

SCOA PROCEEDINGS

JOURNAL OF THE SOUTHERN CALIFORNIA OROFACIAL ACADEMY



PRESIDENT'S MESSAGE

Bach Le DDS MD



I hope all of you are enjoying your summer. We have been through a difficult year and it's hard to believe it has already been over a year since the beginning of the pandemic. Most of our members' offices were temporarily closed as we navigated all of the significant changes brought on by the pandemic. Despite the difficulties, we have all adapted and are now returning to our normal routine. Throughout the difficulties of the past year, I am proud to see that the Academy continued to provide a meaningful platform for camaraderie and quality continuing education for our members. Thank you, members, for your continued participation and enthusiasm in our professional community, and thanks to our sponsors for your incredible support. Finally, I'd like to give a special shout-out of appreciation to our Board of Directors and to Susan Smith, our Executive Director, for their tireless work on behalf of the SCOA.

I was so happy to see many of you at our post-pandemic reopening on April 21 at the Hilton Pasadena. This may have been the first live meeting anywhere after all the virtual meetings during the past year. We adjusted to reduced seating, social distancing, wearing masks and fewer exhibit tables. At that time Los Angeles County had rapidly changed from red to orange and went to yellow a few days before our meeting.

I am pleased to announce that our fall meeting at the Hilton on Wednesday, October 20 will have all previous restrictions lifted by the Pasadena Health Department and LA County. We will have an excellent program, normal seating, and with our exhibit tables around the perimeter of the ballroom.

We look forward to welcoming eight presenters to our fall meeting. Dr Richard Miron from Advanced PRF Education is coming from Florida to present a two-hour workshop on PRF followed by a lecture on its history with recent advancements and formulations of platelet concentrates.

Dr Steven Sadowsky will join us from University of the Pacific Arthur A Dugoni School of Dentistry to present implant treatment for the edentulous patient. Dr Kyle Yip from The Ostrow School of Dentistry of USC will discuss the use of custom plates in OMS.

Dr Bart Silverman is from New York Medical College and NYU School of Dentistry and will present digital workflow in the OMS practice. Dr Jay Malmquist from Portland was on the faculty at Oregon Health & Science University. He will discuss collagen as it relates to implant reconstruction.

Dr Steve Ganzberg is a clinical professor of anesthesiology at the UCLA School of Dentistry. He will talk about the post-Covid patient. Drs Bob Huntington and Jack Lytle will share the history of oral surgeons and societies in Southern California.

Please join us on Wednesday, October 20 at the Hilton Pasadena for an exceptional program and a chance to visit with old and new SCOA members.

SCOA 19th Annual Fall Scientific Meeting Wednesday October 20 at the Hilton Pasadena

Presenters

Richard Miron DDS BMSC MSc PhD
Bart Silverman DMD
Steven Sadowsky DDS
Steve Ganzberg DMD MS
Jay Malmquist DMD
Kyle Yip DDS MD
Bob Huntington DDS & Jack Lytle DDS MD

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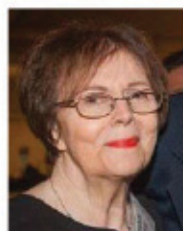
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NEWS FROM SUSAN



So many things have changed. Sales and catering managers I have worked with for many years were furloughed early in 2020 and most have not returned. I have new contacts at all my hotels and have no complaints as they are very efficient.

Most of our members who attended the SCOA Fall 2020 virtual meeting said they wanted to return to live meetings. So that's what we did.

We have invited the United States Navy officers from San Diego back to attend our fall meeting. We always appreciate our own United States Army Reserve officer COL Rick Berrios DDS.

Please let us know if you have topics or presenters you would like for us to invite to speak at our meetings. I will forward your suggestions to the SCOA program committee: Drs Dave Cummings, David Gilbert, Bach Le and Baldwin Marchack.

Our regular sponsors have registered to exhibit on October 20. As you know, we could not put on our CE meetings without the support of these dedicated companies and reps. Please review our sponsor ads to see new products and services and the companies that will exhibit at our fall meeting. Contact information for these reps is on our website

I want to introduce you to my new consultant. Brent Jaworski is experienced with website design and social media marketing. He will also help me with email communication. Brent is available to our members and sponsors when you need assistance with your websites and marketing.

I hope to see you October 20 at the Hilton Pasadena.



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OUR PRESENTERS ON WEDNESDAY OCTOBER 20, 2021



Richard Miron DDS BMSC MSc PhD; Understanding Platelet Rich Fibrin. Dr Miron is lead educator and researcher at Advanced PRF Education and an Adjunct Visiting Faculty in the department of Periodontology in Bern, Switzerland where he completed his PhD studies since 2009. He has published over 300 peer-reviewed articles and lectures internationally on many topics relating to growth factors, bone biomaterials and guided bone regeneration. He is the top ranked researcher on Platelet-Rich Fibrin therapy as per Expertscape independent review.



Steven Sadowsky DDS; Implant Treatment Planning for the Edentulous Patient. Dr Sadowsky is professor and director of implant education at the University of the Pacific Arthur A Dugoni School of Dentistry. He is past president of the American Prosthodontic Society and the Pacific Coast Society for Prosthodontics. He has directed the American College of Prosthodontists (ACP) Annual Review Course for five years. He is Abstract Editor of the International Journal of Prosthodontics and has been appointed to the Editorial Council of the Journal of Prosthetic Dentistry.



