Southern California Orofacial Academy

SCOA PROCEEDINGS

Summer–Fall 2014

President's Message

R DEAN LANG DDS

I want to speak with you about our SCOA continuing education meetings. We are very fortunate to have Dr Bach Le as our program chair. He has numerous contacts in the world of educators and renowned presenters. Bach has been able to secure well-known speakers for our past meetings for which we are grateful. We hope he will continue to share his talents and resources with us for a long time. He and the SCOA program committee work very hard to arrange our meetings and the fruits of their labors are the outstanding programs and excellent attendance we enjoy.

Bach has alerted the board of directors of the increasing difficulty of securing major presenters for our Wednesday meetings. Mid-week meetings result in our speakers scheduling additional days away from their private practices to allow for travel time. This in turn results in higher expenses and honorarium fees. In the case of some presenters who are full-time faculty members, they simply cannot take off in the middle of the week.

I want you to know that we appreciate and depend on the support of all our members. Without your dues payments and registration fees we would not be able to provide the high quality meetings that we have all come to expect from SCOA. The first responsibility of our SCOA board is to our membership, so with this in mind we would like to ask all of you to let us know how you feel about moving our Wednesday meeting to a Saturday in the fall. Our program committee is in the process of planning for our Fall 2015 meeting and it will be very valuable to have your input. Please let Susan know what you think (Keep Wednesday or move to Saturday?) at 626-287-1185 or orofacial@compnow.com. We will review all local football schedules while we gather your responses.

As a side note, we have already planned our Spring meeting for Friday, Saturday and Sunday, April 17-19, 2015 and I hope you will save the dates in your calendars and plan to join us in San Diego.

Speaking of meetings, I would also like to bring up our *Pearls.* These 30-minute presentations on a variety of topics are very popular with our members.

Continued on Page 2

INSIDE THIS ISSUE

SOUTHERN CALIFORNIA OROFACIAL ACADEMY
CAMARADERIE
PROFESSIONALISM
HISTORICAL PRESERVATION
FOUNDED 2001
EXCELLENCE IN ORAL AND MAXILLOFACIAL SURGERY

FALL 2014 IMPLANT MEETING

Wednesday October 29
Hilton Pasadena
8 AM to 5 PM
9 CE/CEU Category 1 Credits
PRESENTERS
Drs Tara Aghaloo, David Cummings, Howard Davis, Kanyon Keeney, Howard Park, Parish Sedghizadeh, Chandur Wadhwani
See Meeting Brochure Insert
For Information & Registration

SCOA ADMINISTRATIVE OFFICE
8236 Garibaldi Ave, San Gabriel CA 91775-2436
Tel 626-287-1185 • Fax 626-287-1515
orofacial@compnow.com • www.socalorofacial.org

Past presenters have expanded my practical knowledge and often enhanced the way I care for my patients. We extend an invitation to all of you to give a presentation on any subject you think will be of interest to our members; from a surgical procedure to a practice management or staff topic. We can all benefit from sharing our expertise and experiences with our friends and colleagues.

This brings me to our 12th Annual Fall Implant Meeting. I hope to see you at the Hilton Pasadena on Wednesday, October 29. We start early now (8 AM) so you may want to spend Tuesday night at the Hilton. We have a group rate and you can check with Susan on that. We are anxious to welcome our seven presenters and the interesting topics they will bring. We have an insert in this issue with CV information about the presenters, clinical details on their topics, schedule for the day and registration form. We'll go 8 AM to 5 PM with a reception from 5-6 PM.

I will see you at the Hilton!
R Dean Lang DDS

SCOA PAST PRESIDENTS

George C Gamboa DDS MS EdD
2001 to 2004

Ross W Prout DDS
2004 to 2006

Robert E Huntington DDS
2006 to 2008

John J Lytle DDS MD
2008 to 2010

Theodore A Tanabe DDS
2010 to 2013

EDITOR'S CORNER

THEODORE A TANABE DDS

The Itinerant Oral Surgeon

My local OMS colleagues talk (and email) once in a while about what is going on in our practices. One topic that recently came up is how to handle complications sent from practices that utilize itinerant oral surgeons. We all agree that there seems to be an uptick in the number of problems popping up regarding inadequate follow-up, non-existent after-hours coverage, and emergency room usage by general dentistry practices that bring in docs to operate sporadically. I'll get to our consensus opinion a bit later.

Why would a general practitioner choose to bring in a surgeon once a month to operate on a slate of patients? I would imagine that there is a financial lure to generate income without doing any work, even if it is a low percentage of the gross, especially since the net income from a referred patient is zero. It may also seem attractive to offer this service to patients who might prefer to stay in their comfortable and familiar surroundings. And an interested GP only has to look in the component dental journal advertisements to find someone willing to come in and operate at his office.

