THE STATE OF VOLUNTEERING IN 2018
MISSION STATEMENT
The Academy of Dentistry International is the international honor society for dentists dedicated to sharing knowledge in order to serve the dental health needs and to improve the quality of life for people throughout the world. Through the development of fellowship and understanding, the Academy endeavors to create opportunities for service in order to assist in the establishment of world peace.
ADI WOULD LIKE TO THANK IVOCLAR VIVADENT AND MR. CHRISTIAN BRUTZER, VICE-PRESIDENT ADI FOUNDATION, AND GLOBAL REGION HEAD ASIA/PACIFIC FOR IVOCLAR VIVADENT, FOR THEIR MOST WELCOME HELP AND FINANCIAL SUPPORT TO THE ACADEMY.

ADI FOUNDATION

ADI WOULD LIKE TO THANK THE ACADEMY OF DENTISTRY INTERNATIONAL FOUNDATION (ADIF) FOR ITS GENEROUS DONATION TOWARD FUTURE PUBLICATIONS OF THE JADI. WITHOUT FINANCIAL SUPPORT, ADI WOULD NOT BE ABLE TO PROVIDE VITAL INFORMATION TO ITS WORLDWIDE MEMBERSHIP.

We need your help! Tell ADI what YOU want!!!

The publications committee is considering reducing the printing and production of issues. Obviously, this would preserve ADI financial resources as well as the environment! ADI yearns to be as environmentally friendly as possible and is trying to follow, support and promote the United Nations Sustainable Developmental Goals. Goal 12: Ensure sustainable consumption and production patterns. ADI can reduce energy consumption by distributing the Journal (JADI) electronically. But, ADI also wants YOU the Fellow to read the communications and feel your time doing so is well spent! ADI wants your feedback, your input and your approval!

There are two ways being considered at this time:

A. One of two issues a year would be electronic only.

B. Both issues a year would be electronic and print. But, ADI would only print and mail hard copies to those who have a hard copy request on file at the Central Office.

Please inform ADI of your publications preference by following the online instructions or returning the “Publications Information and Preference” form on the bottom of Page 4.
The JADI and the ADI website are beginning to develop a twofold purpose, thanks to your comments, advice, and support.

One purpose is to be the yearly reporting medium for activities concerning the Academy and the ADI Foundation.

The second is to be a medium for viewing oral disease as a contributory factor in the exacerbation of the total global health non-communicable disease (NCD) issue in general. We as your publications committee would like to help nurture and maintain a focus on general health issues as they relate to the oral health profession. By reporting on programs and research of the larger medical community and international volunteer organizations, we would like to develop a comprehensive approach to identifying and reporting on those (ADI or not) who have been effective in delivering sustainable health programs and research across the globe directed toward the treatment and prevention of diseases that are directly affected by oral disease.

In an attempt to be ever progressive, the editorial committee has decided to develop two JADI publications per year, the First Issue during the 1st or 2nd Quarter and the Second Issue coming out in the 3rd or 4th Quarter.

These reports have a dual purpose: One is to inform members of activities; the other is to acknowledge the help and contributions of the donors and suppliers of equipment and materials. This is the calling card we will use when we approach potential fellows and the industry for their contributions and donations.

The First Issue will be devoid of the convocation/meeting reports and will tend to focus on the issues described above. In the past, the central issues discussed were sugar, sugar taxation, the global impending water crisis, and the role of dentistry in the age of social responsibility.

The Second Issue of the JADI will continue in the same format we have always used and focus on the events that have concluded for the year, such as the president’s report, convocations, sectional reports, awards, and highlights of some of the volunteer mission reports of fellow dentists.

The current issue will showcase volunteerism and its positive and/or negative effects on worldwide health.

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**PUBLICATIONS INFORMATION AND PREFERENCE**

Please inform ADI of your publications preference by:

A. Updating your ADI Member profile and answering the query “How I prefer to receive Newsletter/Journal Preference.” Please select either Email/Electronic or Mail/Hard Copy to complete this query. Log In, Manage Profile, Edit Bio.