Jay Malmquist DMD; Collagen as it Relates to Implant Reconstruction; Dr Malmquist is a graduate of the University of Oregon and the University of Oregon Dental School. He completed a rotating internship in the US Army and a residency in Oral and Maxillofacial Surgery at Oregon Health & Science University. He is a diplomate of the American Board of Oral and Maxillofacial Surgery and past Treasurer and President of the American Association of Oral and Maxillofacial Surgeons. He has authored chapters on implant surgery and has written articles on bone grafting and tissue regeneration.



Bart Silverman DMD; Digital Workflow in an OMS Referral Based Practice; Dr Silverman received his Doctorate in Dental Medicine from Fairleigh Dickinson Jr School of Dentistry. He completed his Oral and Maxillofacial residency at Westchester County Medical Center. He is an attending physician at Westchester County Medical Center Department of Oral and Maxillofacial Surgery, Clinical Associate Professor at New York Medical College, Adjunct Clinical Associate Professor, Department of Oral and Maxillofacial Surgery at New York University School of Dentistry



Steve Ganzberg DMD MS; The Post-Covid Patient. Dr Ganzberg is a Clinical Professor of Anesthesiology at the UCLA School of Dentistry with over 25 years of experience in pain management. He graduated from MIT and the University of Pennsylvania School of Dental Medicine; pain management training at NYU; anesthesiology training and Master's degree at The Ohio State University. He is a Diplomate of the American Dental Board of Anesthesiology and the American Board of Orofacial Pain. Dr Ganzberg was on the faculty at OSU for 17 years.



Kyle Yip DDS MS MD; The Use of Custom Plates in Oral and Maxillofacial Surgery. Dr Yip received BS, MS, and DDS degrees from UCLA followed by Oral and Maxillofacial residency training at USC. During his residency Dr Yip completed his MD degree at the Keck School of Medicine of USC, and a general surgery internship at the LAC/USC Medical Center. Upon completion of his training, Dr Yip is a full-time Clinical Assistant Professor at USC where he is Chief of Oral and Maxillofacial Surgery at the LAC/USC Medical Center.



Jack Lytle DDS MD and Bob Huntington DDS; OMS in Southern California – Past, Present and Future. Dr Huntington was the third president and a founder of SCOA. Dr Lytle was the fourth president and a founder of SCOA. They are well-known and respected for their past achievements and illustrious careers. Drs Huntington and Lytle were active members and both served as president of the previous Southern California Society of Oral and Maxillofacial Surgeons.

**SCOA 19TH ANNUAL FALL SCIENTIFIC MEETING
WEDNESDAY OCTOBER 20, 2021 • LIVE AT THE HILTON PASADENA**



Pre-Meeting PRF Hands-On Workshop 7:00 to 9:00 California Ballroom
Main Program 8:30 to 5:00 International Ballroom

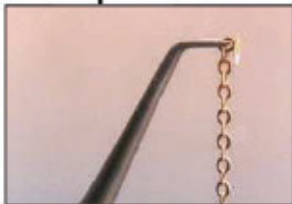
6:00 to 7:00	Setup	SCOA Staff and Reps
7:00 to 8:30	Sign In	Continental Breakfast/Visit with Exhibitors
7:00 to 9:00	Pre-Meeting	Richard Miron DDS BMSC MSc PhD <i>PRF Hands-On Workshop</i> Limited to 16 Must be Registered
8:30 to 9:00	Welcome	SCOA President Bach Le DDS MD/Introductions
9:00 to 10:00	Session I	Richard Miron DDS BMSC MSc PhD <i>Understanding Platelet Rich Fibrin</i>
10:00 to 11:00	Session II	Bart Silverman DMD <i>Digital Workflow in an OMS Referral Based Practice</i>
11:00 to 11:30	Break	Exhibitor Introductions/Visit with Exhibitors
11:30 to 12:30	Session III	Steven Sadowsky DDS <i>Implant Treatment Planning for the Edentulous Patient</i>
12:30 to 1:00	Lunch	California Dentists' Guild Meeting in California Ballroom
1:00 to 2:00	Session IV	Steve Ganzberg DMD MS <i>The Post-Covid Patient</i>
2:00 to 2:30	Break	Visit with Exhibitors
2:30 TO 3:30	Session V	Jay Malmquist DMD <i>Collagen and Collagen Barriers for Regeneration: An Update for the Clinician</i>
3:30 to 4:00	Break	Visit with Exhibitors
4:00 to 5:00	Session VI	Kyle Yip DDS MS MD <i>The Use of Custom Plates in Oral and Maxillofacial Surgery</i> Bob Huntington DDS and Jack Lytle DDS MD <i>OMS in Southern California – Past Present and Future</i>
5:00 to 6:00	Reception	Cocktails and Hors d'oeuvres



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How an Effective Team Leader with an Effective Team Makes Effective Decisions

Roberta Ashley CRNA EdD CHSE



Our first thought for the day: “The frontiers do not lie north, south, east or west, but whenever a human confronts a fact.”

In our previous article we discussed just what characteristics constitute a team leader; and in 15 years of running crisis simulations in our simulation center, my very informal observations support my peers in that the team leader is not always the oral surgeon or even the most senior resident. This becomes even more apparent when I am running an escape room scenario.

Decision making is without a doubt one of the most complex areas of team leadership and one of the most critical skills a team leader can possess. Teams perform best when decisions are made with the input of all involved, are clearly communicated and understood, and when the decisions made by the team leader are accepted by its members. One of the strongest benchmarks of high-functioning teams lies here, i.e., how well members provide input to the team leader and how comfortable the team members are with the team leader’s decision. Poorly functioning teams will display a level of competitive activity which all too often results in resentment from the members. You’ve probably experienced this yourself. Have you ever been in a situation where you perceived your input as ignored, dismissed, trivialized, or belittled? Yes, you say. How well did that end up for the team, and the patient? Or, if the team leader *commands* as opposed to *leads*, members will focus on the *who* as opposed to the *what*, and will either shut down completely, subvert the commander, or turn against one another. This places the patient in real danger, as you might imagine.