Why would an OMS choose to practice as an itinerant surgeon? Certainly there is a financial lure. And there are days when I can absolutely see the attraction in leaving the hassle of billing, scheduling, and staff management to someone else. I would also imagine the overhead is minimal. Maybe the doc is in a residency and is allowed to moonlight – essentially he or she is working as a general dentist and performing oral surgery procedures in a general dental practice. I did this during my training, and am certain that things like this continue today. And there are many newer OMS grads that have not yet committed to a practice of their own or who are not yet busy enough in a fledgling practice, who are perfectly happy to travel and cultivate itinerant work for a living.

A growing practice model of corporate-dentistry has a presence in our area as well. Many of these practices have specialists scheduled on a periodic basis. One such practice referred a patient to one of my colleagues for removal of #17 and 32 only – retaining #1 and 16 for the corporate dental practice to remove as a separate procedure at a later date – despite the seemingly obvious benefit of a single surgery and single healing period for the patient, who was choosing to have the lower teeth removed under an intravenous general anesthesia.

I do see that there is a certain lure in itinerant practice for both the managing dentist as well as the surgeon. In many cases, the amount of debt amassed in attaining an OMS certificate is extremely large. So faced with the prospect of another big loan for a start-up or a giant buy-in to an existing OMS practice, I can understand why a doc might choose to take an itinerant job to knock down some bills and breathe for a while.

So what are the downsides? A few years ago I was talking to a recent OMS grad about how things were going for him. He mentioned that he never fully comprehended that patients sometimes experienced significant post-operative issues after even routine dentoalveolar surgery, because his junior residents saw all of his post-ops. But now in the real world, all of these complaints were coming back through his door. So in a general practice setting, all of these post-surgical patients are coming in for follow-up exams and are sitting in the waiting room next to someone who is getting veneers and tooth whitening – not my idea of great

Continued on Page 5

Dr Tanabe, Continued from Page 4

marketing. And depending on the availability of the operating surgeon, the GP might be the one doing all of these post-operative assessments. I'm not saying that the quality of surgery is necessarily inferior to what I can do. But most OMS docs would admit that the work we do on a daily basis causes local trauma and inflammation that can sometime be significant, and because we are used to seeing it and handling it, we are best suited to assess our patients and manage their post-operative course, especially if they are having problems.

A potential problem can occur if a patient has a post-operative emergency that cannot be handled by the general dentist. In this case, the patient may end up in the local emergency room or in the office of a local oral surgeon. I've been called at one o'clock a.m. by my local ER doc to come in and manage a post-op bleed. The 80-year old patient was unable to get a return call from the dentist's office and he did not know how to contact the itinerant OMS who had removed his tooth, so he went to the ER for help.

So how do you handle issues like this in your area? My policy is to reach out to the surgeon to inform them of the situation and encourage him or her to take care of their patient. We contact the dental office to let them know how much the emergency examination, x-rays, and palliative treatment will cost, and we ask if they want to be billed directly for treatment rendered. If the patient ends up being admitted to the hospital, California law requires that the Dental Board be informed in writing within seven days that dental treatment rendered has resulted in hospitalization of the patient. That information is also conveyed to the surgeon and the dental office.

What was the consensus of my local OMS sounding board? We think that itinerant practice creates the potential for a complication that could have significant negative impact on all practicing OMS docs, not because the quality of surgical care is necessarily lacking, but because the coverage, management, and follow-up is less than ideal. And we don't want to be a dumping ground for neglected patients.

12TH ANNUAL FALL IMPLANT MEETING
WEDNESDAY OCTOBER 29, 2014

HILTON PASADENA
Lectures 8 AM-5 PM
Reception 5 PM-6 PM
9 CE/CME Category 1 Credits

PRESENTERS

Tara Aghaloo DDS MD PhD (OMS) UCLA
Peri-Implantitis:
Updates for the Practicing Clinician

David Cummings DDS (OMS)
Surgical Uprighting of
Malpositioned Second Molars

Howard Davis DDS (OMS)
The Wonders of Oral and
Maxillofacial Surgery

Kanyon Keeney DDS (OMS)
The Art and Science Business
Model of Implant Surgery

Howard Park DMD MD (OMS)
Doing Less to Get More:
Implant Esthetics

Parish Sedghizadeh DDS MS
(OMS Pathologist) USC
Osteonecrosis of the Jaw Associated
with Anti-Resorptive Therapy

Chandur Wadhwani BDS MSD (Prosthodontist)
University of Washington
Restoratively Driven Implant
Failure: 2014 Update

See Meeting Brochure Insert
for Information & Registration

ANESTHESIA UPDATE

JOHN J LYTLE DDS MD

Unusual Sensitivity and Resistance to Intravenous Sedation

In the previous Spring 2014 issue of the *SCOA Proceedings,* a technique was outlined that I advocate for intravenous sedation for office dentoalveolar surgical procedures. It seemed to me that some of the complications that occur during intravenous sedation were less frequent following the technique outlined in that article. Since the spring of 2014 more than three unexpected events have occurred in my presence utilizing that method of sedation so my impression of decreased frequency of complications may be illusory.

