



NEWSLETTER

THE AMERICAN COLLEGE OF PROSTHODONTISTS

AN ORGANIZATION OF SPECIALISTS
DEDICATED TO SERVING THE PUBLIC

ISSN 0736-346X

VOLUME 12

NUMBER 1

SPRING 1984

PRESIDENT'S MESSAGE



As I write this message, I am surrounded by correspondence from many different societies and from many different members. All are important, especially to the writer, and all require action or acknowledgement. As I view the logo on our College letterhead and the date, 1970, I am forced to remember that our organization is only 14 years old and all our achievements and undertakings have evolved in that span of time. It is astounding just how much our College has changed in that fourteen years and how much it has accomplished. It is also exhilarating (and somewhat frightening) to have some faint perception of just how much remains to be done and the avenues that are opening to us. We have become involved in a plethora of professional activities... political, social, educational, and legislative. Some are internal, some external. Some small and seemingly, at the time, of little consequence, some so onerous and complex they require considerable analysis to decide how the most favorable action is best initiated. All are directed to the advancement of our specialty and for the ultimate benefit of the patients served. Hopefully, the other inscription on our logo, *veritas* - truth, is also preserved and advanced through all these actions.

It is becoming increasingly obvious that the College cannot ignore any issue which pertains to our specialty. The inroads of PPO's - preferred provider organizations and groups seeking to organize "insurance dentists" impact on our practice. We are asked by the public about our views on various aspects of our specialty, how they can locate a prosthodontist in their area or an area into which they might

be moving. We are involved with other societies and we are seeking to make our services known to still more, such as our medical colleagues in allied specialties and even to our confreres in our own profession. John Donne said "no man is an island, entire of itself". The same may be said of an organization which has goals and objectives such as ours does. We all have to be involved! Involved with other organizations, our members, the FPO and ADA, legislative bodies who have controls over our practices, involved with the needs of our patients, and involved with the future of our specialty. We have to be able to back up our words with action, and we may have to sacrifice time and money to accomplish worthwhile goals. Fortunately, our members have always been willing to do this. We have reached a plateau, from which we can view not only the plains from which we have come, but also some of the peaks which lie ahead. The budget committee and the Executive Council have held the line on dues increases as long as it has been possible, perhaps too long. A dues

increase is a certain eventuality. When all the facts are known, we will be able to ascertain the needed amount. It will not be capricious, but a reasoned and necessary request. It is also important to the College that each member pay the dues of the F.P.O., for it is only by the number of dues paying members of our organization that we receive representation in that body. I have been encouraged by our recent interactions with that body and your officers are working to insure more progress.

I am sure that each one who reads this message has a slightly different concept of the College. I hope that if you have concerns, ideas or constructive criticisms, that you will let me or one of your other officers and representatives know of them. Our Executive Council meeting in February was one of the busiest ever. July's meeting promises more of the same. The officers, the Executive Councilors, and committee chairmen who meet together do so with one purpose in mind - to make our College the organization it needs to be, the organization it wants to be and the organization it can be. I am so proud of all of you who serve to this end. For those of you who want to be more involved, there is no shortage of tasks - let us hear from you. And, when a College member does something that you really support - make that known too. Encouragement breeds even more enthusiastic action and even greater achievement. Your active involvement is essential in all the tasks of the College. And, speaking of involvement, Nashville and the annual session is not very far away. Make your plans now to attend and be part of the busiest, most rewarding meeting yet.

—Jack D. Preston, D.D.S.

PREFERRED PROVIDER ORGANIZATIONS (PPO'S)

A PPO can be broadly defined as a practitioner, institution or group of practitioners or institutions that enter into an agreement (contract) with a group purchaser of health care, to provide services at an agreed cost. In a PPO, members of the group (employees with health benefits) have the option of selecting a health care provider who is not a member of the PPO, although there is a financial incentive to select a PPO member.

By contrast, an EPO (Exclusive Provider Organization) provides benefits only from providers who are members of the organization.

On January 25, 1984, PPO's were the main agenda item for the California Dental Association Dental Care Conference in Sacramento. The following is material presented by attorney Richard Robinson, Director, Contract Evaluation Services, California Medical Association:

A PPO is a **CONTRACT**, and a contract is a legally enforceable agreement. Therefore, the contract must be studied carefully before it is signed by the dentist. Most contracts have good points and bad points for each of the parties involved. Each individual dentist must decide, on his or her individual situation, whether or not to join a PPO. These are some questions a dentist may consider during the decision process:

1. Are all the parties to the contract clearly identified by name? Can the dentist identify each and every party to the contract?
2. Does anybody or any entity other than the dentist control determinations as to quality of care?

A refusal by the PPO to authorize or pay for care which, in good dental offices should be rendered, does not of itself excuse the dentist who fails to render or offer such care.

3. Under what circumstances can the dentist terminate the contract? What action, notice and/or conduct on the part of the dentist is specifically required to terminate the contract? What period of time is involved?

Most contracts are very easy to enter, just sign your name and in some cases make a payment. But many contracts are very difficult to terminate. Some PPO contracts

require payment for a specified period of time even if the dentist concludes services with the organization.

4. Does the contract permit unilateral changes in terms and conditions of the agreement without prior notice to the dentist and/or without the prior assent of the dentist?
5. If payment to the dentist is subject to a percentage withhold, can the withhold percentage be changed unilaterally without prior notice to the dentist and/or without the prior assent of the dentist?
6. Does the contract provision on dental records comport with state law?
7. If the contract states that the dentist will be bound by Articles of Incorporation, bylaws and/or documents (of the PPO), has the dentist reviewed the documents? Is there a contractual provision for the dentist to be advised of modification of such documents? Is the dentist bound by such modifications?
8. What financial obligations does the contract create for the dentist? Is the dentist liable for any charges for services he/she orders?
The PPO contract may not cover the cost, by way of example, of a TMJ x-ray series. The dentist may be obligated to order a TMJ series to maintain standard of care, and then be the only person obligated to pay for it under the terms of the contract.
9. Does the contract limit referrals to "contract" specialists? Is there a mechanism in the contract for the dentist to be made aware of "contract" specialists? Does the dentist assume any financial liability if he refers a patient to a non-contract specialist?
If the dentist must change his or her referral pattern for a PPO patient, a claim of discrimination could be lodged by the patient.
10. Does the contract place any restrictions on referrals to any specialists?
11. What co-payments, if any, are patients responsible for under the contract? Can the amount of co-payment be unilaterally changed and/or eliminated under the contract?
12. Is there a contractual time limit for the submission of claims? Is there a contractual time limit for the payment of claims? Is there a con-

tractual penalty, such as some defined rate of interest, for delay in receipt of payment?

13. Is there contracting entity subject to the Knox-Keene Act or other licensing requirements? Has it complied?
14. Does the contract mandate that a claim of professional liability against a dentist be submitted to final and binding arbitration? What procedure is utilized in the arbitration process? What time limits are involved in the arbitration process?
The PPO contract may require a dentist to give up his or her right to a jury trial for a malpractice claim.
15. Does the contract specifically provide that the agreement will be governed by California law?
16. Does the contract require the dentist to maintain minimum dental malpractice insurance?
17. Will the dentist have some readily available method of identifying patients under a contractual relationship? Does the contract require that the dentist call and verify patient identification prior to each consultation?
18. Are non-covered charges clearly defined in the contract? Is the patient liable for payment of non-covered charges?
19. Does the contract allow the dentist's name to be used on brochures, other advertising, radio and/or T.V.?

NEWSLETTER The American College of Prosthodontists

Editor
Robert W. Elliott, Jr., D.D.S.
Publications Manager
Linda Wallenborn
Contributor
Lucius W. Battle, D.D.S.



MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS
ISSN 0736 - 346x

The **Newsletter** is the Official
Publication of
The American College
of Prosthodontists

Please direct all correspondence to:
The Editor
8732 Falls Chapel Way
Potomac, MD 20854

20. Does the contract make reference to a peer review and/or utilization review program? Has the dentist obtained a copy of the plan? Are the procedures of the plan subject to unilateral change without prior notice to the dentist and/or without the prior assent of the dentist?
21. Does the contract obligate the dentist to perform any services after the contract is terminated?
22. Does the contract allow for a negotiated fee schedule to be unilaterally changed without prior notice to the dentist and/or without the prior assent of the dentist?
23. Does the contract limit the

number of patients the dentist may (or must) serve over the course of a year?

24. Does the contract require the dentist to be available on a 24-hour basis?
25. Does the contract require a "contract" dentist to arrange for another "contract" dentist to cover during absences and vacations?
26. Does the dentist's professional liability policy cover contractually assumed liability?
27. Does the contract require the dentist to accept all patients referred under the contractual

relationship?

28. Does the contract limit the right of a dentist to contract with any other third party?
29. Does the contract permit termination if the contractor becomes insolvent?

Remember, the dentist's obligation to provide a standard of care remains the same regardless of the contractual restrictions that may be imposed by a PPO.

I highly recommend consultation with a qualified attorney to review any PPO contract a dentist may consider.

—David W. Eggleston, D.D.S.

DELTA PLAN DENTAL INSURANCE

The A.C.P. Prosthetic Dental Care Programs Committee is currently striving to attain separate Delta Plan fee schedules for prosthodontic procedures performed by Prosthodontists. This task is hindered by the small number of Prosthodontists compared to those in other specialties, and further complicated by some Prosthodontists who registered as General Practitioners with their Delta Plan Dental Insurance.

The Prosthetic Dental Care Programs Committee, chaired by Dr. David Eggleston, is requesting that all Prosthodontists register themselves as Prosthodontists with their Delta Plan Dental Insurance.

feel should be included in this Directory. Any suggestions are welcome.

Please address your reply to: Dr. Crystal Baxter, 919 West Carmen, Unit A, Chicago, Illinois 60640.

FROM THE SECRETARY



The Executive Council met in Chicago, February 18 and 19, 1984 and found new ways to test the endurance of its members. Because of the difficulty of finding sufficient, non-conflicting time to complete its agenda, the Council met from 8:00 P.M. to 11:00 P.M. on Saturday night and resumed at 7:30 A.M. for another continuous session until 4:30 P.M. on Sunday. Truly a masochist's weekend delight. As the College grows so grows its workload.

Mark your calendar - "Nashville, October 17-20, 1984." This annual session is shaping up as the biggest and the best we've had. Charlie DuFort, who is annual session co-chairman, showed us slides of the Hyatt Regency Hotel, its meeting facilities and several of the sights of Nashville. It looks like a great place for a meeting. The room rates are great also - \$57 for a single and \$67 for a double. The scientific program Charlie and Jerry DiPietro have assembled looks outstanding. In addition, there will be the research

competition, the table clinics and a select group of commercial exhibits. The Friday afternoon schedule includes the ACP Sections Meeting (all Sections should try to send a representative), the Annual Mentor's Meeting (an excellent meeting is being planned), and the Affiliate/Associate Luncheon and Seminar. (Affiliates will again be guests of the College for this luncheon). A full day Private Practice Workshop will be held on Saturday to avoid all conflicts so that everyone interested can attend. When your spouse sees the list of social happenings being scheduled by Ron LuBovich and his Local Arrangements Committee, you won't be able to leave him/her at home.