So, what does Crisis Resource Management science tell us about the decision-making abilities of high functioning team leaders? Basically, the keys involve the leader’s abilities to identify the problem, obtain commitment from team members, state the plan, and be mindful of continual feedback and adjustments as needed. Let’s start with identifying the problem.

Identifying the problem comes from communication of the problem (from any team member or any other source), soliciting input from other sources, and mentally pausing to think beyond the obvious alternatives. Confirmation biases are a real and present threat if the leader is not acutely aware of them. Battling confirmation bias tendencies takes not only awareness but also some training. Seek this out *before* you need it.

Obtaining commitment requires people skills. Be mindful about how you come across to others, especially if it’s a team which doesn’t work together on a regular basis. Remember to be a leader, not a commander. If you have an emergency manual in your office, besides calling for help, send someone to get it or open it.

State the plan. This may sound like a no-brainer but sadly it is not. Start by making your plan known to your team. Call out your diagnosis and have someone write it down. Open your emergency manual and start from there. Just keep in mind that the emergency manual alone is not enough to save you. Medicine, like aviation, is highly complex, dynamic and sometimes unpredictable; many times, situations can require dozens of decisions that all too often are both technical and relational, such as for example you are dealing with a situation of bronchospasm and/or anaphylaxis. These situations overlap, can become very dynamic and several things can happen at once, and performing one intervention can trigger either an entirely new set of problems which can very rapidly require three more decisions. Sound familiar? Compound this with communication problems and you can have a veritable perfect storm which can quickly go from bad to worse. Revise your diagnosis as needed. As you know, diagnosing is not always a simple or precise science. You and your team will need a strong relationship based on trust and an attitude of doing what is best for the patient in order to be successful.

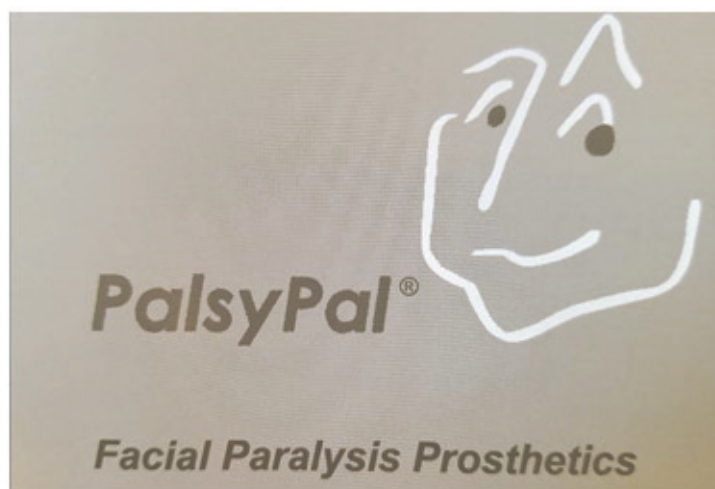
What about “membership” and “followership?”

Think about a lot of television shows and movies you watched as a young person. We have throughout our entire lives been socialized to view leadership as a linear, top down, one way function whose primary function is getting things done. We need to scrap that stereotype if we wish to be effective team leaders

who can make effective decisions when things do not go as planned. Plus, of what use is a leader if there are no followers? Even the finest ship cannot sail without sailors.

Keep this in mind as it is a key concept. The process of transitioning from a dysfunctional toxic hierarchy to a true team is neither simple nor smooth. What our popular culture has taught us about leadership, especially medical leadership, is not only wrong; it is dangerous. Patients pay the price when we continue to stubbornly operate on what we think we know about effective traditional leadership. Learning an entirely new set of role parameters and behaviors takes training and practice; and trust among team members takes some very intense and courageous training and looking in the mirror. Nevertheless, this process is critical: and as I always say, it's better to learn these things in the simulation center than in the courtroom. Teaching yourself how to listen while teaching your team members to speak up is a process indeed. Recall the case of the USC OB/GYN George Tyndall. His inappropriate behaviors towards patients were known about and joked about by nursing for years before one nurse finally spoke up. While this is an extreme example, dental assistants have always believed, and some have been selected, to be deferential and not speak up to their employer. This has led to patient deaths, tragedies and legislative action, as you may recall.

Next: Leadership: Fostering a Work Culture of Inquiry, Advocacy, Assertion and Conflict Resolution.



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When Patient Phobias Turn into Medical Emergencies

Laura M. Cascella, MA, CPHRM*



Patient anxiety or fear related to medical or dental treatment can be problematic and concerning in various ways. These fears may manifest as nonadherence to treatment protocols or appointments schedules, behavioral issues, or — in extreme cases — medical emergencies. The case studies below offer two examples of how patient anxiety and fear contributed to medical emergencies.

Case Example 1

A patient who had an extreme phobia of dental care was diagnosed with generalized periodontitis and agreed to a treatment plan of root planing, chemotherapy, and aggressive maintenance. The night before the patient's appointment, she took 10 mg of diazepam, which the periodontist prescribed. The morning of the patient's appointment, she ate breakfast and inhaled a moderate amount of cannabis on her way to the appointment to try to relax.

Because of the patient's anxiety, she was offered the option of having the procedure done using nitrous oxide analgesia. Unfortunately, the practice had no nitrous oxide protocol in place. Thus, few questions were asked about the patient's recent ingestion of food or other substances. Prior to starting the procedure, the patient's nitrous oxide level was increased twice due to her anxiety. Shortly into the procedure, the patient vomited, aspirated some of her vomitus, and lost consciousness.