B. You may email the Central Office your preference at info@adint.org or complete this form and return via fax +1(419)542-0992 or mail.

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Please circle your Newsletter/Journal Preference: Email/Electronic Copy OR Mail/Hard Copy
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If all global volunteers from around the globe gathered and built a nation, that nation would be the ninth-biggest country in the world, and counting only the value of the hours donated, it would rank 30th on the list of countries by gross domestic product, generating an equivalent of around US$400 billion. Considering that volunteers donate more money than non-volunteers and that through their social networks they help influence even more donations and vital educational messages in the fields of prevention, advocacy, safety, etc., they are a real asset to society and global business.

Dentists and their staff and families are well represented in this volunteer group, and their actions have certainly had an impact on the disease-adjusted life years, DALYs, of almost half the global population. However, global oral health has not improved in the last 25 years, and the cumulative burden of untreated oral conditions dramatically increased between 1990 and 2015 from 2.5 billion to 3.5 billion people, with a 64% increase in DALYs due to oral conditions throughout the world. Major demographic changes will worsen the future picture significantly. Although ADI counts many excellent members in every field of dentistry, its impact on reducing the level of oral diseases would probably have made news had their actions been coordinated and measured within the Academy and with other dental and non-dental organizations.

Nevertheless, ADI is on a positive track and keen to make a difference in providing voluntary service to those in need, where doing good shall be not only for the heart but also for the mind. ADI has taken various volunteering actions in fields outside of treatment and care.

A few examples include the following:

• The Journal of the Academy of Dentistry International, JADI, has been hyped as the best of its kind in the world of oral health volunteering. Volume 4 Issue 2 is available now! www.adint.org

• ADI sponsored a major symposium at the World Congress of Preventive Dentistry in New Delhi on dental volunteerism and social responsibility through cooperation with the International Association for Dental Research, IADR

http://www.adint.org/?page=symposiumnewdelhi

• ADI sponsored two seminars at the Greater New York Dental Meeting dealing with the impact of sugar and water on oral and general health and with oral health literacy and addressing the global burden of disease and the United Nations’ Sustainable Development Goals: Dental Volunteerism and Professional Social Responsibility.

• ADI has also presented a Portable Aqua Unit for Live-saving, PAUL, which produces potable water without any energy source, at a seminar at the IDS Cologne, Germany, the largest dental show in the world, and organized a live demonstration with the scientist-developer, Prof. Franz-Bernd Frechen.

• ADI has presented at the United Nations’ Conference for Non-Governmental Organizations and attended several UN briefings for NGOs.

• ADI has reached out to non-dental organizations and interest groups.

All these examples of ADI activities share the same target: making this world a better place and getting people engaged to work towards globally accepted goals expressed by the United Nations 2030 Agenda—the Sustainable Development Goals, or SDGs for short.

With sustainability and the SDGs in mind, what impact would it have to act together for a plastic-free
world? A lot is known about the negative aspects of plasticizers, which negatively influence the endocrine system, favoring diseases from diabetes to cancer. But are we all aware that endocrine disruptors such as bisphenol A are dangerous to the point that the formation of the enamel of the first molars and central incisors is interrupted? Just think of how a synergistic global action would see world citizens of all stripes involved in protecting health and the environment: sports and professional divers dismantling embarrassingly huge plastic islands floating in the Pacific Ocean and the Caribbean Sea, wayfarers collecting plastic waste in nature, dentists, physicians, chemists, educators, industry of almost any kind, and just people. We must unite with other groups to avoid poisoning our land and seas—for without healthy land and seas, there cannot be healthy life and wellbeing for humans. Dentists would work together with people in collaboration with plastic-producers and plastic utilizers, such as the automobile, nautical, and especially food industries, in supporting the United Nations’ Sustainable Development Goals #15 Life on Land, #14 Life below Water, and #12 Responsible Consumption and Production. ... Sounds almost like a dream.

The 17 SDGs are not individual choices; progress needs to be made across all if any single one is to be truly achieved. Dentists can do a lot for nice and healthy smiles, but they can do even more to advocate and involve everyone in the natural development of healthy smiles of future generations—mavericks are out; we want to team up and achieve goals together.