All Diplomates of the American Board of Prosthodontics will be voting in June to select a new Board examiner. **Dr. Kenneth A. Turner** is the nominee of the College. Assuming he will be one of the two or more candidates selected by the new Council for the Affairs of the American Board of Prosthodontics, I encourage all College members to support Ken. I have the privilege of assembling and submitting the necessary documentation to support his nomination and I can assure you that he deserves your support. Professionally, he is exceptionally well qualified and he possesses all the personal qualities to ensure that he will be a most capable, fair, objective, open-minded, compassionate and empathetic board examiner. Please give Ken Turner your support.

Don't miss Nashville! The meeting will be great! The social events super! And some important decisions will need to be made at the business meeting that will affect the future of the College and all of us personally.

—William A. Kuebker, D.D.S.

ADVANCED PROSTHODONTIC TRAINING PROGRAM DIRECTORY

Plans are now being made by the American College of Prosthodontists to publish a directory of Advanced Prosthodontic Training Programs. This Directory would describe each program individually, and be available to dental schools, other dental organizations and to members of The American College of Prosthodontists.

It is intended that the directory be helpful to students interested in pursuing a career in prosthodontics by aiding them in choosing a program which best suits their goals and limitations.

Dr. Crystal Baxter, Chairman of the Education and Advancement Committee, Publications Division, would like your input as to what information you

SIX NAMES OVER NASHVILLE

Like Texas' Allegiance to six flags, Nashville has given allegiance to six names: the Bluffs, French Lick, Fort Nashborough, Athens of the South, Music City, and of course, Nashville. These names trace the history and development of the city to the present day.

Prior to 1710 there were only Indians occupying the Bluff. The general area was used as hunting grounds. French fur traders, Charles Charleville and Timothy Demonbreun, some of the first white men in the area, established a trading post near a salt lick. Because of this, the first settlers from the East called the site French Lick, which it was called until 1779.

James Robertson, an Englishman from North Carolina, and a party of eight men arrived here and started building shelters in 1779. They renamed the site Fort Nashborough for General Francis Nash of North Carolina. In 1780, after the arrival of the John Donelson party, the first civil government in Middle Tennessee was formed by the signing of the Cumberland Compact by 256 settlers. In 1784, because of anti-British sentiment in the area, the name was changed again from Fort Nashborough to Nashville.

Athens of the South was to be still another name, one which would stick even to this day. This reputation is richly deserved. Starting with Davidson Academy, which later became the University of Nashville, and including Vanderbilt University, Fisk University, one of the first private schools dedicated to the education of blacks, Meharry Medical College, which has educated more black doctors than all other Medical Colleges in the world combined, Nashville has progressed to seventeen Colleges and Universities. The replica of the Parthenon was such a popular exhibit during the Tennessee State Centennial in 1897, that the city, already called the Athens of the South, decided to build a permanent replica in Centennial Park. It remains the only full-scale facsimile of the Parthenon in existence.

Nashville today is Music City! Not only is this the home of country music, but also blues, gospel, and rock. By 1950 every major record company had offices and studios in Nashville. More singles are recorded here each year than anywhere in the world. WSM's Grande Ole Opry is America's longest



The Nashville Skyline

running radio show. It was first broadcast in 1925.

Nashville's historic houses, government buildings, parks, and museums are open to the public, and they have

much more to tell about Nashville. Don't miss them as a part of your experiencing this exciting city. (From information furnished by the Tennessee Historic Society.)

DENTAL INSURANCE RESEARCH SHOWS WHO IS COVERED

If you are covered by a dental benefits program, it is likely that you are a white male between the ages of 30 and 44, that you earn more than \$30,000 a year and live in the western United States. You are likely to be a college graduate and hold an executive or professional level job, and/or are a union member. You probably vote a Republican ticket and go home every night to a household with children under the age of 13.

This profile of the typical beneficiary was drawn from a national study on dental insurance recently conducted by the Roper Organization, Inc., for the Delta Dental Plans Association, Chicago, which is the coordinating agency for the 43 Delta Dental Plans in the United States.

The study showed that nearly half of those employed full-time have dental insurance, and that most are male. The largest age group covered was the 30 to 44 range with 45 to 59 a close second. The majority earn \$30,000 or more, while those who earn \$20,000 to \$30,000 rank next. Forty-two percent are white, 37 percent are black.

The western U.S., where dental insurance was initiated, has the most employed people with coverage. The

industrial northeast and midwest tie for second place and the southern part of the country is last.

Dental coverage is highest among unionized workers with 70 percent of union members surveyed indicating that they had this benefit. Those who hold executive or professional positions are among nonunionized blue collar workers.

According to the survey, the majority of subscribers are college graduates, and Republicans slightly outrank Democrats. Forty-five percent have children under the age of 13, while 42 percent have children in the 13 to 18 age range.

According to the survey, forty-two percent of the nation, or an estimated 90 million people, now have dental care coverage, making it the fourth most common benefit. Hospitalization is first, major medical plans second and physician costs third.

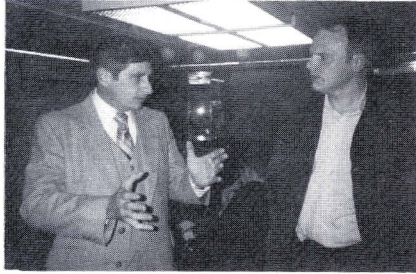
Though dental coverage was practically unknown on a national scale as recently as 15 years ago, the Roper poll indicates that it has quickly become a highly valued benefit. When those surveyed were asked what parts of their total health coverage they might consider terminating, only 16% of those employed full-time and 15% of those now having coverage mentioned dental benefits as one of the first two or three plans they would drop.

The poll also dealt with dental health habits. About 74% of those in the sur-

tu
the

vey group who are employed full-time and have dental coverage reported that they see the dentist about once a year. In contrast, 61% of full-time employees without coverage said they have annual dental visits.

The Delta system is a network of not-for-profit organizations offering group prepaid dental benefit programs. In 1983, Delta Plans covered 15 million people and paid out an estimated \$1 billion to covered subscribers.

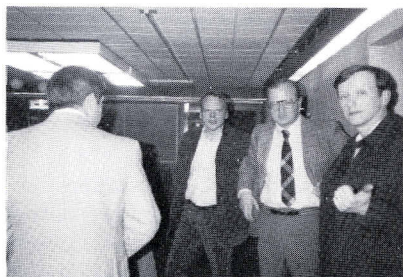


I said, "You're right Doctor!"

COLLEGE HOSTS BOARD EXAMINEES

On February 14, 1984, The American College of Prosthodontists hosted a cocktail party at the Marriott Hotel for the candidates who had taken Part I of the Board Exam in Chicago. The room was provided by the American Equilibration Society, which was holding their Annual Session on February 14 and 15. Refreshments were provided by The American College of Prosthodontists. Dr. Baxter, Chairman of the Education and Advancement Committee, Publications Division, made local arrangements for the party. Over 30 examinees took advantage of the get-together.

The room allowed the candidates to have a place to stop, relax and talk to their colleagues who had taken the Board. Several mentors, including Drs. Woody and Battle, also stopped by. It is planned to continue this get-together as a yearly event.



"I'm glad it's over!"

KENNETH A. TURNER NOMINATED FOR A.B.P.

The College has nominated Dr. Kenneth A. Turner, Professor and Chairman of the Department of Fixed Prosthodontics at the College of Denstry at the University of Iowa, for membership on the American Board of Prosthodontics. The nomination has been sent to the Council for the affairs of the A.B.P.

Dr. Turner received his dental degree from the University of Wisconsin in 1963 and subsequently served in the U.S. Army till 1971 when he joined the faculty at Northwestern University as Associate Professor. He received his certificate from the American Board of Prosthodontics in 1970.

His training included both removable and fixed prosthodontics and he left Northwestern to become the Director of the Graduate Program in Prosthodontics at Emory University.

A member of Omicron Kappa Upsilon, he received the "outstanding academic Professor" award at Emory School of Dentistry in 1976. Currently he is President-Elect of the Fixed Prosthodontic Section of the American Association of Dental Schools.

He has served or is serving on numerous committees and authored or coauthored a number of articles or texts published in the dental literature.

Dr. Turner is eminently qualified for the position for which he has been nominated. College members are asked to support his candidacy.

SYNOPSIS OF PAPERS PRESENTED AT THE SAN DIEGO ANNUAL OFFICIAL SESSION

By: Dr. Lucius W. Battle

TITLE: The Prosthodontic Aspect of Ridge Augmentation Procedures

Presenter: Dr. Richard Grisius

Dr. Grisius enumerated the various methods of treating edentulous patients who have extensive resorption of the alveolar ridge. He presented the following techniques for treating extremely resorbed alveolar ridges:

(1) Modification of the denture technique to include:

- (a) Wax impressions
- (b) Metal bases
- (c) Hardy Cutters
- (d) Coe Masticators

- (e) Tissue conditioning materials
- (2) Use of split-thickness skin graft vestibuloplasty:

Dr. Grisius described preparation of the surgical stent to accommodate the STSG. He presented the surgical technique and emphasized that the relatively short healing period of three to four weeks was an advantage with this particular technique.

(3) Metallic implants for minimal bone situations:

- (a) Subperiosteal implants
- (b) Staple implant: allows no vertical loading
- (c) Ramus frame implant

(4) Cartilagenous augmentations:

This technique is not used by the profession at the present time.

(5) Hydroxylapatite augmentations:

The use of durapatite or calcite augmentations has presented some problems that are inherent with the technique. For example, implant particles may flow into unwanted areas and cause various problems such as paresthesia, or the particle implant may not become fixed in its prescribed location and may "float".

(6) Marrow graft with stent:

Unfortunately, this type of augmentation resorbs rapidly under functional loading.

(7) Visor technique by Harle:

This is an augmentation technique that resists resorption better than most augmentations. The problem associated with this technique is the high degree of paresthesia produced.

(8) Rib graft augmentation procedure was also reviewed by Dr. Grisius for treatment of a mandibular edentulous ridge that has extreme resorption. The technique follows:

- (a) Mount pre-surgical casts at the correct occlusal vertical dimension and maxillomandibular relation to prevent the development of abnormal jaw relationships with the augmentation.
- (b) The mandibular rib graft should be placed lingual to the crest of resorbed ridge.
- (c) Pack the rib graft with bone chips during surgical placement and fixation of the graft.
- (d) The split-thickness skin graft vestibuloplasty is initiated after healing.
- (e) Place the denture flanges short of the scar band to prevent inflammation at the STSG border.
- (f) Dr. Grisius recommends use of balanced anatomic denture teeth with no anterior contacts.

- (g) Callus formation on the STSG indicates a need for occlusal correction—relief for the denture base is not required.