Clearly, midazolam in higher doses than previously utilized (10 mg. or less) may safely be given if titrated to patient response and used in conjunction with modest amounts of fentanyl (50 to 100 micrograms) and ketamine 25 to 50 mg. Combined with carefully administered local anesthesia to provide a well localized, dry surgical field, routine removal of teeth can be accomplished with relative ease by individuals without a great deal of experience as OMFS surgeons. Within the past months, I have encountered two cases that demonstrate that although complications are rare, they still occur as they did with all previous techniques.

The first is unexpected extreme sensitivity to benzodiazepines. We continue to advocate 2 mg. initial doses of midazolam but in the average patient in the prime of life, this often has little visible effect on the level of consciousness and there is a tendency to increase this initial dose to 5 mg. or more when determining what one will administer when faced with a lineup of multiple young patients in a busy private practice.

An ultrasensitive patient will appear at some point in your practice and will become apneic on a 5 mg. initial increment. Often it will be a young female; perhaps an Asian from the Philippines; but the patient may not fit this typical group who more often display sensitivity to anesthetic agents. Fortunately midazolam can be reversed with flumazenil. When the complication occurs as it did recently to me with a fully monitored patient, the smooth flow of patients in an operating schedule is disrupted by the need to ventilate the patient, determine whether or not to give a reversal agent, whether or not to give additional agents other than local anesthesia, and whether or not to continue the case. In the case described, bag and mask ventilation, administration of local anesthesia and surgical stimulation restored ventilation and the case proceeded uneventfully. Had the patient not responded to these simple time-honored techniques, I would have administered 0.2 to 0.4 mg. of flumazenil.

A second complication that occurred reminded me of the prolonged delirium seen in some teenagers emerging from procedures in the seventies and eighties from methohexital and diazepam anesthesia and before that in the fifties and sixties from large doses of methohexital alone.

A 14-year-old Hispanic boy weighing approximately 100 pounds presented for removal off a mandibular cyst. The procedure proceeded uneventfully over a 30-minute period and the patient required a total of 12.5 mg. of midazolam administered in incremental doses over 20 minutes. In addition he received 100 mcg of fentanyl, 25 mg. of ketamine and two carpules of articaine 4% with epinephrine 1/100,000.

At the conclusion of the procedure, the midazolam was reversed with 0.2 mg. of flumazenil. The patient was responsive but somewhat sleepy. He was transferred to a

Continued on Page 7

Dr Lytle, Continued From Page 6

wheelchair for transport and observed due to continued somnolence. After approximately five minutes he became agitated and stood up from the chair and tried to walk. He was restrained and returned to the dental chair. Four residents, an assistant and an attending were required to overcome what one can only describe as superhuman strength for restraint of this rather small boy.

He was not responsive to vocal command, seemed unaware of his surroundings, was fearful and had a fixed delusional stare reminiscent of that seen with hallucinogenic medications. After 45 minutes he quieted, his mother and brother were permitted to talk to the patient and he was discharged home after another 30 minutes. His mother reported that he went to bed upon arriving home, slept for two hours, awoke with no memory of any of the events after his initial induction and has progressed well and seems entirely normal to his family.

I speculate that this reaction was in response to the 25 mg. of ketamine that may have been too much for this young person. Ketamine is available to us at the Ostrow School of USC in 50 mg. per ml. and generally we start with one half ml. containing 25 mg. In our office, we have the drug in 10 mg. /ml concentration and perhaps we could have avoided this difficult emergence by administering a smaller dose of ketamine. The reaction may also have been avoided by not reversing the midazolam. Although it was not determined if this patient had ADHD, it has been suggested that this group of patients may be more likely to have an atypical emergence from sedation.

As in many clinical settings in dental schools, we see a greater number of patients who seem to have great resistance to sedative agents of all types. These individuals are often muscular males in early manhood through midlife. If they have developed tolerance to alcohol and/or narcotics, they may display incredible resistance to our sedative agents. When the amount of midazolam is approaching 30 mg. and the patient still seems very reactive to stimulation, I still revert to propofol or methohexital.

The purpose of this short article is to remind experienced operators and warn those new or relatively new that you will encounter patients who do not react to sedative agents in the way the vast number of “normal” patients do. When this situation arises, take a step back and devote your attention to this atypical patient response. If that means cancelling other cases you have scheduled or even shutting the office to permit careful management of sedation gone awry, do it.