Emergency medical services was called; while awaiting their arrival, the doctor tried to establish an airway but was unsuccessful. Despite attempted resuscitation at the scene and the hospital, the patient died.

Case Example 2

A patient who had broken his wrist in a motorcycle accident presented to an ambulatory surgery center for repair of the fracture. The patient, who was visibly anxious upon arrival, was seated in the waiting area to fill out forms. Once the patient completed the forms, he was instructed to remain in the reception area until called. More than 40 minutes went by, with the patient becoming increasingly nervous. Eventually the patient was moved into the preoperative area, where a nurse attempted to place an intravenous (IV) line. After several unsuccessful attempts, the nurse commented that the anesthesiologist "might have to go through the foot," and then abruptly left the area.

The patient, who was already sweating and jittery due to his anxiety, began to panic upon hearing how they might insert the IV line. He stood up from the bed and began to pace, complaining that he felt short of breath. Although his wife — who was in the preoperative area with him — tried to calm him and get him to return to the bed, the patient continued to wander around the area. A few seconds later, the patient fainted, falling and hitting his head on a medical cart and then the floor. Emergency medical services was called, and the patient was transported to the hospital where he was treated for a concussion and edema.

Risk Management Strategies for Phobic Patients

When developing policies for managing anxious or phobic patients, healthcare providers and organizations may want to consider establishing:¹

- Protocols for premedication (e.g., providing sedation the night prior to surgery or treatment), with clear and specific instructions about when and how the patient should use the medication as well as any potential risks

- Policies related to appointment scheduling and treatment duration (e.g., scheduling phobic patients in the morning to reduce compounding apprehension, or splitting lengthy procedures into shorter sessions when possible)
- Strategies for minimizing the time patients spend in the reception or pretreatment areas (e.g., asking patients to fill out forms prior to their appointments to reduce waiting time)
- Requirements for monitoring patients' vital signs (e.g., establishing baseline measurements at a visit prior to the surgery or procedure, which providers and staff can compare with perioperative measurements)
- Protocols for sedation during treatment and pain management during and after the surgery or procedure

In addition to office protocols and administrative considerations, healthcare providers also can implement other risk-reduction strategies for working with anxious or phobic patients, such as:²

- Developing open lines of communication with patients through active listening and attentiveness
- Explaining to the patient in advance what to expect and what steps will be taken as part of treatment
- Expressing empathy and reassurance (e.g., reassuring the patient that he/she is not alone in feeling anxious or fearful)
- Fostering positive nonverbal communication (e.g., through eye contact and comforting gestures)
- Using behavioral or relaxation techniques to reduce patient anxiety (e.g., the show-tell-do technique)
- Introducing distractions to help divert the patient's attention (e.g., pleasant background music and short breaks from treatment)
- Offering environmental accommodations (e.g., lowering or raising the temperature in the operatory to the patient's liking or providing the patient with a blanket)

Even with the utilization of these strategies and techniques, some patients might still suffer from medical or dental treatment phobia. For patients who are extremely anxious or fearful, a referral to a mental health professional for evaluation and treatment might be beneficial.

**Certified Professional in Health Care Risk Management*

Endnotes

¹ Malamed, S. F. (2010). Knowing your patients. *Journal of the American Dental Association*, 141(Suppl 1), 3S–7S.

² Appukuttan, D. P. (2016, March). Strategies to manage patients with dental anxiety and dental phobia: literature review. *Clinical, Cosmetic and Investigational Dentistry*, 8, 35–50. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC4790493/; McMaster, R., & Garristo, G. A. (2012, February). Practical considerations for treating the anxious dental patient. Oral Health Group. Retrieved from www.oralhealthgroup.com/features/practical-considerations-for-treating-the-anxious-dental-patient/

Note from Susan: I will send links to a **Claims Data Report** and an article on **Avoiding Risks in Dental Practice** from MedProGroup to all members following publication of this issue. These documents will also be posted on our SCOA website www.socalorofacial.org.



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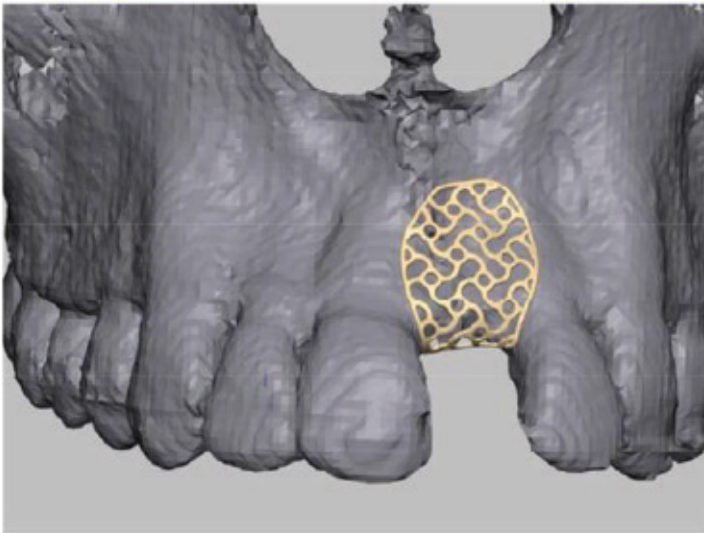
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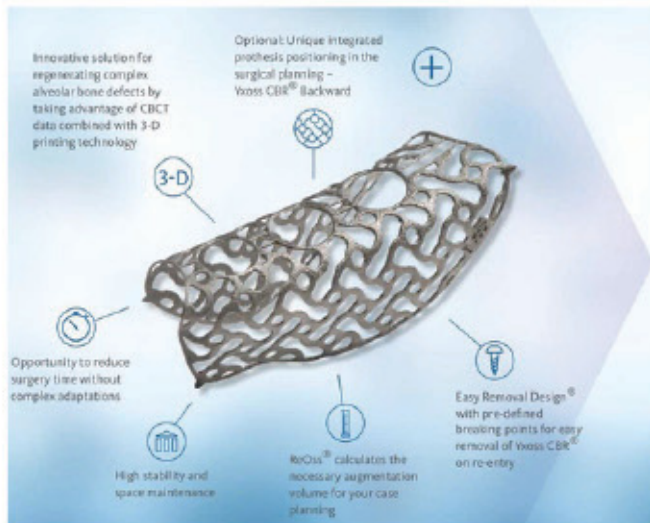
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Surgical Antibiotic Prophylaxis – Should We Premedicate for Every Implant Procedure? David Cummings DDS