Dr. Grisius concluded by stating that a 50% loss of the rib graft augmentation occurs within the first 30 months postoperatively; however, a wider, better quality ridge remains.

Inquiries pertaining to this essay should be addressed to Dr. Richard J. Grisius, Department of Prosthodontics, Georgetown University School of Dentistry, 3900 Reservoir Rd. N.W., Washington, DC 20007.

TITLE: A Clinical Study of Alveolar Ridge Augmentation Utilizing Durapatite

Presenter: Dr. Dwight J. Castleberry

Dr. Castleberry presented results of a clinical research study that was conducted at the University of Alabama utilizing Durapatite as an adjunct to ridge augmentation. A four-year follow-up of patients who received the Durapatite augmentation was included in this clinical study.

Dr. Castleberry briefly discussed five types of ridge augmentations, including:

- (1) Marrow grafts: Vitallium trays are used to support the marrow particles. Rapid resorption occurs with this technique unfortunately.
- (2) Rib grafts: Rapid resorption is also a characteristic of this technique.
- (3) Vestibuloplasty: Vertical ridge height must be available for this technique to be effective.
- (4) Split-thickness skin graft: This is an adequate treatment modality that provides more available ridge surface area but is technique sensitive.
- (5) Subperiosteal implants: One of the primary complications associated with this technique is the breakdown of bone surrounding the bone screws.

Dr. Castleberry made the following comments regarding the Durapatite ridge augmentation technique.

- (1) Stents made on diagnostic casts can be helpful at times when placing the Durapatite.
- (2) The mixing of sterile saline solution with Durapatite is acceptable; blood from the patient is not necessary for this purpose.
- (3) Place the Durapatite subperiosteally with a syringe; do not use pressure to push material from the syringe.

- (4) Do not place Durapatite at the incision site.
- (5) Marrow does not have to be combined with Durapatite for successful augmentations.
- (6) The Durapatite augmentation technique is a relatively simple procedure; the material is bio-compatible and non-resorbable, requiring no donor site.

Evaluation of patients participating in the University of Alabama Clinical study of Durapatite ridge augmentations resulted in the following conclusions:

- (1) The augmentation adds volume to the mandible. It helps to reduce pathologic fractures of the mandible.
- (2) The augmentation "seems to reduce further bone resorption."
- (3) A five-percent compaction of Durapatite particles occurs.
- (4) New dentures can be made three months after surgical placement of the Durapatite augmentation.
- (5) The following Durapatite augmentation criteria achieved ratings of good to excellent:
 - (a) Ability to masticate
 - (b) Retention of Durapatite particles within the surrounding tissues
 - (c) Apposition of the Durapatite to the ridge
 - (d) Patient satisfaction with the augmentation
 - (e) Clinical assessment of stability
 - (f) Overall clinical assessment of Durapatite

Dr. Castleberry concluded his presentation by discussing the following complications that have been encountered with Durapatite augmentations:

- (1) In this study, 8% of the patients developed dehiscence.
- (2) In this study, 28% of the patients developed parathesia or sensory loss to the lip and associated structures.
- (3) In this study, 6% of the patients experienced sloughing of Durapatite particles.
- (4) "A floating implant with no bony attachment can occur with hydroxylapatite augmentations." Dr. Castleberry stated that this phenomenon has not occurred with patients in the Durapatite clinical study at the University of Alabama.

Inquiries pertaining to this essay should be addressed to Dr. Dwight Castleberry, University of Alabama, School of Dentistry, Birmingham, Alabama 35233.

TITLE: Head and Neck Abnormalities with Dental Significance

Presenter: Dr. Harry Baddour

Dr. Baddour challenged the audience with the following concept: "Over-all patient approach is necessary for correct treatment planning." He presented a series of patients having malformations and disease processes that impact on the successful practice of dentistry.

The first patient described by Dr. Baddour was an adult man suffering from Eagles syndrome or carotid artery syndrome. Concerning the etiology of Eagles syndrome, Dr. Baddour said that 4% of the population is symptomatic. A history of trauma and/or tonsillectomy usually precedes Eagles syndrome. Palpation of the anterior tonsillar pillar will "trigger" this extremely painful entity, and treatment is accomplished by surgical reduction of the elongated styloid process.

Dr. Baddour described the treatment of an older man suffering from acromegaly, a pituitary disease in adults caused by a benign adenoma that produces excess growth hormone. Orthognathic surgery was performed on this particular patient to correct the malocclusion created by enlargement of the mandible.

Dr. Baddour presented an interesting patient history that included extraction of a mandibular third molar. Although the patient lost a large volume of blood immediately after the extraction, the clinician fortunately had the presence of mind to re-insert the molar tooth back into its socket under pressure. This procedure probably saved the patient's life because the bleeding was not controllable. Dr. Baddour stated that the diagnosis for this patient was arteriovenous malfunction. He recommended the arteriogram for diagnosis of these malfunctions. Proper diagnosis of this condition is essential to prevent possible tragedies in the dental office.

Inquiries pertaining to this essay should be addressed to Dr. Harry Baddour, OMNI Offices, 1869 Highway 45 N. Bypass, Jackson, Tennessee 38301.

DUES INCREASE?

The College has undertaken many projects to support the specialty of prosthodontics and in turn improve the ability of our members to practice in the best interests of the public they serve. These all require financial support.



Executive Council at work.

At the same time inflation has affected the costs of services provided members. This includes increases in Central Office rent, salaries, fringe benefits, and equipment costs.

Dues have not been increased since 1979. In that time membership has increased significantly.

Efforts have been made to hold the line cost wise by such measures as initiating commercial exhibits at the Annual Official Session and reducing clinician expenses at the Scientific Session.

Still, costs are rising faster than income and that means additional revenue is needed. A dues increase may be proposed effective in January 1985. If so, it will be voted on in Nashville in October.

USE OF COLLEGE LOGO

The Executive Council deliberated at length concerning the use of the College logo in the yellow pages of the telephone directory. The following was determined as the procedure to be followed to achieve this end:

Contact Dr. Thomas J. Balshi to obtain camera ready copy of the logo for use in the ad. His address is Upper Dublin Professional Center, 1244 Fort Washington Avenue, Fort Washington, PA 19034. Then, send the ad copy to the Central Office so that the Director may verify membership in the College of the prosthodontists whose names are listed in connection with the logo.

Billing for the ad will be to the Central Office. These costs will be charged in turn to the requesting group.

GRAND OLE PROSTHODONTICS 1984 COLLEGE MEETING

LOCATION: Nashville, Tennessee

HOTEL: Hyatt Regency Nashville

DATE: October 17-20, 1984

ANNUAL SESSION

CO-CHAIRMEN:

Charles R. DuFort
and

Girard J. DiPietro

PLAN NOW!

PLEASE MARK YOUR
CALENDAR TODAY!

VOICE YOUR OPINION

The College business is accomplished by the work of **active** committees. The College is fortunate to have many intelligent, motivated, informed young men and women to chair and be members of these groups.

If you would like to serve on a College committee next year write to the President-Elect, Dr. Robert Sproull telling him of the capacity in which you wish to serve.

If you have an idea or an opinion you wish to voice to the Executive Council, convey it to a committee person listed below, their addresses may be found in the College roster — Do it now, the next meeting of the Executive Council is in Denver, Colorado on the 12th, 13th, & 14th of July.

COMMITTEES FOR 1984

Constitution and Bylaws

Dr. Robert J. Sarka, Chm.	2 years
Dr. Frederick S. Muenchinger	1 year
Dr. Ross H. Hill	1 year
Dr. Arthur R. Frechette	2 years
Dr. Gordon E. King	3 years
Dr. Robert J. Everhart	3 years

Education and Advancement

A. Information and Publication

Dr. J. Crystal Baxter, Chm.	2 years
Dr. Stephen L. Welsh	1 year
Dr. Daniel L. Hall	1 year
Dr. David P. Donatelli	2 years
Dr. Edmund Cavazos	3 years
Dr. Robert Flinton	3 years

B. Implementation of Aims and Goals

Dr. Howard Landesman, Chm.	3 years
Dr. Don G. Garver	3 years
Dr. Joseph J. Berte	3 years
Dr. Charles R. DuFort	3 years
Dr. Donald R. Nelson	3 years

Membership and Credentials

Dr. Phillip V. Reitz, Chm.	1 year
Dr. George E. Monasky	1 year
Dr. Michael L. Myers	2 years
Dr. Frederick J. Finnegan	2 years
Dr. Lucius W. Battle	3 years
Dr. Ann Sue von Gonten	3 years

Research

Dr. Thomas P. Sweeney, Chm.	1 year
Dr. F. Michael Gardner	1 year
Dr. Gerald D. Woolsey	2 years
Dr. Nelson M. Davisson	2 years
Dr. Lawrence Gettleman	3 years
Dr. John B. Houston	3 years

Public and Professional Relations

Dr. Thomas J. Balshi, Chm.	3 years
Dr. John Burton	1 year
Dr. Francis E. Clark	1 year
Dr. John E. Ward	1 year
Dr. John R. Hansel	2 years
Dr. Earl W. Simmons	2 years
Dr. Robert D. Grady	3 years
Dr. Roy T. Yanase	3 years
Dr. Philip H. Ruben	3 years

Necrology and Eulogy

Dr. John D. Mose, Chm.	1 year
Dr. Richard J. Persiani	2 years
Dr. Robert J. Dent	3 years

Ceremonies and Awards

Dr. John S. Ostrowski, Chm.	1 year
Dr. Peter F. Johnson	2 years
Dr. Gerald T. Ballard	3 years

Color and Color Matching

Dr. Kenneth A. Turner, Chm.	2 years
Dr. Marion J. Edge	1 year
Dr. S. George Colt	2 years
Dr. E. Richard McPhee	3 years
Dr. Gerald V. Butler	3 years

Prosthetic Dental Care Programs

Dr. David W. Eggleston, Chm.	3 years
Dr. Daniel Y. Sullivan	1 year
Dr. Juan B. Gonzalez	1 year
Dr. Donald F. Nelson	2 years
Dr. Howard J. Charlebois	2 years
Dr. Paul P. Binon	3 years

Nominating Committee

Dr. Stephen O. Bartlett, Chm.	
Dr. Robert C. Sproull	
Dr. Mark E. Connelly	
Dr. John E. Rhoads	
Dr. Richard J. Grisius	

The Private Practice

of Prosthodontics

Dr. Daniel F. Gordon, Chm.	2 years
Dr. Lawrence S. Churgin	1 year
Dr. Thomas J. McGarry	1 year
Dr. Alan E. Zweig	2 years
Dr. John T. Goodman	3 years
Dr. Gerald M. Barrack	3 years
Dr. Baron Barnett	3 years

Site Selection

Dr. Alex Koper, Chm.	3 years
Dr. Louis B. Jannetto	1 year
Dr. Raleigh A. Holt	1 year
Dr. Carl J. Drago	2 years
Dr. Stephen F. Bergen	2 years
Dr. Ronald D. Woody	3 years

Linda Wallenborn (ex officio)

Budget

Dr. Robert C. Sproull	
Dr. Noel D. Wilkie	
Dr. John B. Holmes	
Linda Wallenborn (ex officio)	

Area and Regional Sections

Dr. Stephen O. Bartlett, Chm.	3 years
Dr. Thomas J. Balshi	1 year
Dr. William B. Love	1 year
Dr. Dana E. M. Kennan	2 years
Dr. Juan B. Gonzalez	2 years
Dr. Albert R. Hube	3 years
Dr. Dennis J. Weir	3 years

Annual Session Co-Chairmen - 1984

Nashville, Tennessee

Dr. Charles R. DuFort	
Dr. Girard J. DiPietro	

Local Arrangements Chairman - 1984

Nashville, Tennessee

Dr. Ronald P. LuBovich	
------------------------	--

Historian

Dr. James A. Fowler, Jr.	3 years
--------------------------	---------

Associate Editor to the J.P.D.