A second observation is that given the opportunity to determine the concentration of sedative agent you anticipate using, select the more dilute. In the case of midazolam, it is easier to titrate with 1.0 mg/ml than with 5.0 mg./ml. In the case of ketamine, select 10 mg./ml rather than 50. mg./ml. This gives the operator more volume to administer and less likelihood of overdose utilizing a more concentrated solution.

I believe that the long-term success of the specialty of oral and maxillofacial surgery rests largely on the continued ability of practitioners to provide pain and stress-free procedures that are cost effective and remain outside the government mandate relating to patients’ right to health care. We are approaching our centennial as an organized specialty of dentistry. General anesthesia and intravenous sedation have been important tools in maintaining our competitive edge over other dental specialties and with medicine. Our great strides in patient monitoring, office evaluations, permitting of practitioners and promoting lifelong learning and maintenance of competency in anesthesia will continue to make oral and maxillofacial surgery unique.

Jack Lytle
John J Lytle DDS MD
jacklytle@sbcglobal.net
mobile 818-929-0103

SCOA BOARD TRANSITIONS

R Dean Lang DDS
President

John Scaramella DDS
Treasurer

Ted Tanabe DDS
Editor

COL Bob Hale DDS
At-Large Board Member

Jim Jensvold DDS
At-Large Board Member

Dr Jensvold with his patient from Temecula.

DR JIM JENSVOLD is retiring after 12 years as exhibits chairman and webmaster. The SCOA board appreciates Jim's many years of being the liaison with our sponsors. Jim developed SCOA's PowerPoint continuous loop sponsor presentation. He built and maintained the SCOA website for members to review information about upcoming meetings and make online dues and registration payments. Jim will continue on the board of directors as an at-large member.

www.socalorofacial.org

NEW MEMBERS

Scott R Adishian DDS
Prosthodontist, Pasadena

Paul G Bohman DDS
OMS, Ventura

Jeffrey M Caputo DDS
OMS, Mission Viejo

Jeffrey L Foltz DDS
OMS, Reseda

Judy Lanfried
Hermosa Beach

Ramin Shabtaie DDS
OMS, Los Angeles

To Our Members: Let us know of your OMS colleagues, referring doctors or residents who would like to join SCOA. We will contact them, send information with past publications for them to learn about us, and invite them to our October 29 meeting.

David Gilbert DDS, Membership Chair
Kevin Lew DDS MD, Residents Chair

ROBERT G HALE DDS aka COL ROBERT G HALE ACTIVE DUTY UNITED STATES ARMY

Welcome Home Bob, Sue Ellen, Austin and Tyler!! From SCOA

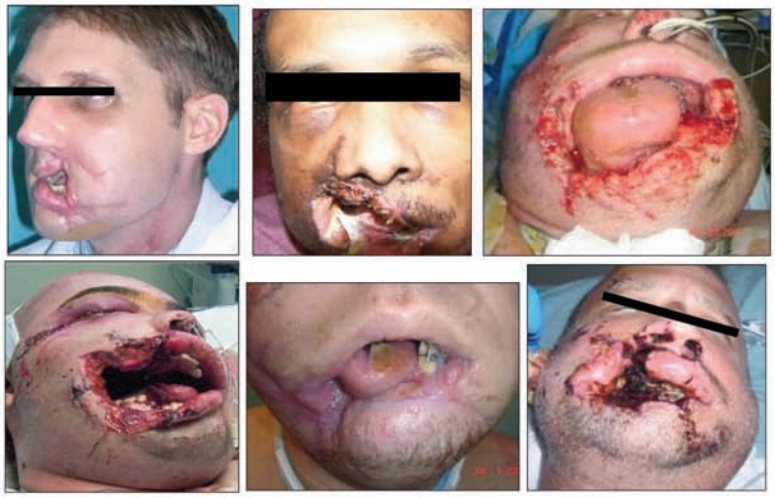
By Susan Leslie Smith

Dr Bob Hale was an early member of SCOA and our first editor. He contributed to the design of our impressive SCOA logo. Bob continued as editor after he unexpectedly went from reserve status to active duty in 2003 by presidential order. He was deployed to Kuwait with his reserve unit, the United States Army 801st Combat Support Hospital. Bob's unit was scheduled to be in the war zone for 90 days but kept getting extended. After six months his unit was sent to Afghanistan. When Bob returned from active duty he initiated significant format changes in our newsletter and gave it a new name: *SCOA Proceedings*.