ADI is a unique place where people meet. Come in; it’s much more than dentistry—there is a whole world out there!
My last news update to you focused on the 2017 Foundation Board meeting and grant funding. This brief note will highlight the ADI Foundation’s most recent activities.

Our sponsorship agreement and the $4,000 contribution to support the American Dental Association Foundation’s International Dental Projects Workshop on May 11, 2018, was completed in March.

Consideration for funding a project using money that has been released from a previously designated library fund is still on the agenda.

The Finance Committee under Foundation Vice President and Committee Chairman Mr. Christian Brutzer meets via teleconference approximately four times yearly with our investment advisor, Ms. Carla Koren from Morgan Stanley. Most recently, on April 10, approval was given to transfer $15,000 into the Foundation’s checking account from the investment account in anticipation of project funding and grant distribution for this calendar year. It is important for the membership to realize that our endowment account is managed in a very disciplined manner. This approach has enabled the account to grow steadily over the long run while minimizing the risks that are inherent in market investing.

Finally, I look forward to August through October. That is when the Foundation’s Grants Committee reviews worthy project applications. The committee then submits its recommendations to the full board for approval. This is the real work of the Foundation. It is always a rewarding feeling to know that we are able in some way to contribute to improving dental care throughout the world.

Fraternally yours,

Thomas L. Brink, DDS, FADI
ADI Foundation President

Please consider giving to the ADI Foundation. Together we all make a difference! Or give online at: www.adint.org/DonateADIF

Mail to: ADI Foundation 3813 Gordon Creek Drive, Hicksville, OH 43526 USA

Donation Amount: $25 ______ $50 ______ $75 ______ $100 ______ $250 ______ $500 ______ $1000 ______ $2000 ______ $2500 ______ Other $___________________ Any amount is appreciated!

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WORLD HEALTH DAY ADVOCATES FOR UNIVERSAL HEALTH CARE!

Understanding the opportunities for oral health through sharing common goals with the rest of the world

David C. Alexander, BDS, MSc, DDPH, FADI
Vice President, International Affairs

Nearly every day, the media inform us that it is the day to observe a World (fill in the blank) Day. What are these days, why do they happen, and who selects them? Are they all true? Are some of them fake?

World Days, and Weeks, Months, Years, or Decades, are officially sanctioned by the United Nations itself or one of its main organs, such as the World Health Organization, UNICEF, etc. Such observances are officially designated through approved motions by the member states of these world bodies. For a complete listing, see www.un.org/en/sections/observances/international-days/.

April 7 marked this year’s World Health Day, made even more significant in that it celebrated the 70th anniversary of the founding of the World Health Organization and therefore presented a time to reflect on all its many accomplishments over those 70 years. Looking back seldom benefits the future, so in addition to the anniversary, the theme for this year’s observance is Universal Health Coverage— for everyone, everywhere, building on Goal 3 of the United Nations 2030 Agenda—the Sustainable Development Goals—and #healthforall.

Universal Health Coverage in this year’s campaign is based upon a few key facts (here are two):
• At least half the world’s population is currently unable to access essential health services.
• Almost 100 million people are forced into extreme poverty (surviving on less than US$1.90 per day) because they are forced to pay for essential health services.

Universal Health Coverage
• means that all people and communities receive the health services they need without suffering financial hardship.
• enables everyone to access the services that address the most important causes of disease and death and ensures that the quality of those services is good enough to improve the health of the people who receive them.
• is not only about medical treatment for individuals but also includes services for whole populations such as public health campaigns—for example, adding fluoride to water or controlling the breeding grounds of mosquitoes that carry viruses that can cause disease.

Under the official umbrella of the WHO, many organizations, governmental and non-governmental, take part and collaborate to build synergies and make progress towards the common
goals. No one organization or country can succeed alone, and as healthcare professionals, we can only succeed ourselves through interprofessional collaboration with other health workers.

The WHO also designates and marks some specific disease- or condition-related days (TB, AIDS, No-Tobacco, etc.); see http://www.who.int/campaigns/en/.