Dr. Dale H. Andrews	3 years
---------------------	---------

Ad Hoc Central Office Local

Advisory Committee

Dr. Kenneth L. Stewart, Chm.	
------------------------------	--

Dr. Robert M. Morrow
Dr. James A. Fowler, Jr.

Ad Hoc Committee on Prosthodontic Nomenclature

Dr. Dean L. Johnson, Chairman
Dr. Carl W. Schulter
Dr. Joel C. Gelbman
Dr. Edwin H. Smith, Jr.
Dr. Don W. Morgan
Dr. Lawrence Gettleman
Dr. Harold W. Preiskel
Dr. Stephen F. Bergen
Dr. Robert C. Sproull

Ad Hoc Committee on the International College of Prosthodontists

Dr. Jack D. Preston, Chairman
Dr. Thomas J. Balshi

Ad Hoc Committee on the Advancement of the Specialty of Prosthodontics

Dr. Girard J. DiPietro, Chairman
Dr. John E. Rhoads
Dr. Robert W. Elliott, Jr.

Ad Hoc Committee on the Review and Revision of Goals and Objectives

Dr. Cosmo V. DeSteno, Chairman
Dr. Noel D. Wilkie
Dr. Mark E. Connelly

Ad Hoc Committee to Study Administration of Committees

Dr. Noel D. Wilkie, Chairman
Dr. Kenneth L. Stewart
Dr. John D. Mose

Ad Hoc Committee on Ethics

Dr. Samuel E. Guyer, Chairman
Dr. Donald O. Lundquist
Dr. C. Gordon Monteith
Dr. Cathy J. Smith
Dr. Harley H. Thayer

Ad Hoc Committee on Commercial Exhibits

Dr. Mohammad Mazaheri, Chairman
Dr. Vernon Y. Kwok
Dr. Niles F. Guichet
Dr. Richard A. Smith

Ad Hoc Committee on Dental Laboratory Service

Dr. Mark E. Connelly, Chairman
Dr. Ronald H. Jarvis
Dr. Thomas L. Huff
Dr. Thomas E. Miller
Dr. Thomas A. Wight
Dr. Frank E. Pulskamp

Ad Hoc Committee on Geriatrics

Dr. James S. Brudvik, Chairman
Dr. John P. McCasland
Dr. Robert H. Sprigg

Ad Hoc Committee on the Care of the Maxillofacial Patient

Dr. Dorsey J. Moore, Chairman
Dr. Stephen M. Parel
Dr. Mohammad Mazaheri
Dr. Martin J. Cain, Jr.
Dr. Michael A. Carpenter

Ad Hoc Committee on Real Estate

Dr. Robert M. Morrow, Chairman
Dr. Thomas J. Balshi
Dr. John D. Jones
Dr. Edmund Cavazos, Jr.
Dr. Harold Schwartz



The Hermitage is the restored home of Andrew Jackson, the 7th president of the United States.

MAKE YOUR NASHVILLE RESERVATIONS NOW

Dr. Charles DuFort, co-chairman of the Annual Official Session in Nashville, reported to the Executive Council Meeting in Chicago that the room rates at the Hyatt Regency, Nashville are set at \$57.00 & \$67.00 for single and double occupancy respectively.

It is recommended that you make your reservations **NOW** and take advantage of these most reasonable room charges.



Belle Meade Mansion was known as the "Queen of Tennessee Plantations" and was the first of the nation's thorough-bred breeding farms.

WASHINGTON SCENE

The following are quotations from the Washington News Bulletin Vol 17, No 1, February 1984, a publication of the American Dental Association.

1984 in Washington is going to be highlighted by the budget deficits and the elections. The budget problems will require most of the limited legislative time available to the Congress. The election year orientation, however, makes it fairly unlikely that tough decisions will be taken.

Preferred Provider Organizations: No further hearings have been scheduled on H.R. 2956, the Preferred Provider Health Care Act introduced by Representative Ron Wyden, D-OR. This legislation would override state laws which could impede the development of PPOs. Included would be an override of state freedom of choice laws and laws which prohibit discrimination in

the benefits offered to employees of a single employer. The House Commerce Committee has indicated, in a review of the issues facing it during 1984, that no further action is scheduled on this bill. However, Representative Wyden will attempt to include his proposal, perhaps with some modifications, as an amendment to one of the numerous health bills which are to extend expiring health programs. The Association has expressed its strong opposition to this legislation to override state laws.

Fluoridation: The Association has been invited to testify on legislation, H.R. 3850, which would re-establish a federal program of categorical grants for fluoridation. Under the provisions of the bill, known as the Children's Preventive Health Act, states and local governments would be eligible for up to \$39 million in assistance to initiate and expand fluoridation activities. Direct or categorical grants for fluoridation programs ended in 1982 with the establishment of the Preventive Services BlockGrant authority. Although fluoridation is one of the eligible areas for block grant support, many states have elected to use these federal funds for other preventive services. The purpose of H.R. 3850 is to provide a national focus and an identifiable source of federal assistance for state and local fluoridation programs.

Federal Employees Health Benefits: Senator Hatch, R-UT, has introduced a bill, S. 2252, to authorize a voucher system for federal employees to obtain their health benefits. Each employee would receive a voucher authorizing a federal health benefits contribution. The employee could then apply this voucher to any approved health benefits plan. If the cost of the plan is less than the voucher amount, the employee would receive the difference in cash.

Legislation introduced by Representative Mary Rose Oakar, D-OH, which would mandate comprehensive dental services among those benefits which must be offered to federal employees has not received further consideration following Subcommittee hearings last year. While the cost of adding dental and certain other benefits may impede progress of the bill (H.R. 656), certain other changes in the federal employees program also proposed by the bill are of interest and may help move it toward enactment.

State Legislation:

Denturism: Bills to establish the independent practice of denturism have

state legislatures of Hawaii, Kentucky and Mississippi. In addition, a voter initiative has been profiled in the state of Montana. The four proposals contain similar language and, in many respects, duplicate the 1982 initiative approved in Idaho. Provisions in these proposals include: independent practice, complete and partial denture services, independent licensing boards, grandfather provisions and educational and apprenticeship requirements for individuals who do not meet the initial licensure requirements.

State Dental Boards: In 1983, the ADA House of Delegates adopted Resolution 40H calling for additional state dental board funding and authority for patient protection activities.

In regard to funding, a number of states in the past several years have raised their licensing and registration renewal fees to meet the increasing costs of examining and discipline. At the same time, some state dental boards have been authorized to impose fines as a form of discipline or penalty in cases where dentists have been found guilty of unprofessional conduct. While these fines are a form of discipline, they also generate revenue for the board to assist in covering its expenses. Some states also impose hearing (or user) costs on licensees who are found guilty of unprofessional conduct. The rationale for imposing these costs is that since the hearing was necessitated by the defendant's conduct, the licensee should pay for the costs of the hearing if he or she is found guilty. In those states that have a business or sales tax on professional services, it may be possible to direct some of the money generated by those taxes to pay for board activities. Similarly, taxes on soft drinks, chewing gum and candy could generate revenues for public dental health programs as well as patient protection activities.

Last year, some 12 states adopted changes in their dental practice acts expanding the disciplinary powers of the state dental boards. Definitions of unprofessional conduct have been updated in several states to include provisions on overbilling third-party payers and continuing competence and to bring advertising sections in line with recent court decisions. In addition, the trend is to give the boards increased authority to take summary action in emergency situations and to permit greater latitude in the types of discipline that may be imposed. In lieu of suspension or revocation of license,

many boards now may issue a reprimand, place a dentist on probation, impose restrictions on the procedures that may be performed, impose a fine for lesser infractions or order restitution to a patient or third-party payer. At the same time, there is greater attention to the problem of physical or mental impairment and increased sensitivity that these are health problems that may be handled separately from violations of the law.

Members are encouraged to provide their State and Federal Representatives with their views related to legislation affecting the practice of dentistry.

DATES OF THE ANNUAL OFFICIAL SESSION

The next Annual Official Session will be held in Nashville according to the following schedule:

Monday and Tuesday, October 15-16, Executive Council Meeting.

Wednesday, Thursday, and Friday, October 17, 18 and 19, Annual Scientific Session.

Saturday, October 20, Private Practice Seminar.

WILLIAMSBURG FOR ORLANDO

The Executive Council at its meeting in Chicago voted to change the site of the 1986 Annual Official Session from Orlando, Florida to Williamsburg, Virginia. All College members should note this change which, it is understood, is in harmony with the 1986 meeting of the Academy of Maxillofacial Prosthetics.

**QUESTIONS?
IDEAS?
PROBLEMS?
Call The
Central Office
(512) 340-3664**

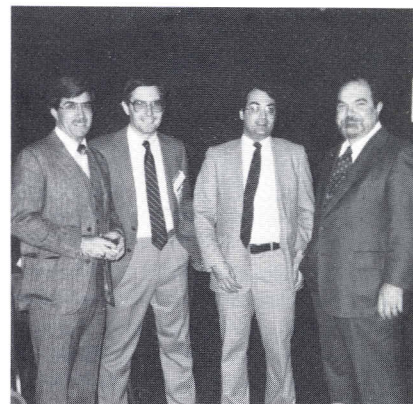
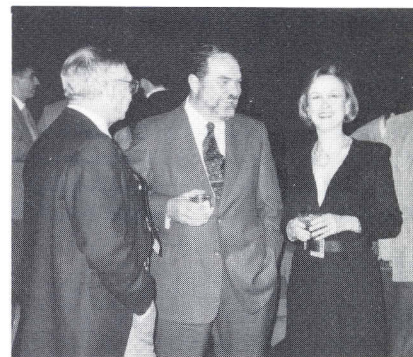


PRIVATE PRACTICE WORKSHOP — WHEN?

The day to hold the Private Practice Workshop was the subject of considerable discussion at the recent meeting of the **Executive Council in Chicago**.

Should it be a full day? Should it be on Tuesday, Wednesday or Saturday? These questions and others which may be raised by private practitioners need to be answered so that the workshop can be scheduled as nearly as possible to meet the requirements of those who wish to participate in it. At the same time, it is desired that the workshop not conflict with other portions of the scientific program.