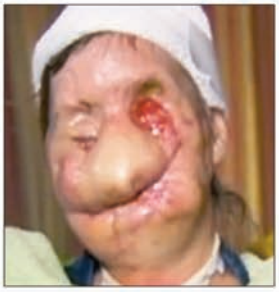
After one year in combat zones, Bob returned to Southern California, but not to his own surgery center that he and Sue Ellen had decided to sell when he deployed. One week after his return, Bob stopped to visit his friend Jim Jensvold; he was overwhelmed to see that Jim had added *Robert G Hale DDS* to his office door. Bob practiced with Jim for a short time…until making the decision to return to active duty. This turned out to be Brooke Army Medical Center, a level 1 regional trauma center at Fort Sam Houston in San Antonio where he trained Army oral and maxillofacial residents plus residents from the Air force and the University of Texas.

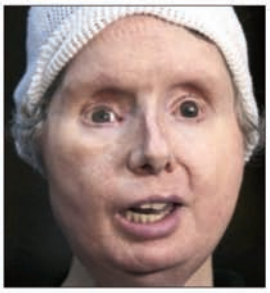
In 2008 Bob went to Washington D.C. to testify on the need for research into the face transplant. He was asked by a general officer to take command of the Army's Dental and Trauma Research Detachment. Bob continued his interest in battle injuries to the face, closing facial wounds of soldiers returning from combat overseas, and subsequently to facial restorations and the face transplant. Bob's recent presentation at the SCOA 12th Annual Spring Scientific Meeting was *Facial Restoration after Battle Injury – Face Transplants to BioMask Research*.

Bob was offered a move from San Antonio to a new commanding position in Washington DC but decided after 11 years to return to Southern California and to practice with Jim Jensvold in Woodland Hills. Bob and Sue Ellen will write their own stories in our next issue. In the meantime, Bob is sharing photos of his patients, research and devices in this issue.



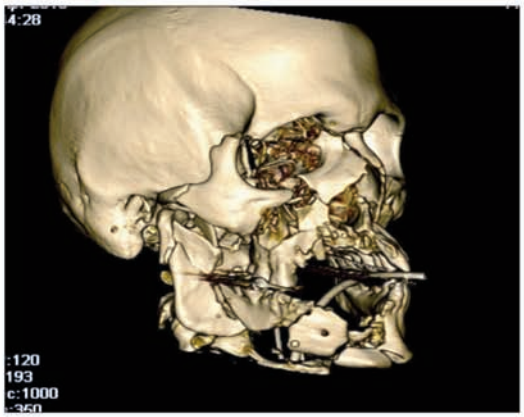
Other than total loss of face, greater than 50% loss of lips is an indication for allotransplantation.





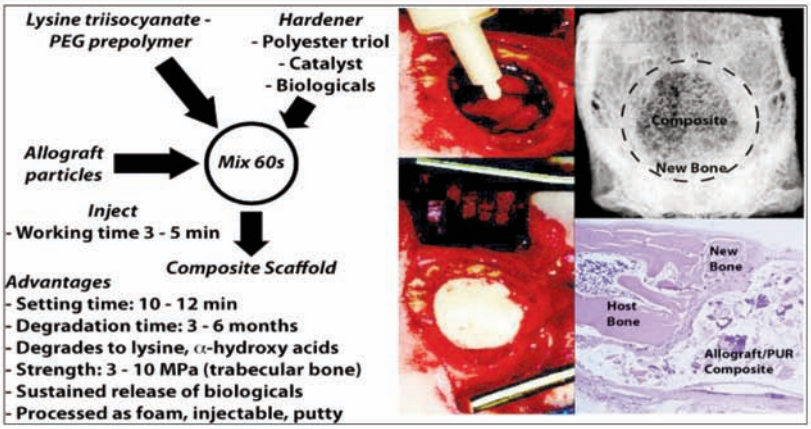
Karla Nash had dozens of tissue transfer procedures to replace facial features avulsed after a chimpanzee attacked her. Second photo shows her result after one procedure of allotransplantation. The attack resulted in loss of her eyes. Critics of the face transplant argued "Since she couldn't see the result, why bother subjecting her to the risk of surgery and lifetime immunosuppression?" Obviously the critics had no concept of facial function.

CMF Bone Injuries

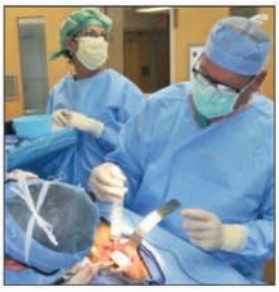


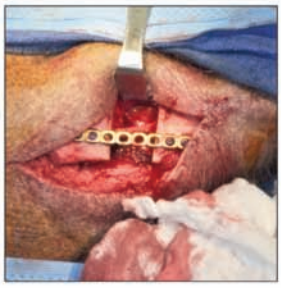
Soldier was struck with a non-exploding RPG. Bone grafting is required but no ideal graft or regenerative system is available.