Only a couple of weeks immediately before World Health Day, you may have noticed World Oral Health Day. For approximately 15 years, FDI World Dental Federation, the principal representative body for more than one million dentists worldwide, has designated a World Oral Health Day, originally scheduled in September in the first years and now on March 20. Browsing a few social media sites, one develops the impression that this year’s celebration was about dentists, with little if any mention of the financial and disability burdens that oral diseases place upon humanity, and that communities with the most disease have no access to dental care whatsoever. Reviewing http://worldoralhealthday.org may help one understand why dentistry is consistently regarded as outside the mainstream of health care and seldom gets the priority for resources the burden of oral diseases deserves. Not participating in or supporting the globally accepted theme of Universal Health Coverage, World Oral Health Day was marked by signature visuals of a young lady writing on yellow sticky notes and applying them to her bathroom mirror. For the half of the world’s population that have no access to essential health services, I wonder how many have ever seen a bathroom mirror, let alone a yellow sticky? The burden of oral diseases affects 3.5 billion people, a one billion increase over the last 25 years. Is it time for the dental profession to get in step with the rest of the world and work collaboratively towards the officially approved World Days and their goals so we all achieve more—or do we continue to make it all about us, the dental professionals, and our middle-class patients fortunate enough to live in a middle- or high-income country? For there is no health without oral health!
Is It Still MY ADI?
Robert L. Ramus, DDS, FADI
Executive Director

Over the past ten years or so, a seismic shift has taken place with respect to the roles that professional associations play in the lives of their members. Denis Lee Yohn explains in a recent review (1) that three factors have changed the 20th-century model of what associations have become and what they do:

1. Members have access to information and training online, from many sources. That formerly was only available from sponsored meetings and associations.

2. Decreasing income and mandatory budget cuts.

3. Millennial professionals are paradoxically more involved with more causes, but feel less loyalty to any one group.

Here at ADI we have felt the impact of those factors as all of us grapple with the rapidly changing technology and health care environment. We are adapting our programs and outlook to more effectively deliver on our mission statement to “aid in the improvement of the dental and oral health and well-being of people worldwide.” In addition, we now proclaim that ADI is “The International Honor Society for Dentists Promoting Social Responsibility of the Dental Profession.” We have invested heavily in online platforms for engaging you and our colleagues in meaningful discussion, Our goal is to bring more healthcare professionals to a common table to change the way healthcare is delivered for the better.

What can you do to help us achieve that goal? A thousand things really, but here are a few practical first steps that would make a real difference.

1. Get engaged in the conversation.
Follow ADI on Twitter or like us on Facebook. Engage yourself in the Community Blog or Forums on the ADI Website. Let us hear from you, your voice is magnified and we can all learn how to help “improve the oral health and well-being of people worldwide”.

2. Get involved in leadership.
We do not need a committed minority promoting the changes that need to occur in oral healthcare. We know you do not want to just wear a lapel pin or add another line to your CV. You want to drive a community that changes the culture of how we treat healthcare. We need an army of passionate, informed clinicians stepping up to maximize ADI’s potential for good. Here’s our promise: show your capacity for that leadership and we will find a way for you to contribute!

3. Renew your membership and recruit a colleague.
Want to increase your influence? Reproduce yourself by sponsoring a colleague to join us in the fight to deliver better healthcare and education worldwide.

There has never been a better time to be a part of the only community of dentists that advocates for a total health approach to oral health. This is not your grandfather’s ADI, it’s yours. Seize the opportunity to make it what we would all like it to be – a vibrant, alive community of dedicated clinicians providing education, support and advocacy across the full spectrum of healthcare. Let’s do this together!

(1) Yohn DL. To stay relevant, professional associations must rebrand. Harvard Bus Rev. 2016; Jan.5
Editor’s note: The following article is meant to probe and invite ideas on the evolution of the concept of volunteerism. Admittedly, this piece is US-centric in its observation, but it might have resonance in other parts of the globe. The views expressed are those of the author and not a reflection of the official position of the Academy of Dentistry International.