Please address your responses to these questions together with other suggestions to the Chairman of the Committee on the Private Practice of Prosthodontics, Dr. Daniel F. Gordon, 1441 Avocado Avenue, Suite 508, Newport Beach, California 92660.



The College Mixer in Chicago was well attended.

NEWS FROM SECTIONS

Pennsylvania: The Pennsylvania Section of the College lists the following as its Officers and Directors for 1984.

Dr. Barry D. McKnight, President; Dr. Thomas J. Balshi, President-Elect; Dr. Edward W. McCarthy, Vice President; and Dr. Bernard H. Olbrys, Secretary-Treasurer.

Directors are Dr. Mohammad Mazaheri, Dr. John W. Harrison, Dr. George E. Monasky and Dr. Howard J. Charlebois.

—Barry D. McKnight, President

Metropolitan Washington Section:

The National Capital Area Section of the American College of Prosthodontists met at the National Naval Medical Center on Tuesday, April 24, 1984. The program for the evening was presented by the Second Year Graduate Prosthodontics Students at Georgetown University. They were introduced by their mentor, Dr. Richard Grisius, and presented the following subjects:

"A Comparative Study of the Neutral Zone and the Conventional Complete Denture" by Dr. Chung-Wen Yang.

"The Rotational Path Removable Partial Denture: A Study of Retention" by Dr. Georgina Villongco.

"A Tomographic Study of the TMJ of Edentulous Patients" by Dr. Costas Hatjigiorgis.

Approximately seventy members and guests were present for the dinner and scientific session.

—Marvin L. Baer, Chairman

Section Presidents/Chairmen

California: Duncan H. Wallace, 2613 Pierpoint Blvd., Ventura, CA 93001

Georgia: Michael A. Carpenter, 3019 McCully Dr., Atlanta, GA 30345

Maryland: Harry B. Schwartz, 1403 Catlyn Pl., Annapolis, MD 21403

Missouri Valley: Richard E. Coy, School of Dental Medicine, Alton, IL 62002

National Capital Area: Marvin L. Baer, 4432 Airlie Way, Annadale, VA 22003

New England: Remo A. Sinibaldi, Lewis Wharf Bay 237, Boston, MA 02110

New Jersey: William H. Pruden II, 312 Warren Ave., Ho-Ho-Kus, NJ 07423

Ohio: William A. Welker, 1053 Firth Ave., Worthington, OH 43085

Pennsylvania: Ernest B. Mingleddorf, 900 Coopertown, Rd., Bryn Mawr, PA 19010

South Carolina: Robert V. Keith, 4 Carriage Land No. 305, Charleston, SC 29407

South Texas: James A. Fowler, Jr., 12519 Chateau Forest, San Antonio, TX 78230

Tennessee: Carl W. Schulter, 7770 Poplar Ave., Ste. 107, Germantown, TN 38138

ABP ISSUES REVISED GUIDELINES

The pamphlet entitled "History, Information and Examination Requirements of the American Board of Prosthodontics" has been rewritten and contains several changes from the 1981 edition. Some of the changes are summarized below. (For definitive information consult the 1984 publication.)

- Sections headed history, definition and general statements of purpose are essentially unchanged.
- To be board eligible one is now required to have successfully completed an accredited program.
- Eligibility requirements for Canadian dentists are addressed and are essentially the same as for U.S. dentists.
- Duration of eligibility is generally limited to 8 consecutive years (4+4) once an individual's application is accepted and approved by the Board.
- In the patient presentation Phase I Part 2, the fixed partial denture need not replace one or more posterior teeth.
- The guidelines relating to the patient presentation have been considerably amplified.
- All candidates in Phase II Part 1 may now utilize one chairside dental assistant.
- Information relating to Phase II Part 1 has been greatly modified in all divisions, removable, fixed and maxillofacial prosthodontics.
- Appropriate professional attire is mandated.
- If the candidate fails any part three (3) times, board eligibility is forever forfeited and may not be reestablished except under unusual extenuating circumstances which the Board may determine.
- Certification will be revoked if the annual fee is 6 months delinquent.

The above items are supplied for your interest only. Consult the new guide for definitive information

For the people **now in the examination process**, considerable leniency will be extended to allow adaptation to the new procedures, according to Jack Preston, a member of the Board.

"IMPROVE YOUR IMAGE SEE A PROSTHODONTIST"

The Chairman of the Public and Professional Relations Committee wants to develop a bumper sticker which will increase the public awareness of what prosthodontists are and/or what they do.

Do you have a suggestion? Someone of the College's 1400+ members must have some "gem" waiting for recognition.

Tell it to Chairman Thomas J. Balshi. Call him at (215) 646-6334.

COLLEGE INSURANCE PROGRAM NEEDS SUPPORT

Treloar & Heisel have informed Dr. Sproull, the President-Elect, that participation in the College sponsored insurance program has been minimal and may therefore be discontinued for lack of interest.

Members are urged to review the program described in previous **Newsletters** and participate in it if the insurance offered by Treloar & Heisel meets their needs.

Dr. Sproull noted that in any event those policies purchased through the program will remain in effect.

ADA ISSUES REPORT ON PROSTHETIC CARE BY NONDENTISTS

The ADA has recently published a Status Report on the Delivery of Prosthetic Care by Nondentists in the U.S. and Canada. The report provides up-to-date information on laws in Arizona, Colorado, Idaho, Maine and Oregon that allow nondentists to provide prosthetic care. Statutes in eight Canadian provinces also are discussed. In addition, the report covers program administration, licensing and examination activity, education curricula, law violations, fees and practice locations. Copies of the report may be obtained from the Council on Prosthetic Services and Dental Laboratory Relations at ADA Headquarters.

MEMBERS IN THE NEWS

Dr. John Rhoads - named Section Editor of the JPD in Fixed Prosthodontics.

Dr. Stephen O. Bartlett - named Psi Omegan of the Year for South Carolina.

IADR ABSTRACTS

The following are abstracts of papers, presented at the March 1984 meeting of the International Association of Dental Research in March in Dallas, Texas, which are of interest to Prosthodontists.

Summary of a paper entitled "Intra-oral Saliva Reservoirs for (E)dentulous Patients Suffering from Severe Xerostomia", by Drs. E. J. 's-Gravenmade, A. Vissink, A. K. Panders, L. L. Visch, and A. Vermey of the University of Groningen, The Netherlands.

Many people suffer from "dry mouth". Those especially handicapped are patients irradiated for oral cancer and those patients receiving drug therapy with the dry mouth as a side-effect. Researchers at the University of Groningen, The Netherlands, have developed a mucin-containing artificial saliva whose properties, e.g., lubrication and wettability, resemble those of natural saliva. The use of artificial saliva by means of dripping, sucking, or spraying the liquid is unnatural and can be disturbing to the patient in his routine social contacts. Thus, until now, artificial saliva has had only limited appeal.

At the General Session of the International Association of Dental Research, Dr. Hans 's-Gravenmade reported a more natural means of artificial saliva application, using an intra-oral reservoir as a container. The reservoir is easily filled and cleaned, and can be worn by both denture and non-denture patients. This technique enables patients to enjoy their routine daily activities for a couple of hours without the discomfort of a dry mouth.

Summary of a paper entitled "Properties of a New High Expansion Core Material for Porcelain Crowns", by Dr. W. J. O'Brien of the University of Michigan.

Ceramic threads among the gold. Researchers at the University of Michigan, have developed a high-strength ceramic for use in reinforcing dental crowns. It is designed to replace the porcelain-bonded-to-gold crowns which have become too expensive for many Americans since the price of gold has skyrocketed in recent years. The new ceramic replaces the gold as a reinforcement to make a crown with adequate strength for restoring most front teeth.

Speaking to researchers at the General Session of the International

Association for Dental Research, Dr. William O'Brien told the gathering of the advantages of the new ceramic: It is cost-effective (since the ceramic can be bonded directly to the porcelain, as opposed to the old practice of using alloys to bond gold crowns), and it does not stop x-rays, thus allowing the dentist to check the health of the underlying tooth.

Summary of a paper entitled "Morphological Effects of Nicotine and Ethanol on Oral Mucosa", by Drs. B. K. Hall, C. A. Squier, and A. Lee, of the University of Iowa College of Dentistry.

Oral pathologists have suspected for some time that people who smoke and drink heavily might have a greater chance of getting cancer in certain oral sites than do people who indulge in only one of these habits.

Drs. Christopher Squier and Barbara Hall, University of Iowa, speculated that this might be due to alcohol's ability to enhance the uptake of carcinogens (present in tobacco products) by tissues in the mouth. Measurements of the absorption of these substances across the mouth lining were made; the tissues were also examined for evidence of damage, with the aid of the electron microscope. It was found that alcohol did cause an increase in the uptake of tobacco carcinogens in the sensitive floor-of-mouth regions. This is an interesting finding in view of the fact that the floor of the mouth is one of the most common sites for oral cancer.

Summary of a paper entitled "Cariogenicity of Sweetened Soft Drinks", by Drs. A. I. Ismail, B. A. Burt, and S. A. Eklund, of the University of Michigan.

Could the frequent consumption of soft drinks be detrimental to your dental health? Yes, according to a recent analysis of a large-scale survey in the U.S. Drs. A. I. Ismail, B. A. Burt, and S. A. Eklund, of the School of Public Health, University of Michigan, found that children and young adults reporting frequent consumption of soft drinks were at an increased risk of having high caries scores, even after accounting for differences in consumption of other sugary foods between those with low and high caries-causing capabilities. The results of this study challenge the belief—long-held by some—that only highly retentive foods can be cariogenic and points to the danger of the frequent consumption of soft drinks by children.

This study was based on the results of a national survey of Americans in

1971-74. Information was collected on the oral health and dietary habits of over 20,000 Americans between the ages of one and 74.

Summary of a paper entitled "Physical Therapy for Mandibular Movement and Jaw Pain", by Dr. Francis M. Bush, of the Virginia Commonwealth University School of Dentistry.

Does the stress of opening your mouth cause jaw pain? If so, this discomfort may represent signs and symptoms of pain coming from either a covering of the jaw muscles, malfunction of the jaw joint, or both.

"There may be relief for your bite," Dr. Francis M. Bush of the Virginia Commonwealth University told the gathering of scientists at the IADR's General Session today. One solution to ease the pain can be physical therapy.

Dr. Bush found that five treatments involving moist heat, ice, and ultrasound effectively increased mouth opening and improved side motion of the jaw. Application of a refrigerated spray produced similar, but temporary, relief. Physical therapy reduced the number of tender muscles. Following therapy, patients reported that two-thirds of the pain was gone. Slightly over one-half of the patients had no recurrence of pain after one year.

Summary of papers entitled "A New Technique for the Diagnosis of TMJ Disorders" and "Arthrophonometry of the TMJ", by Drs. Thomas Gay, UCONN, and Charles Bertolami, Harvard School of Dental Medicine, respectively.