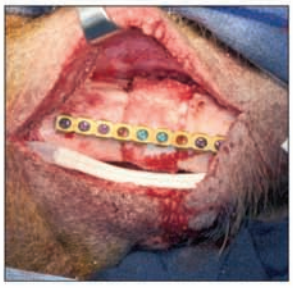
Injectable Polyurethane Biocomposite Scaffold System to Deliver rhBMP-2

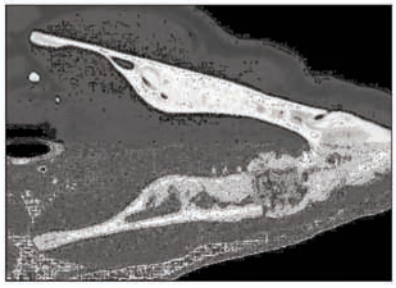


A new scaffold system is being developed that is space maintaining, flowable and moldable (degradable lysine molecules with urethane chemical bonds) that releases rhBMP with a favorable pharma-kinetic profile.

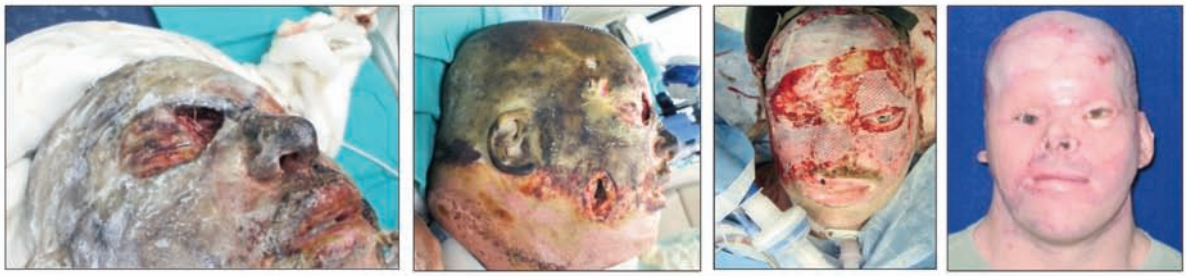






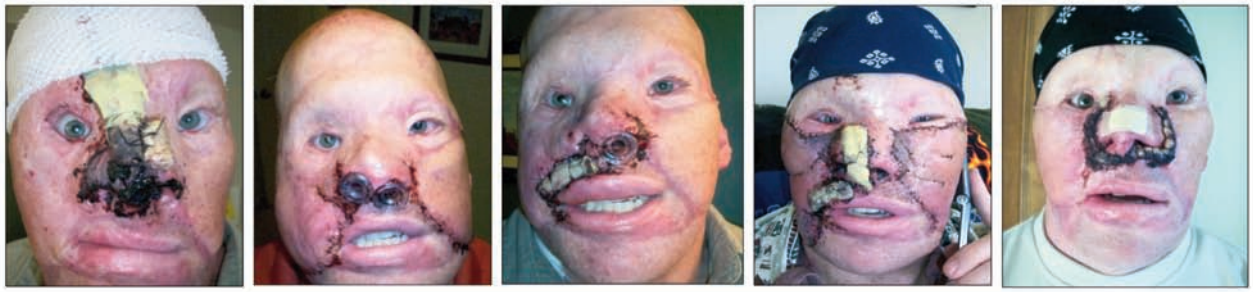


This new rhBMP carrying scaffold system has been developed and tested extensively on large preclinical models. Our industry partner plans to test system in non-human primates before clinical trials.



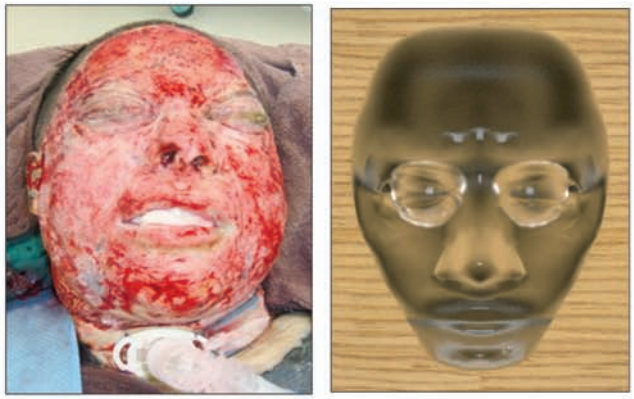
Face burns occur in over 8% of service members injured in the face during battle. Hypertrophic scars and contractures require multiple procedures to improve function but the results are still dismal.