As Oral and Maxillofacial Surgeons we need to make difficult decisions every day for our patients. These decisions can be potentially life threatening and we make them based on what we feel will provide the best outcome for each of our individual patients. There are risks with all surgical procedures and there are risks with antibiotic prophylaxis. How do we know when to premedicate and when not to? Should we premedicate every patient for every implant that we place? Is it necessary? What is the chance of my patient having an anaphylactic reaction to something I have prescribed? These and many more questions are issues that go through our minds every day as we treat our patients.

In the United States alone surgical site infections contribute an additional cost of \$10 billion dollars per year. (1) Surgical site infections are caused by bacteria that enter through incisions made during surgery. (2) According to the CDC the incidence of surgical site infection in the US is approximately 2.8%. (3) Surgical site infection prevention is defined as the prevention of infectious complications by administering an effective antimicrobial agent prior to exposure to contamination during surgery. (4)

Why should we consider antibiotic prophylaxis for every dental implant procedure that we perform? Bacterial colonization of the implant surface and surgical site infection have been implicated in early implant failure. (5) Implant failures will occur but anything we can do to minimize this risk is something that each clinician should consider. In 2015 the European Academy of Osseointegration put out a summary and consensus statement on this topic. Their conclusions were that in “straightforward” cases antibiotic prophylaxis has not been shown to have a beneficial effect and in “complex” cases (grafting, immediate implant placement and/or a compromised patient) a beneficial effect of antibiotic prophylaxis cannot be excluded. (6) In 2008, Abu-Ta performed a prospective randomized controlled clinical trial where he premedicated with 1 g of Amoxicillin and 500 mg of Amoxicillin qid for two days post op. He showed that antibiotics do not provide significant advantages concerning postoperative infections where proper asepsis was maintained. The incidence of implant failure was 4%. (7) An older study by Gynther reported no significant difference with incidence of infections when comparing 790 implants with an antibiotic prophylaxis vs no antibiotic prophylaxis. His conclusion was it appears that antibiotic prophylaxis for routine dental implant surgery offers no advantage for the patient. (8)

On the contrary, Nolan performed a double blind random controlled clinical trial where he found an 18% increase in implant survival with patients being premedicated with 3 g of Amoxicillin and no postoperative antibiotics. The incidence of implant failure was 17.8% (9) Esposito has probably published the most on this topic. He performed two multicenter placebo-controlled randomized clinical trials and completed a Cochrane Database meta-analysis review. In both of his randomized clinical trials he found no statistical difference comparing an antibiotic premedication vs a placebo. All of the patients did perform a preoperative rinse with Chlorhexidine and then 2 g of Amoxicillin one hour prior to the procedure. No postoperative antibiotics were given but patients were asked to continue with the Chlorhexidine rinses for one week postoperatively. The control group did perform a preoperative rinse with Chlorhexidine and postoperatively for one week also. The first trial had a total of 330 patients and the second was performed because the author felt there needed to be a larger sample size. The second trial had a total of 706 patients and the protocol was exactly the same. The results for both showed no statistical difference but both showed 2-4 times the number of implant failures in the group without the antibiotic prophylaxis. The incidence of implant failure for both of these articles was 5.1% and 4.7% respectively. (10,11) Esposito further went on and performed a meta-analysis and published the results in the Cochrane Database of systematic reviews. In this review he states that scientific evidence suggests in general, that antibiotics are beneficial for reducing failure of dental implants placed in ordinary conditions. Specifically, 2 or 3 g of Amoxicillin given orally, as a single administration, one hour preoperatively, significantly reduces failure of dental implants. No significant adverse events were reported. It might be sensible to suggest the use of a single dose of 2 g prophylactic Amoxicillin prior to dental implant placement. It is still unknown whether postoperative antibiotics are beneficial, and which antibiotic is the most effective. (12) Two recent meta-

analyses showed a reduction in failed implants. Cannullo showed a 5.4% reduction in failed implants and Sanchez showed a 1.9% reduction. (13,14)

In an older study, Dent performed a comprehensive prospective multidisciplinary study with a large number of implants (2641) so in my opinion this is a really good sample size. None of these patients in the study used a pre and/or postoperative rinse of their mouths with Chlorhexidine. They had 2.6% failure without antibiotics and 1.3% with antibiotics. His analysis revealed a higher implant failure rate when antibiotics were not given. (15) In all the previous studies (7,9,10,11,12) all the patients underwent a pre and/or post-operative rinse of their mouths with Chlorhexidine so this obviously could have an effect on the outcome of incidence of postoperative infections. Veklsler showed that the salivary bacterial load was reduced by 97% when patients rinsed with Chlorhexidine for 30 seconds, expectorated and rinsed again with Chlorhexidine for an additional 30 seconds. This reduction in bacterial loads persisted for 60 minutes. (16) To me this makes the Dent study even more accurate since his patients did not rinse with the Chlorhexidine and this could have changed the environment.

