tbody>
</table>

*the dental team is encouraged to register

The Henry Spenadel Continuing Education Programs are held at our facility at 622 Third Avenue in midtown Manhattan.

Call the Education Staff at (212) 573-8500 for full program information and to register.