The ADI is chartered on the underlying premise of volunteerism. Since its inception in 1974, we have spent the last 44 years existing on the notion of the ADI credo that volunteerism within the ADI “directly aids in the improvement of the dental health and wellbeing of people worldwide.” In view of the new world we live in today, it is important to review how the ideals of volunteerism have evolved since ADI was founded and ask the question, “What has shaped the concept of volunteering and the zeitgeist of the world in the last half century?”

In 1974, the Internet was not invented yet, and household terms such as social media, Amazon, Google, and myriad other words that have become household terms today were not yet introduced and certainly not part of our regular daily lexicon. We lived in a world of the home or office phones and “snail mail.” Volunteerism was something that was associated with political, civic, or church groups, and it was for the most part, at least in the United States, locally impactful to those within a specific community.

The 1990s changed the world with the invention of the Worldwide Web by computer scientist Tim Berners-Lee. As the Internet began to morph into the “Megamind” it has become today, so too has the concept of volunteering. Volunteering, although carrying on the traditional roles it established prior to 1990, has also become a business, with many varied travel opportunities to volunteer one’s talents (real or perceived) showing up on the net. Many are good, some bad, but they certainly changed the perception of volunteering from its pre-1990s concept to a more global view of helping others. There evolved the knowledge of more opportunities to participate globally and to fulfill two desires, one of travel and one of charity.

On Sept 11, 2001, and in late 2007 to 2008, the world as we knew it changed forever, and with it, many of the factors that defined volunteerism as ADI had historically perceived it. Suddenly, travel restrictions made it less easy and more expensive than it had been in the past. International politics made it harder to work with governments in trying to develop sustainable health programs within their individual borders. A new for-profit industry called voluntourism began to emerge, targeting individuals with the means to combine a trip to a country with compelling environments and a volunteer experience. These trips developed by travel companies, usually for non-professional people, emphasized a vacation environment along with the benefit of helping others. Many times emphasis was not placed on the development of sustainable long-term educational and nutritional programs as related to medicine or dentistry. Professional volunteerism, the kind that works with local communities to better the long-term medical and oral health of the local of people, still remained viable. However, travel, supplies and trained professionals became more difficult to obtain due to financial and political constraints. Certainly to be a volunteer took on many meanings.

Another factor that has led to the decline of dental volunteerism is the change in the needs of the dentists graduating from dental schools today. In 1974, the cost of dental education was $20,000–30,000. Today in 2018, the cost has risen tenfold to $200,000–300,000. Young professionals today find they need to get a dental “job” to pay off debt rather than mentor/associate for a few years and eventually buy out the retiring dentist or physician. That coupled with the “I want it now” zeitgeist of many today has led to a younger generation that is highly indebted and stressed about time and money. If they do find the desire to volunteer, they do it through episodic volunteerism, where they may volunteer in more available non-committed programs found on the Internet that many be to their liking while staying closer to home to spend less time and money.

Remote Area Medical (www.ramusa.org) is a good example of episodic volunteerism.
Is ADI Facing a Generational Issue?

R. L. Fulton, MA, DDS, FADI

Let’s take a look at the five generations that have evolved surrounding the fellows of ADI. The following information was developed by the Pew Research Center, Wikipedia, and Volunteer Hub (https://www.volunteerhub.com/blog/recruiting-boomers-gen-xers-and-millennials/).

THE SILENT GENERATION: 1927–1945
Dr. Albert Wasserman (1921–2013)
Values: Traditionalists.

Children of this era were expected to be seen and not heard and valued old-time morals, safety, security, and consistency. Hardworking, civic-minded, and loyal to their country and their employers, they were raised in a paternalistic environment. The silent generation was taught to respect authority, and conformity and conservatism were prized. They tended to be good team players, generally didn’t ruffle feathers or initiate conflict in the workplace, and liked to feel needed.

BABY BOOMERS 1948–1964
Most of the Executive Council of ADI
Values: Self-involved.