If we choose to premedicate for the implant surgical procedures then choosing an antibiotic that will be effective against the most common bacteria is very important. These bacteria include aerobic streptococci, anaerobic gram-positive cocci and anaerobic gram-negative rods. (9) Taking these guidelines into consideration, Penicillin is the first choice of antimicrobial for prophylaxis in dental implant surgery. (17) There are no clear guidelines on the correct choice of antibiotic, dosage or duration. (9) So, what is the best antibiotic for premedication of implants? It is most interesting to note from our medical colleagues that surgical antibiotic prophylaxis is very well documented and there does not appear to be any confusion in terms of protocols. Our local hospital has a set protocol based on an algorithm developed by MD Anderson at the University of Texas. For head and neck surgeries, if the surgical site is considered clean then the patients are given 2 g of IV Cefazolin for patients weighing < 120 kg and 3 g if the weight of the patient is > 120 kg. For clean contaminated surgical sites, the protocol is IV Ampicillin and Sulbactam 3 g. (18) Most of the studies (7,9,10,11,12) have used Amoxicillin for their antibiotic of choice based on the microbacteria involved with dental implant surgery but Lindeboom compared 2 g of Penicillin to 600 mg of Clindamycin as a single preoperative dose in patients treated with block grafts without implant placement. He found no statistical differences in postoperative infections between these two antibiotics. (19) Most surgical antibiotic prophylaxis regimens are based on the American Heart Association guidelines for the prevention of bacterial endocarditis. (9) (Figure 1) Based on the articles (7,9,10,11,12) presented here Amoxicillin appears to be the antibiotic of choice.

Figure 1. Antibiotic Regimens for a Dental Procedure Protocol: Single Dose 30 to 60 Minutes Before Procedure

Situation	Agent	Adults	Children
Oral	Amoxicillin	2 g	50 mg/kg
Unable to take oral medication	Ampicillin OR Cefazolin or Ceftriaxone	2 g IM or IV	50 mg/kg IM or IV
		1 g IM or IV	50 mg/kg IM or IV
Allergic to Penicillin or Ampicillin-oral	Cephalexin* OR Azithromycin or Clarithromycin OR Doxycycline	2 g	50 mg/kg
		500 mg 100 mg	15 mg/kg <45 kg, 4.4 mg/kg >45 kg, 100 mg
Allergic to Penicillin or Ampicillin and unable to take oral medication	Cefazolin or Ceftriaxone†	1 g IM or IV	50 mg/kg IM or IV

*Clindamycin is no longer recommended for antibiotic prophylaxis for a dental procedure. IM indicates intramuscular; and IV, intravenous. *Or other first- or second-generation oral Cephalosporin in equivalent adult or pediatric dosing. †Cephalosporins should not be used in an individual with a history of anaphylaxis, Angioedema or urticaria with Penicillin or Ampicillin.

If we decide to premedicate, what is the best surgical protocol? Deeb surveyed the American Association of Oral and Maxillofacial surgeons in 2015 on the use of routine antibiotic prophylaxis in conjunction with dental implant placement. The results of the survey showed 25 different preoperative antibiotic regimens. The most common regimen was 2 g of Amoxicillin preoperatively and no postoperative antibiotics. There were no specific recommendations for a specific antibiotic or protocol but he suggested the need for a large scale randomized controlled trial. (20) A similar survey was performed in the United Kingdom and it showed similar results. There was no consensus on a set choice of antibiotic prophylaxis for routine implant placement in the UK. Interestingly in that survey more than 21% of the respondents said they prescribed antibiotics for routine dental implant procedures because of fear of litigation. (21)

Again, most surgical antibiotic prophylaxis regimens for dental implants are based on the American Heart Association (AHA) guidelines (Figure 1) for the prevention of bacterial endocarditis. (9) In 1955 the AHA developed its first protocol for patients with bacterial endocarditis undergoing dental procedures. At that time the recommendation was for patients with congenital or rheumatic heart disease to receive 600,000 IU of Penicillin intramuscularly if undergoing dental extractions and po Penicillin for five days postoperatively. (22) Over the years there have been many updates since then including the change in 1990 from Penicillin to Amoxicillin due to its more favorable pharmacokinetic and pharmacodynamic characteristics. (23) In 1998 the American Heart Association changed their recommendations for premedication regarding postoperative antibiotics for bacterial endocarditis. They still included a preoperative dose of Amoxicillin but eliminated the postoperative dosing regimen. (23) In 2006 Fonseca followed 12,299 patients during their hospital stay for surgical site infections. All types of surgeries were included and they had 6140 patients receive only one dose of Cefazolin and the other 6159 had multiple doses of antibiotics. They found that the rate of surgical site infections went from 2% to 2.1% which was not statistically significant. They concluded that by only using a single dose antibiotic that there was no change in the incidence of surgical site infections and that it saved their hospital an average of \$1980 per day. (24) The old saying that "less is better" may be prudent for antibiotic prophylaxis for dental implant therapy also. Based on the studies included in this article, the most common protocol was Amoxicillin 2 g one hour prior to the procedure with no postoperative antibiotic dosing. (7,9,10,11,12)