Is it possible to diagnose diseases of the temporomandibular joint by analyzing the sounds the joint makes when the jaw moves? At the General Session of the International Association for Dental Research, two researchers, Drs. Thomas Gay and Charles Bertolami, from the University of Connecticut and Harvard University Dental School, respectively, described a new technique they term "Arthrophonometry", that uses joint sound for clinical diagnosis.

It is estimated that between 20 and 50% of the population is afflicted by pain and impaired function of the TMJ. Until now, it has been difficult to diagnose these patients, because the common symptoms of pain and dysfunction can result from either a displaced (or slipped) disc, a degenerative disease (arthritis), or a disease of muscular origin. Present diagnostic techniques rely on painful and expensive

x-ray procedures. However, because each of the three major diseases of the TMJ produces different mechanical conditions within the joint, and since these mechanical events can be recorded as sound patterns, the diseases can be easily diagnosed by analyzing the sound patterns produced during movements of the TMJ. This is accomplished by placing a small, highly-sensitive contact microphone over the area of the TMJ, a simple and painless procedure which takes less than ten minutes. Drs. Gay and Bertolami report complete success of the technique in clinical patient trials, and predict that, in the not-to-distant future, arthrophonometry will be routinely used in the dental office as a screening technique for TMJ function.

**AMERICAN COLLEGE OF PROSTHODONTISTS
EIGHTH ANNUAL
JOHN J. SHARRY
PROSTHODONTIC RESEARCH AWARD
COMPETITION
FIRST PRIZE - \$1,000**

DATE: October, 1984
LOCATION: Nashville, Tennessee
ELIGIBLE: Prosthodontic Graduate Students and Residents or Board Eligible Prosthodontists who completed their training after October 1980.
INFORMATION: Dr. Thomas P. Sweeney
 1427 N. Nash Street, Apt. 20
 Arlington, VA 22209

**"AFFILIATE" PROPOSED TO
DESIGNATE MEMBERS OF
FPO MEMBER
ORGANIZATIONS**

At its February meeting in Chicago, the Executive Council of the FPO voted to recommend to the House of Delegates a Bylaw change to ---"change the term "individual member" to "affiliate" when referring to the individual members of Member Organizations who have paid dues to the Federation."

In other actions the Executive Committee recommended that the title of Central Office Director be changed to Executive Director.

The Committee noted that the public education program, for which \$40,000 had been allotted, was being financed through a deficit budget for 1984 and that if it were to continue in 1985, a dues raise would be necessary.

The following were nominated as consultants to the ADA Council on Dental Education: Drs. Dwight Castleberry, Alex Koper, Howard Landesman, Kenneth Rudd, and Dale Smith.

President Atwood reported on his attendance at the Speciality Groups meeting which met in Anaheim prior to the 1983 ADA House Delegates meeting. He stated that the attendees did not

wish to formalize the conference; that basically the members only wished to meet to discuss items to be brought before the ADA House of Delegates; that the endodontists would sponsor the meeting in 1984 and that both the FPO President and President-Elect should attend.

It was noted that dues receipts were down approximately 6% from the same period in 1983. 603 ACP members had paid the FPO assessment.

Finally the following were nominated for office in 1984-85:

President-Elect, Dr. John E. Rhoads;
 Vice President, Dr. Kenneth Rudd;
 Secretary, Dr. Robert C. Wesley;
 Treasurer, Dr. James M. Fairchild;
 Associate Editor, Dr. Robert D. Schweitzer

Members attending the meeting:
 Dr. Thomas J. Balshi
 Dr. Harold Berenstein
 Dr. Lawrence J. Calagna
 Dr. Robert D. Grady
 Dr. Abraham Ingber
 Dr. Richard D. Lowe
 Dr. Glen P. McGivney
 Dr. A. Patterson
 Dr. B. Larry Pedlar
 Dr. Jack D. Preston
 Dr. Douglas N. Riis
 Dr. Gary S. Rogoff
 Dr. Paul Schmitman

CAN YOU ANSWER THESE ?

1. Radiation to which area causes the most xerostomia and trismus?
 - a. Lateral border of the tongue
 - b. Base of the tongue
 - c. Nasopharnx
 - d. Soft palate
 - e. Floor of the mouth
2. Which are complications of radical neck surgery?
 - a. Bilateral and unilateral yield significant morbidity
 - b. Fistulas are the most common complications
 - c. Carotid artery blow out
 - d. Loss of trapezius muscle function
 - e. Spinal accessory nerve damage
3. If post soldering, a greenish stain occurs on the porcelain with no damage to glaze, what is the most likely cause?
 - a. Overheating
 - b. Flux on the porcelain
 - c. Investment contacting the porcelain surface

**"A.C.P. MEMBERS
ATTENDED
OSSEOINTEGRATION
MEETING"**

Thirteen A.C.P. Fellows and Associates and an oral surgeon team mate attended the University of Toronto's Osseointegration implant training program on February 27 - 29, 1984. The week was marked by excellent lectures, clinical examinations, and hands-on technique training.

The session organized and presented by Dr. George Zarb was highlighted by P. I. Branemark who, with other Swedish colleagues, developed the Osseointegration implant concept.

1984 SURVEY OF DENTAL PRACTICE UNDER WAY

In February, the ADA Bureau of Economic and Behavioral Research launched its 1984 survey of dental practice with a mailing to 5,000 practitioners throughout the country. Data supplied by dentists participating on a voluntary basis in these annual ADA surveys has proven to be an invaluable source of information on the characteristics and trends in the practice of dentistry, according to Kent Nash, Ph.D., Bureau director. "The Bureau encourages dentists receiving the questionnaires to complete them as accurately and promptly as possible," Dr. Nash said. Complete confidentiality is assured, and no survey information about individuals is released to other Association agencies or outside groups. The purpose is to provide national and regional statistics on the private practice of dentistry in the United States.

WAS YOUR NET INCOME UP IN 1983?

Increases in dental fees again lagged behind increases in medical costs in general in 1983, according to a survey just released by Procom. But dentists plan to start catching up in 1984, they indicated.

Dentist readers of three Procom newsletters, **Update**, **Dental Care Marketing**, and **Impressions**, responded to a survey to gauge fees of 14 most frequently performed kinds of dental treatment. Dentists also revealed their 1983 gross and net incomes, the amounts of their accounts receivable, numbers of patients seen in a typical week, and the amount of marketing they do.

Respondents raised their fees an average of 5% during the year, while medical costs rose 6.4%, according to the National Bureau of Labor Statistics. But they plan to raise fees an average of 7% during 1984. Incomes rose slightly more rapidly than fees. For solo practitioners, gross incomes increased 5.9%, and net incomes 5.5%. Group practitioners realized larger increases in both gross and net.

The portion of gross income earned from cases covered by dental insurance increased from 53% to 56% for both solo and group dentists.

Readers of Procom's newsletters

tend to be high achievers. Solo dentists' gross incomes averaged \$212,900, up \$12,000 from 1982. Net incomes were \$75,100, up \$3,900. More than half the respondents said their accounts receivables were higher, averaging \$42,000. Only 18% said they were owed less money in 1983 than in 1982. Dentists said they were seeing 57 patients per week, on the average.

A full 69% of respondents said they participated in some form of marketing activity in 1983.

Procom collected fee and income data for seven regions of the nation. More specific results are also given for nine of the largest states.

A copy of the results includes five detailed tables, and an analysis for each region. It is priced at \$8 and may be obtained from Procom, 5799 Tall Oaks Rd., Madison, WI 53711.

ADA OFFERS REVISED DENTURE MARKING MANUAL

Because of dentistry's continuing focus on the importance of denture identification, the ADA has recently revised its manual, **Techniques for Denture Identification**. The booklet outlines five methods for identifying dentures and includes new suggestions for a surface marking technique. A summary of state laws and a list of denture identification kit manufacturers also are included. The booklet is directed to dentists wishing to identify their patients' dentures and to nursing home personnel desiring to provide this service for their residents. Copies of the booklet may be obtained from the Council on Prosthetic Services and Dental Laboratory Relations at ADA Headquarters. The following states now require that identification be placed in dentures: California, Illinois, Kansas, Maine, Minnesota, Montana, New Jersey, Indiana and West Virginia.

CLASSIC ARTICLES, VOLUME IV

The College has published 3 volumes of classic articles relating to prosthodontics. These books contain reprinted articles by authors who are recognized by the profession for their expertise and insight into prosthodontics. The books form a ready reference

for the practitioner and student of the specialty to the historical background and base of our field of interest.

The American College of Prosthodontists is now considering publication of a Fourth Volume of Classic Articles. Your suggestions and recommendations are necessary and valued.

Please send them as soon as possible to: Dr. Crystal Baxter, Chariman, Education and Advancement Committee, Publication Department, 919 West Carmen, Unit A, Chicago, Illinois 60640.

ADA TO HOST WORKSHOP ON METALS BIOCOMPATIBILITY

A workshop on the biocompatibility of metals in dentistry will be held July 11-13, 1984 in the Hillenbrand Auditorium of the American Dental Association in Chicago. The workshop, sponsored by the National Institute of Dental Research and hosted by the Association, will examine a broad range of issues including potential allergic reactions, methods to assess allergic potentials or hypersensitivity of patients, the relationship - if any - between metals and general health, and alternative restorative procedures. The workshop, in addition to reviewing current knowledge in the field through presentation of invited papers, will make recommendations for future research. If you desire additional information, contact the Council on Dental Materials, Instruments and Equipment of the Association.

NOTICE TO AFFILIATE MEMBERS

New Affiliate (student members) of the American College of Prosthodontists are advised that 1984 issues (commencing January 1984) of the Journal of Prosthetic Dentistry have been mailed.

The publisher regrets any inconvenience caused by the delay.

**As you wander thru life,
Whatever be your goal,
Keep your eye on the donut,
Not upon the hole.**

Annon

Thomas D. Wise, D.D.S., M.S.



Complete dentures require occlusal correction after processing. Many methods for occlusal correction have evolved and these are centered around two basic concepts. The first concept involves remounting of the processed dentures on an articulating instrument and refining the occlusion by selective grinding. The second concept involves a variety of methods which attempt to harmonize the occlusion by locating and eliminating interfering cusps directly in the mouth. Patients with: (a) good mandibular coordination; (b) well-formed alveolar ridges; (c) a favorable jaw relationship and (d) a high degree of adaptability to a prosthesis will probably accommodate to complete dentures regardless of the technique used in occlusal refinement.

The procedure of occlusal refinement is an essential phase of complete denture prosthodontics. All dentures require occlusal correction after processing to overcome interceptive occlusal contacts and other discrepancies which are the result of processing plus errors which are inherent in any technique. Many methods for correcting complete denture occlusion have evolved and these are centered around two basic concepts.

The first concept depends on the use of an articulator. This involves remounting of the processed dentures on an articulator and refining the occlusion by selective grinding.

The second concept does not incorporate the use of an articulator. It involves a variety of methods which attempt to harmonize the occlusion by locating and eliminating interfering cusps directly in the mouth.