From Poor Would Control to Incremental and Minimal Improvements



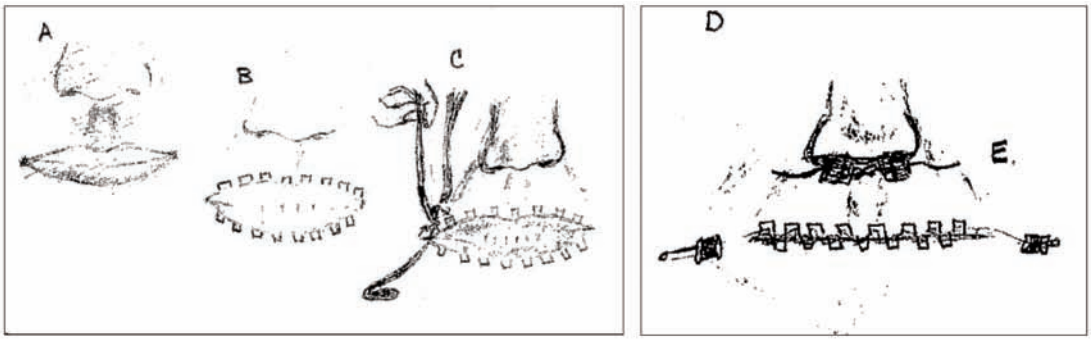
Google "Todd Nelson" and "Beyond the Battlefield" to read a Pulitzer-prize winning article published in the Huffington Post which chronicles the burden of facial burns. Also videos are available on same Google webpage.

Early Debridement and Facial Wound Bed Preparation



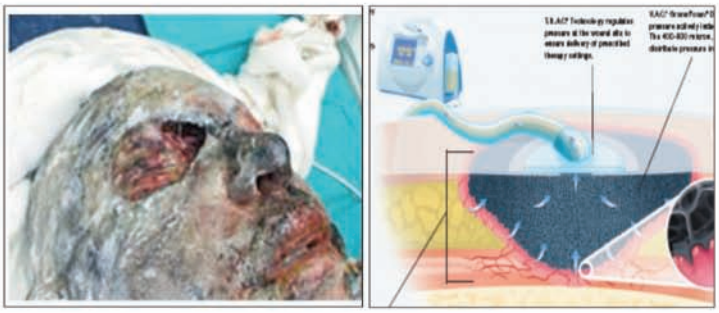
The BioMask concept has been in development for four years. After facial debridement the BioMask is used as a sealed wound chamber to quell the inflammation and prepare the wound for sequential closure using tissue engineering products.

The BioMask has a textured undersurface that allows for delivery of therapeutic agents through fluid infusion or evacuation of fluids and stabilization of dermal substitutes through Negative Pressure Wound Therapy.

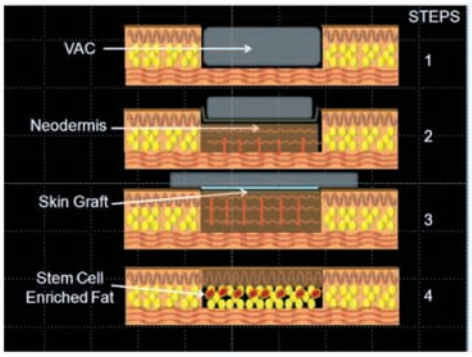


The obvious question is how will the patient tolerate the treatment and what about the oral/nasal orifices and eyes? A patient with a critical face burn will have a tracheotomy and J-tube early in care. The eyes are sealed with Frost sutures, nose plugged with silicone and mouth sealed using titanium stables around the skin/mucosa vermillion and sealed closed with a polyurethane vessel retraction cord. Every four hours neuro checks are done by releasing the Frost sutures and the oral cavity suctioned by releasing the lip cord. The eyes and mouth will be covered with module parts of the BioMask that can be removed and resealed (Ziploc type system) without disrupting entire BioMask. [These patients are also the patients of Rosann Berg, surgical assistant to COL Hale at BAMC; the lip-sealing device is her invention. Rosann is a civilian; she became COL Hale's executive assistant at DTRD.]

THE BIOMASK: Wound Chamber with NPWT Function Overview



BioMask Concept ▶



1. Wound chamber and NPWT BioMask to optimize wound bed.
2. Application of Custom Neodermis under NPWT BioMask.
3. Replace Epithelium – "Spray-on skin" or ultra-thin STSG.
4. Inject Fat below neodermis/Stem cell enriched fat to remodel.

Bob says that bone regenerative material for soldiers will help everyone, especially dental-implant patients. As far as the skin regenerative, there are all kinds of situations where civilians need to have facial skin resurfaced and replaced. Spray-on skin is in clinical trials at BAMC and it is revolutionary. It is something that probably would not have been developed if there wasn't a war and an urgent need for it.