As a side note the AHA literally has just made changes to the SBE prophylaxis for dental procedures (Figure 1). Amoxicillin is still the recommended antibiotic of choice but if the patient is allergic to Penicillin, then the new recommendations are to use Cephalexin 2 g po, Azithromycin 500 mg po, or Doxycycline 100 mg po 30-60 minutes prior to the procedure as an alternative. They have removed Clindamycin as a recommendation for someone who is allergic to Penicillin. (25)

If you decide to premedicate for any Oral and Maxillofacial procedure there are inherent risks. Risks of antibiotics are usually minor nausea, vomiting, diarrhea, urticaria but more serious adverse events can occur including pseudomembranous colitis and fatal anaphylaxis. The incidence of antibiotic-associated diarrhea ranges from 5% to 39% and pseudomembranous colitis complicates 10% of the cases of antibiotic-associated diarrhea. (26) Antibiotics such as Clindamycin and second or third-generation Cephalosporins are most consistently implicated with pseudomembranous colitis. (27) In 2003 a study by Rao was performed comparing the incidence of clostridium difficile antibiotic-related diarrhea in hospitalized patients with Levofloxacin versus Amoxicillin. There was no significant difference between Levofloxacin and Amoxicillin groups in the incidence of clostridium difficile antibiotic related diarrhea. (28) There are approximately 29,000 deaths per year in the United States due to pseudomembranous colitis. (29) The current population of the United States is 328 million so that means the annual incidence of fatalities annually from pseudomembranous colitis is 0.008%.

Life-threatening anaphylaxis is always a concern with any surgical antibiotic prophylaxis protocol. Anaphylaxis accounts for 500 deaths in the United States per year and drug allergy is the most common cause. (28) The estimated incidence of allergy to Amoxicillin ranges from 1-10%. These ranges cannot be interrupted with full confidence since not all allergic reactions are properly diagnosed. (30) The risk of fatal anaphylaxis with Amoxicillin is not well documented but the risk of fatal anaphylaxis with Penicillin is estimated to be 1:100,000 or 0.001% per year in the United States. (31)

There are many risks associated with antibiotic prophylaxis and we as healthcare professionals must ensure that the benefit of preventing complications outweighs the risk related to an abundant prescribing of antibiotics. When we make a decision to premedicate with antibiotics for routine dental implants, we all must answer the question of what is the likelihood of my patient having a fatal anaphylactic reaction versus my implant failing. (Figure 2 and Figure 3). When looking at the incidence of both of these concerns the percentages are very low. Albertsson performed a retrospective study in 2016 on 10,906 implants and revealed an early failure rate of 6.36%. (32) The early implant failure rate in the articles that are presented here are 4%, 4.7%, 5.1% and 6.36% respectively. (7,10,11,30) The incidence of fatal antibiotic anaphylaxis is 0.001% for Penicillin.

Again, as Oral and Maxillofacial Surgeons we have to make difficult decisions for our patients every day based on the risk-benefit ratio. Each surgeon is entitled to his/her own opinion but in my mind based on the percentages presented here, the risks of premeditating for routine dental implants outweigh the risks of losing a dental implant without antibiotic prophylaxis.