Methods of Occlusal Refinement

Articulator Concept

The articulator was the basic instrument with which Schuyler^{1,2}, formulated his fundamental principles in the correction of occlusal disharmony in both the natural dentition and artificial dentures. His procedures involved the selective grinding or reduction of specific tooth inclines on the processed dentures after the dentures had been remounted on the articulator according to new interocclusal records. His principles were the basis for the principles of articulation commonly referred to as the "B-U-L-L Rule".

Approximately 25 years later in 1959, Schuyler³ presented a less rigid con-

cept on the significance of centric relation as related to complete denture occlusion. He advanced the articulating instrument 0.5 mm. to 0.75 mm. when arranging teeth; thus, providing a slight range of anterior-posterior freedom for the mandible and a slight freedom in intercuspation.

Swenson^{4,5,6} had long advocated selective grinding with the dentures mounted on an articulator as the proper method for perfecting complete denture occlusion. His reasons for using an articulator were twofold: (1) The resiliency of tissue precludes equilization of pressure in various denture positions and (2) Denture bases shift or move under incline plane stresses without the dentist being aware of the discrepancy.

It is generally accepted that denture bases can shift during functional movements. Shepard⁷ reported on a cinefluorographic study related to denture base dislodgement during mastication and he observed movement in all dentures. Smith, et al,⁸ reported on the mobility of artificial dentures during comminution. They reported a range of movement of 1.5 mm. laterally to 2.5 mm. anteroposteriorly.

Pound⁹ gave support to the basic principles of Swenson. Pound advocated the remounting of dentures in the proper relations to the hinge axis, by means of intra-oral wax check bite records that can be duplicated. He said "this is possibly our surest control for stress distribution, and may be a phase of denture construction easily overlooked because our patients readily develop convenience occlusions that

to the eye seem accurate."

Nagle and Sears¹¹ refined the occlusion of complete dentures by remounting the processed dentures on an articulator from new interocclusal records. However, they modified their technique for patients who had a tendency to close slightly anterior to centric relation. This was accomplished by setting the articulating instrument approximately 1 mm. protrusively. The teeth were then spot-ground to balance in the slightly protruded position. Finally, the teeth were milled on the articulator.

Non-Articulator Concept

Brill¹¹ refined the occlusion of complete dentures by attempting to locate deflective contacts in the mouth with articulating paper. He observed that bodies with a thickness of .06 mm. can be perceived between the teeth of complete dentures. Brill concluded that dentists cannot restrict their thinking to articulators and dental mechanics. He stated "patients have occlusal sense, articulators have not."

Shanahan^{12,13} described a procedure for correcting the occlusion after studying mandibular movements during function. He divided mandibular movement into two classes - masticating and nonmasticating. In the masticating movements the mandible moves along a cyclical path and generally in a vertical direction. The nonmasticating movements are the lateral and protrusive excursions.

Shanahan recommended correcting the occlusion in excursions by putting wax on the occlusal surfaces and directing the patient to close in centric

occlusion and then move the lower teeth from side to side. Perforations and tears in the wax indicated premature contacts which were marked on the teeth and subsequently reduced. The correction of contacts in the masticating cycle was accomplished by placing wax over the occlusal surfaces and having the patient chew food for one or two minutes. Premature contacts were marked and eliminated in similar fashion.

Skinner¹⁴ concluded that the articulator had misled us in concepts regarding jaw movements and as a result of mechanically oriented concepts, we have been lax in studying the physiology of mastication.

Another commonly used method for occlusal refinement of complete dentures utilized an intra-oral central bearing device. Pleasure¹⁵ described the use of the Coble balancer. In grinding prematurities, he followed the B-U-L-L formula on the second molar teeth on the working side because, as he observed, the chief function of the second molars on dentures was to provide balancing contacts in gliding movements. However, he reversed the formula on the first molars and premolars, and reduced the lower buccal and upper lingual cusps. His rationale for such a scheme of tooth alignment was its consistency with the "closure-toward-centric" movement, which was the essential chewing movement. Thus, he tended to imitate the physiologic pattern of occlusal wear which was most often seen in natural dentitions.

This occlusal scheme developed by Pleasure was in accordance with the extensive studies reported by Moses.¹⁶ Moses studied both animal and human teeth and concluded that wear was a normal phenomenon and that the physiologic pattern of occlusal wear was anti-Monson in character. Moses contended that an anti-Monson curve was the best way of setting artificial teeth for maximum stability.

Trapozzano¹⁷ analyzed factors in equilization of pressure relative to intra-oral central bearing devices. It had been claimed that equilibrium by means of the central bearing point would be "assured." Theoretically, equilization of pressure would be assured only under certain conditions. For example, proper equilization of pressure may be expected when the ridge relation is normal. However, when the mandibular ridge protrudes or retrudes or when the mandible is in motion, the slightest biting pressure exerted by the patient may result in an

excessive amount of pressure on the anterior or posterior parts of the ridges, and faulty equilization of pressure results.

The major drawback of central bearing devices according to Trapozzano was related to the denture bearing area. If the bases were supported by bony structure, the application of pressure anywhere on the opposing ridge or bearing area would produce little or no dislodging or tilting of the denture bases. However, since the bases rest on tissue which may vary in density from almost cartilaginous to extremely soft and mobile, the bases can easily be displaced by the application of pressure.

Another important factor according to Trapozzano was the angle at which the central bearing pin contacts the opposing plate. If the ridges were perfectly parallel and it were possible, therefore, to have the central bearing pin come in contact with the opposing plate at a right angle, any pressure exerted by the central bearing point on the opposing plate directs the forces at a right angle to the ridges, and the bases tend to be seated. If, however, the central bearing point makes contact with the opposing plate at some angle other than a right angle, shunting of the bases is likely to occur. This situation is another factor in the failure to obtain equilization of pressure.

Silverman¹⁸ used an intra-oral central bearing device as an aid in refining the occlusion of complete dentures. He used the Coble balancer to remove premature contacts in centric occlusion only. He removed the Coble balancer while equilibrating in lateral and protrusive excursions. He placed thin articulating paper between the upper and lower teeth and instructed the patient to rub the upper and lower teeth together from side to side, or from right to left. The markings shown on the interfering inclines of the cusps were reduced with appropriate stones. Carborundum paste was used to mill-in the occlusion as the last step in the procedure.

Silverman maintained that the static articulator movements and positions based upon physical and geometric laws are not truly functional and should be substituted by methods that abide by the physiologic laws of function as seen in the mouth during incision, mastication, and speech. Thus, he observed, it was most important that the final equilibration be completed in the mouth. He further asserted that there was no known articulator which could duplicate the exact physiologic

and functional movements of the patient's mouth.

Brudnik and Wormley¹⁹ described a method for refinement of monoplane occlusions which included the use of an intra-oral central bearing device. After the dentures were processed, the mandibular denture was related to the maxillary denture by means of a centric relation interocclusal record and mounted on an articulator. The maxillary occlusal surface was made flat by rubbing it against fine abrasive paper. The occlusal corrections for the centric position only were made on the mandibular teeth with the aid of articulating ribbon. The Coble balancer was now mounted on the dentures and eccentric interferences were identified directly in the mouth by means of articulating ribbon and the interferences were then eliminated. The authors recognize that the guidance factor of the temporal-mandibular joint and the resiliency of basal seat tissues are uncontrolled variables and must be considered and compensated for in the technique.

RELATED INVESTIGATIONS

The bodily side shift of the mandible had been observed for many years. Johan Ulrich, some twelve years before Bennett's publication in 1908, reported on lateral excursions of the mandible. This article was rediscovered and published by Posselt.²⁰ Ulrich had concluded that the axis of the left or right lateral movement was not located in the working condyle but was located posteriorly and medially to the working condyle, and that the axes were not stationary at any moment.

Brotman²¹ studied the vertical and saggital rotational centers. He concluded that the vertical axes usually lie posterior to the transverse hinge axis. As such, it was theoretically impossible to duplicate movements about the vertical axis on an articulator which used spheres as condyles. However, he noted this potential inaccuracy was probably too minute to be of practical significance or clinical detectability. He concluded that an articulator in which the distance between the vertical rotational centers was adjustable was desirable in order to minimize occlusal errors.

Beck²² analyzed articulators according to their guide paths and range of movements and described why they cannot perform movements identical to those of the mandible.

Jankelson, Hoggman, and Hendron²³ performed a study on the physiology of the stomatognathic system utilizing a cinefluorographic tech-

nique. In no case was there any evidence of tooth balance during incision, and tooth balance had no part in the stabilizatin of the maxillary dentures. The dentures were stabilized by the tongue. There was no evidence of balancing tooth contacts in eccentric jaw movements during eating. The authors suggested that eccentric balance teeth was not a physiologic necessity, nor that lack of eccentric balance impaired masticating function. They also observed that gliding movements (non masticatory grinding) bore no resemblance to the movements occurring during chewing.

Kurth²⁴ studied mandibular movements in mastication and divided mandibular movement into a gliding, or free movement, and an actual chewing stroke of mastication. He observed that these two movements were congruent for a very short distance near the centric relation position. This was in contrast to Jankelson who found no evidence of the gliding movement during mastication.

Schweitzer²⁵ made observations similar to those of Kurth. Schweitzer demonstrated that the functinal chewing strokes and lateral movements (rubbing movements) were not completely divided either before or after the level of maximum intercuspation was reached. There was evidence of some rubbing together of the teeth during the final phase of natural function.

SUMMARY

The procedure of occlusal refinement has become an essential phase of complete denture treatment. Many concepts and techniques are utilized for this purpose, among these are:

1. the selected grinding of remounted dentures on an articulating instrument, and

2. various intra-oral techniques which attempt to locate interfering cusps directly in the mouth.

Noted prosthodontists such as Schuyler, Swenson, and Pound consider the remounting of the processed dentures on an articulator to be an acceptable method. Primarily, they follow the fixed paths of an articulator for refining the occlusion.

Others, Brill, Shanahan, Skinner, Silverman and Pleasure rely on the individual jaw movements for refining the occlusion. A variety of techniques were developed to locate interfering cusps directly in the mouth.

CONCLUSION

It is apparent that there are many acceptable techniques for refining the occlusion of complete dentures. Patients with: (a) good mandibular

coordination; (b) well formed alveolar ridges; (c) a favorable jaw relationship and (d) a high degree of adaptability to a prosthesis will probably accommodate to complete dentures regardless of the technique used in occlusal refinement. As the probability for success becomes less favorable, then our approach becomes more critical, and circumstances should dictate one technique or another.