Dental and Trauma Research Detachment
United States Army Institute of Surgical Research
Fort Sam Houston TX 78234-631115

2014 ANNUAL SPRING SCIENTIFIC MEETING REPORT

BACH LE DDS MD
Program Chairman

Thanks to all of our Spring 2014 presenters. Dr Daniel Spagnoli discussed *Reconstruction and Biologics.* Dr Ray Melrose asked: *Is it Important to Distinguish between Lichenoid Reactions and Lichen Planus?* Dr Peter Krakowiak presented *Accelerated Molar Uprighting and Forced Molar Eruption using Implant Microanchorage.* Dr Bob Huntington reminisced with *OMS History and Practice in Southern California "The Fires."* Dr Clark Stanford discussed *Implant Therapy in the Growing Patient.* Drs Scott Adishian and Larry Lytle presented *Clinical Experience and Treatment Modalities with All-on-4 Procedure.* Col Bob Hale related his experience with research and treatment for *Face Restoration after Battle Injury – Face Transplants to BioMask Research.*

We appreciated the participation of our loyal exhibitors with special recognition for Diamond Sponsors: **BioHorizons, Dentsply** and the **United States Army.**

OUR PRESENTERS

1. Dr Daniel Spagnoli
2. Dr Ray Melrose
3. Dr Peter Krakowiak
4. Dr Bob Huntington
5. Dr Larry Lytle
6. Dr Clark Stanford
7. Dr Scott Adishian
8. Dr Bob Hale

2014 SPRING SCIENTIFIC MEETING

Photography by
Ron Stewart Pictures

2014 SPRING SCIENTIFICMEETING

Photography by Ron Stewart Pictures

IN MEMORIAM

Robert W Thompson DDS
July 30, 1922 – March 31, 2014
SCSOMS President in 1977

Dr Bob Thompson was born in Los Angeles and grew up in San Marino. He attended South Pasadena High School and South Pasadena Junior College. After completing his education at the USC School of Dentistry, he practiced Oral Surgery in San Pedro and Torrance for over forty years. His love for golf prompted him to serve as president of the SCGA and also the CGA. He passionately cheered for his beloved Trojans, driving his bus, the Big T Special, to the LA coliseum where he occupied the same seat for over fifty years. Applying his oral surgery skills, he served his country as part of the US Navy, and contributed to his community as both a Rotarian and a Shriner. Bob traveled the world playing golf and practicing his Spanish. He is survived by his three children, Stephanie Rieth, Greg Thompson and Judy Thompson, three grandchildren and two great-grandchildren. Bob will be remembered for what he did best, laughing, telling jokes, and recounting stories from his long, full and interesting life.

Dr "Big Bob" Thompson came to all of our SCOA Desert Meetings to play golf and socialize. This photo was taken in 2007: Drs Ross Prout, Dan Copps and Bob Thompson.

BAHIA RESORT HOTEL
On Mission Bay in San Diego
Friday ▪ Saturday ▪ Sunday
13 CE/CME Category 1 Credits

Saturday Dinner Cruise for
Your Family and Guests on the
Historic William D Evans Sternwheeler

Cocktails, Dinner and Dancing
While Cruising on Mission Bay

PRESENTERS

Audrey Boros MSc DDS (OMS Pathologist)
Oral Pathology Associates Los Angeles
Update on HPV-Related Disease

Jay Malmquist DMD (OMS)
Private Practice Portland Oregon
Bone Grafting, Bone Regeneration and Dental Implant Surgery

Frank Pavel DMD (OMS)
Center for Oral and Facial Surgery,
San Diego and El Cajon
Sinus Augmentation via Physiolift (Controlled Hydrolic Pressure)

More Presenters and Pearls TBA

Meeting Brochure will be Mailed Soon

Be sure to visit these sponsors on October 29 at the Hilton Pasadena to show our appreciation for their loyal support of SCOA continuing education programs

DIAMOND SPONSOR

BIOHORIZONS
SCIENCE • INNOVATION • SERVICE

SILVER SPONSORS

ACE SURGICAL SUPPLY CO

H & H Company
FINEST QUALITY INSTRUMENTS

Oral Pathology Associates, Inc.

ADIN Implants

HI-TEC IMPLANTS
LEADER IN DENTAL IMPLANT TECHNOLOGY
USA 1-800-452-0582

Osteohealth
INNOVATIVE DENTAL SOLUTIONS

BRADYPRICE & ASSOCIATES

MTI

pact-One
dental technology EXPERTS

Carestream DENTAL

PIEZOSURGERY INCORPORATED

CSI CRITICARE SYSTEMS, INC.

maXeus
Community Tissue Services
1-800-452-0582

SNOASIS MEDICAL

Dental Implant TECHNOLOGIES

MPS
Medical Purchasing Solutions

SNAP ON OPTICS™

DENTSPLY IMPLANTS

straumann

Surgical Solutions USA

GARFIELD REFINING

Nobel Biocare

XEMAX
SURGICAL PRODUCTS, INC.

Geistlich
Biomaterials

ONE REP
incorporated

zimmer | dental