Figure 2



Figure 3

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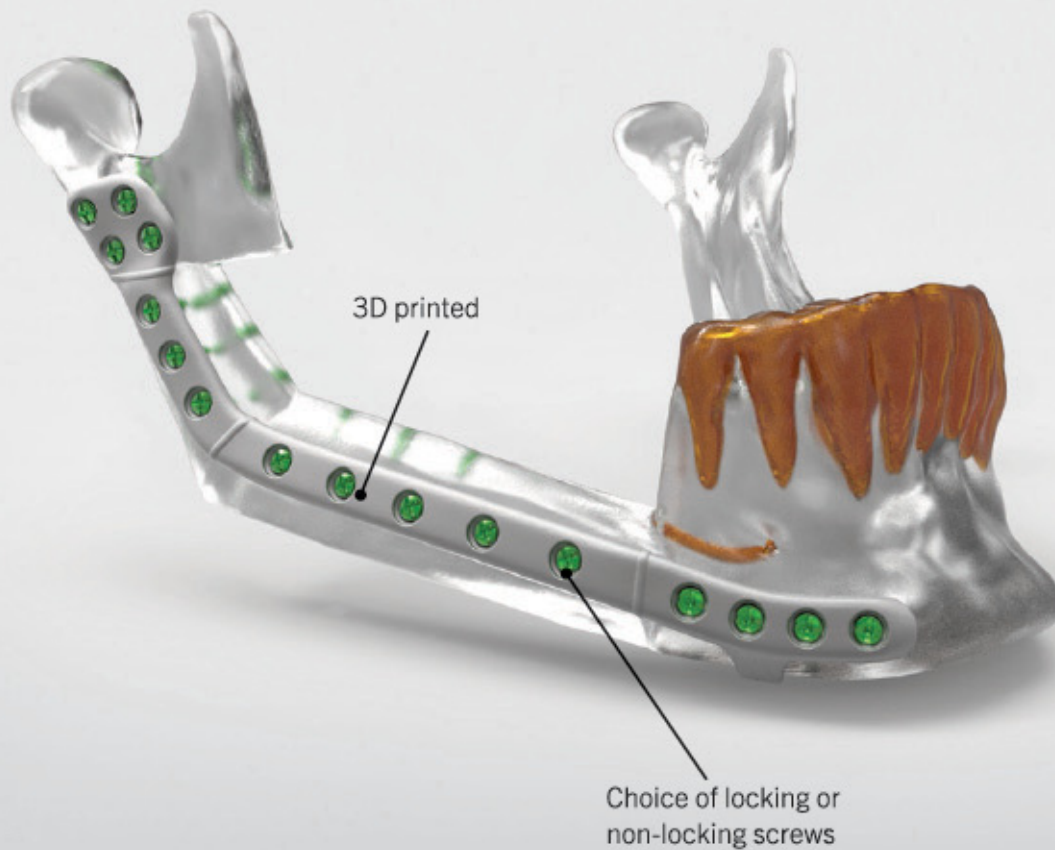
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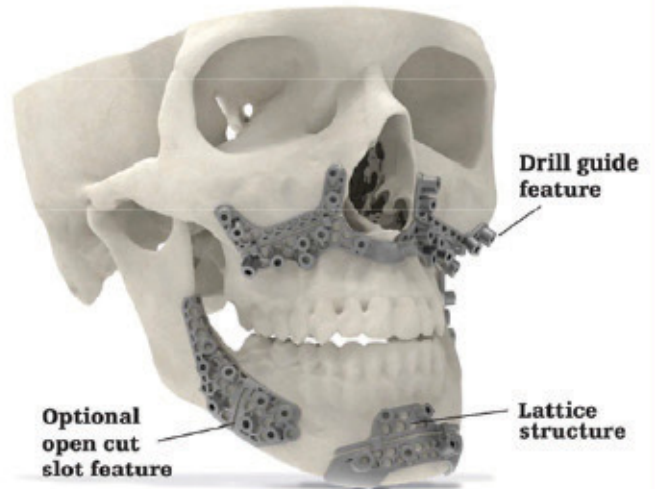
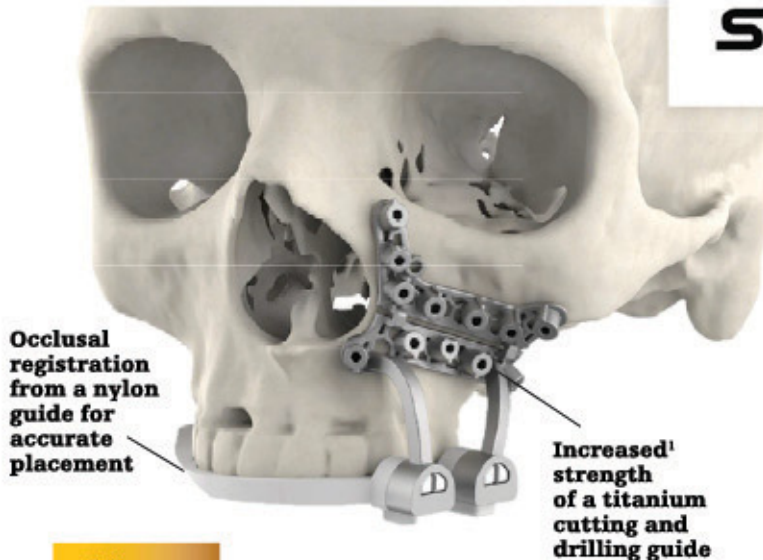
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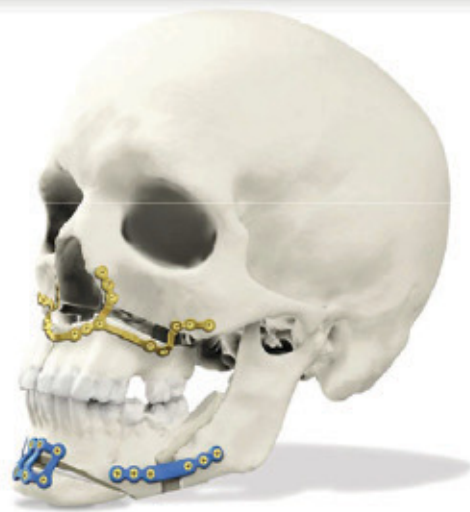
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In Memoriam

John McAndrew DDS
December 21, 1927 ~ September 16, 2020 (age 92)



John and Therese McAndrew

Dr McAndrew was born on a farm in Lost Nation, Iowa, the 10th and last child of Philip McAndrew and Jan McGonigle McAndrew. He was a beneficiary of the GI Bill after serving in Korea as a young man. He attended St Ambrose College in Davenport, Iowa and the University of Iowa Dental School where he earned his DDS degree. After moving to California with his growing family (eight children) in 1956 he worked as an Oral Surgeon in Santa Ana for over thirty years.

Larry Dermody DDS JD
Passed away September 5, 2020

Dr Dermody was a native of Minnesota and graduated from the University of Minnesota School of Dentistry with his DDS degree. He served two years in the United States Navy at Camp Pendleton in Oceanside, California. He entered the USC Oral and Maxillofacial program at USC which was then chaired by Dr Marsh Robinson. His fellow residents were Drs Gerry Mitchell and Bob Huntington. Upon completion of the program Larry spent several years in association with Dr Big Bob Thompson in Torrance, joined by two other USC residents, Drs Mike Gibson and Bob Sutter. Drs Dermody, Gibson and Sutter had a long and successful practice in Sunnyvale, California. They brought outpatient general anesthesia to Northern California Oral Surgery offices which had previously utilized mainly IV sedation. Larry completed a law degree and was active in malpractice defense cases. He also attended flight training school and obtained his private pilot's license all while practicing full time. He reenlisted in the United States Navy during the Gulf War and spent several years as a Captain serving on an aircraft carrier in the Red Sea.

Drs McAndrew, Dermody, Gibson and Sutter with their wives joined us at our SCOA desert meetings for many years.



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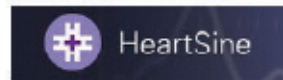
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