REFERENCES

- Schuyler, C. "Fundamental Principles in the Correction of Occlusal Disharmony, Natural and Artificial", J. Am. Dent. Assoc. 22: 1193-1202, 1935
- Schuyler, C. "Full Denture Service as Influenced by our Understanding of Tooth Selection and Articulation," J. Prosthet. Dent. 2: 730-736, 1952.
- Schuyler, C. "An Evaluation of Incisal Guidance and Influence in Restorative Dentistry," J. Prosthet. Dent. 9: 374-378, 1959.
- Swenson, M. G. Outline of Full Denture Prosthesis, New York: New York University Press Book Store, 1932, P. 140.
- Swenson, M. G. Complete Dentures, St. Louis: The C. V. Mosby Co., 1940, P. 472.
- Swenson, M. G. Swenson's Complete Dentures, Sixth Edition, Carl O. Baucher (ed.), St. Louis: The C. V. Mosby Co., 1970, P. 568.
- Sheppard, I. "Denture Base Dislodgement During Mastication," J. Prosthet. Dent. 13: 462-468, 1963.
- Smith, D. E., Kydd, W. L., Wykhuis, W. A., Phillips, L. A. "The Mobility of Artificial Dentures Communion," J. Prosthet. Dent. 13: 839-856, 1963.
- Pound, E. "Lost-Fine Arts in the Fallacy of the Ridges," J. Prosthet. Dent. 4: 6-16, 1954.
- Nagle and Sears, Denture Prosthetics-Complete Dentures, Second Edition, St. Louis: The C. V. Mosby Co., 1962, P. 427.

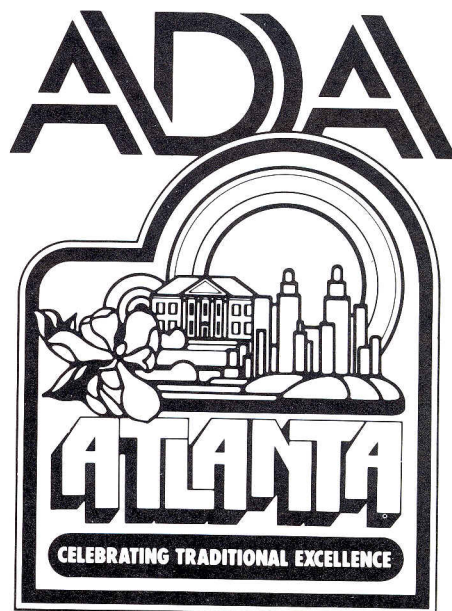
- Brill, N., "Reflexes, Registrations, and Prosthetic Therapy," J. Prosthet. Dent. 12: 123-127, 1962.
- Shanahan, T. E. J. "Dental Physiology for Dentures," J. Prosthet Dent. 2: 3-11, 1952.
- Shanahan, T. E. J. "Physiologic and Neurologic Occlusion," J. Prosthet Dent. 3: 631-632, 1953.
- Skinner, C. N. "Physiology of the Occlusal Coordinatin of Natural Teeth, Complete Dentures, and Partial Dentures," J. Prosthet. Dent. 17: 559-565, 1967.
- Pleasure, M. A. "Occlusion of Cuspless Teeth for Balance and Comfort," J. Prosthet. Dent. 5: 305-312, 1955.
- Moses, C. H. "Studies in Articulation," J. Prosthet Dent. 2: 326-352, 1952.
- Trappozzano, V. R. "A Comparison of the Equalization of Pressure by Means of the Dentrul Bearing Point and Wax Check Bites," J. Am. Dent. Assoc. 38: 587-591, 1949.
- Silverman, M., Occlusin in Prosthodontics and In the Natural Dentition, Washington, D.C.: Mutual Publishing Company, 1962, P. 141.
- Brudnik, J. S. and Wormley, J. H. "Methods of Developing Monoplane Occlusions," J. Prosthet. Dent. 19: 573-580, 1968.
- Posselt, V. "The Human TMJ: Kinematics and Actions of the Masticatory Muscles," J. Prosthet. Dent. 9: 399-406, 1959.
- Brotman, D. "Hinge Axes - Part II Vertical and Saggital Rotational Centers," J. Prosthet. Dent. 10: 873-877, 1960.
- Beck, H. "Selectin of an Articulator and Jaw Registrations," J. Prosthet. Dent. 10: 878-886, 1960.
- Jankelson, B., Hoffman, G., Hendron, J. A., "The Physiology of the Stomatognathic System," J. Am. Dent. Assoc. 46: 375-386, 1953.
- Kurth, L. E., "Mandibular Movements in Mastication," J. Am. Dent. Assoc. 29: 1769-1790, 1942.
- Schweitzer, J., "Masticatory Functin in Man," J. Prosthet. Dent. 11: 625-647, 1961.

AMERICAN DENTAL ASSOCIATION

125TH ANNUAL SESSION

ANNUAL SESSION
OCTOBER 20-25, 1984

SCIENTIFIC SESSION
OCTOBER 20-23, 1984



125th ANNIVERSARY
CELEBRATION

CLASSIFIED

Stipend available: Applications are being accepted for a postgraduate program in Prosthodontics commencing July 1985. A two year certificate program or a Masters of Science program is available. A small stipend is awarded to program participants. For information write to Dr. Mark M. Stevens, Director, Postgraduate Prosthodontics Program, University of Maryland, Dental School, Baltimore, Maryland 21201.

Position Available: Editor of **NEWS-LETTER** of leading speciality organization in prosthodontics. No experience necessary. Determination to maintain an information bridge between the officers, other representatives and the organizational membership is highly desirable. Address response to Dr. Robert C. Sproull, 10912 Gary Player Drive, El Paso, Texas 79935, or call 915-593-8046 (office) or 915-598-9277 (home); and to the Central Office Director, Ms. Linda Wallenborn, 84 N. E. Loop 410, Suite 273 West, San Antonio, Texas 78216.

Notice: The Prosthodontic Research Section of the American Association for Dental Research (AADR) is announcing the Novice Prosthodontic Research Award. Participants are eligible for a \$1000.00 (one thousand dollar) winners award. This award is sponsored by the Coors Biomedical Company of Lakewood, Colorado. The deadline for submission of abstracts is October 15, 1984. Further information is available from Dr. A. Albert Yurkstas, Tufts University School of Dental Medicine, One Kneeland Street, Boston, MA 02111.

WERE YOU RIGHT?

Answer: C & D

Reference: Maxillofacial Rehabilitation; Beumer, Curtis & Firtell, p. 47-49

Answer: B, C, D, E

Reference: Maxillofacial Rehabilitation; Beumer, Curtis & Firtell, p. 103-104

Answer: B

Reference: Johnson, Humford, Dykema; Modern Practice in Dental Ceramics; p. 232

BOOKS AVAILABLE

The "Study Guide for Certification", "Classic Prosthodontic Articles" and the "Index to the Journal of Prosthetic Dentistry" are available. To get your copy (ies) of these valuable books, complete the form below and mail to the Central Office Director, 84 N.E. Loop 410, Suite 273 West, San Antonio, Texas 78216.

Name _____

Address _____

City _____

State _____

Zip _____

- I would like ___ copy(ies) of the "Classic Prosthodontics Articles" Volume I (Price Members \$20.00; Non-members \$25.00)
- I would like ___ copy(ies) of the "Classic Prosthodontics Articles" Volume II (Price Members \$20.00; Non-members \$25.00)
- I would like ___ copy(ies) of the "Classic Prosthodontics Articles" Volume III (Price Members \$20.00; Non-members \$25.00)
- I would like ___ copy(ies) of **SOLD OUT** 2ND EDITION of the "Study Guide for Certification" (Price Members \$15.00, **SOLD OUT** mbers \$20.00) (Includes all previous years questions.)
- I would like ___ copy(ies) of the REVISED 1981, 1982 and 1983 Phase I, Part I Questions and Answers for the American Board of Prosthodontics as a Supplement to the Study Guide (Price \$3.00)
- I would like ___ copy(ies) of the "Index To The Journal of Prosthetic Dentistry" (Price Members \$25.00; Non-members \$35.00, plus \$3.00 postage for out of the country mailings)

Amount enclosed \$ _____

Make checks payable to:

The American College of Prosthodontists



Item

ACADEMIC ROBES

To obtain order forms and material samples complete the form below and mail to: Central Office Director, 84 N.E. Loop 410, Suite 273 West, San Antonio, Texas 78216.

Name _____

Address _____

City & State _____ Zip _____

	Regular Material #1119	Delux Material #87
DOCTOR'S GOWN (with lilac front panels and sleeve bars outlined with gold nylon braid)	\$201.81	\$251.18
SQUARE STIFF MORTARBOARD CAP (with gold nylon tassel)	\$ 17.00	\$ 21.50
REGULAR DOCTORAL HOOD (with dental school colors)	\$ 68.35	\$ 85.17

Please send order form and material samples

NEWSLETTER
THE AMERICAN COLLEGE
OF PROSTHODONTISTS
 Dr. Robert W. Elliott, Jr., Editor
 8732 Falls Chapel Way
 Potomac, Maryland 20854
 Address Correction Requested
 Forwarding & Return Postage Guaranteed



BULK RATE
 U.S. POSTAGE
PAID
 Permit No. 1001
 San Antonio, Texas

ARTICLES BEARING COLLEGE SEAL



The following are available. To obtain the items desired,
 please complete the form below and mail to the Central Office
 Director, 84 N.E. Loop 410, Suite 273 West, San Antonio, Texas 78216

NAME _____
 ADDRESS _____
 CITY & STATE _____ ZIP _____

CHECK ITEMS
 YOU WISH
 TO ORDER

Jewelry (ea)	14K	10K	1/10 DRGP	(Plate) Number	Jewelry (ea)	14K	10K	1/10 DRGP	(Plate) Number
Pinette	<input type="checkbox"/> \$ 67.50	<input type="checkbox"/> \$ 50.50	<input type="checkbox"/> \$20.50	_____	College Key	<input type="checkbox"/> 69.50	<input type="checkbox"/> 51.50	<input type="checkbox"/> \$ 21.85	_____
Tie Bar	<input type="checkbox"/> 72.50	<input type="checkbox"/> 55.50	<input type="checkbox"/> 26.50	_____	Lapel Pin	<input type="checkbox"/> 67.50	<input type="checkbox"/> 50.50	<input type="checkbox"/> 20.40	_____
Cuff Links	<input type="checkbox"/> 143.50	<input type="checkbox"/> 110.50	<input type="checkbox"/> 39.00	_____	Ladies Charm	<input type="checkbox"/> 67.50	<input type="checkbox"/> 50.50	<input type="checkbox"/> 20.30	_____
Tie Tacs	<input type="checkbox"/> 67.50	<input type="checkbox"/> 50.50	<input type="checkbox"/> 20.45	_____					_____

OTHER ITEMS (ea) — Blazer Pocket Patch—Old \$9.00 Number _____ Wall Plaque \$23.10 Number _____
 Blazer Pocket Patch—New \$16.00 Number _____

In ordering 1/10 DRGP (Plate) Jewelry, Blazer Patches and Wall Plaques, please enclose check to cover costs, which includes mailing, payable to the American College of Prosthodontists.

***Note:** 14K and 10K jewelry are special order items and prices fluctuate with the costs of gold. You will be billed for the items you order on receipt by the Central Office of the manufacturer's invoice. Do not send check with order for 14K or 10K items.