The 1960s are remembered as a time of political protests. Radical experimentation with new cultural experiences, cultural unrest, and cultural experimentation were justified as being directed toward spiritual or intellectual enlightenment. “Boomers” have had a very good track record of volunteering, hovering around a 30% volunteer rate each year.

GENERATION X: 1965–1980
Values: Very independent.

Known as the latchkey generation, they had less adult supervision as children. They are sometimes characterized as slackers, cynical and disaffected. Some of the cultural influences on Gen X youth were the musical genres of grunge and hip-hop music and indie films. In midlife, research describes them as active, happy, and achieving a work–life balance. They have the highest volunteerism rate of all generations at 29.2%, of whom 40% volunteer in education close to home.

Values: Care about issues, not organizations.

Millennials are “woke”: more aware of social issues. They don’t fit the mainstream and are more independent: 67% want to start their own businesses. They have advanced technological knowledge but also the ability to master new skills in creative ways. Due to the many forms of information available, they are becoming the most educated generation.

They don’t volunteer as much as baby boomers or members of Generation X—though their rate of 21% is respectable—and they care about issues, not organizations. According to the CEO of Achieve and researcher for the Millennial Impact Derrick Feldman, “What motivates millennials is a desire to affect THEIR cause through YOUR organization with THEIR friends. They are searching for organizations that will help them further the causes they are passionate about. Not just a single organization.” (https://associationfoundationgroup.org/news/the-next-25-years-engaging-millennials/)

GENERATION Z: 1990s–mid-2000s
Values: Confused about their identities and the future.

Generation Z will carry on the values and concerns of millennials but be completely immersed in technology and social media. Generation Z students see themselves as being loyal, compassionate, thoughtful, open-minded, responsible, and determined.[46] However, they see their Generation Z peers as being quite different from their own self-identities. They view their peers as competitive, spontaneous, adventurous, and curious, all characteristics that they do not see readily in themselves.[46] In addition, some authors consider...
that some of their competencies, such as reading competence, are being transformed due to their familiarity with digital devices, platforms, and texts.

A 2013 survey by Ameritrade found that 47% of Generation Z in the United States (considered here to be those between the ages of 14 and 23) were concerned about student debt, while 36% were worried about being able to afford a college education at all.[41] This generation is faced with a growing income gap and a shrinking middle-class, which all have led to increasing stress levels in families.

For ADI to be a significant presence in health care in the 21st century, we must first and foremost understand the worldwide playing field we are competing on and how that world differs dramatically from the world that existed in 1974.

Here are some thoughts for you to consider:

1. ADI must define who ADI is and where its role is with the rest of the myriad health NGOs that exist in the world today.

2. ADI must focus on global achievements of total healthcare as it relates to all of the non-communicable diseases as they relate to oral health.

3. ADI must begin to take a more dynamic and politically active role in the real causes of poor oral health, excess sugar consumption, and lack of education.

4. ADI must rethink its ideas about being strictly a dental honorific society without actively showing direct reportable results from its endeavors because the society we live in today cares about issues, not organizations, and demands that change.

5. And last but certainly not least, ADI must understand the needs, drives, and lifestyle of the constituency we are seeking to be future leaders. They care about results, episodic volunteering and giving to multiple causes, not joining single focused societies.

6. The Baby Boomers of the ADI must give way to the thinking of the Millennials and Generation Z’s. More tech and less talk.

Volunteering is something that everybody understands in the United States, and it is highly valued throughout the community. Students are used to volunteering because it’s part of their culture and education. I’ve seen enthusiastic students and leaders travel to Mexico, Guatemala, or the Amazonas jungle year after year. Every time, two concepts meet together: the will to volunteer and the spirit of adventure.

Gathering dental units and materials and going into the jungle to treat people is something unique, and you won’t find any South American dentist doing it. You may only see some isolated example performed by locals.

As an ADI fellow, I am in the same position as any US volunteer, but I only have to drive half an hour from my dental office to find a group of low-income families we can help.

Los Tréboles Educational Center provides education and social support to children and teenagers in the area of Flor de Maroñas, Montevideo, Uruguay. Its
aim is to be part of building their education in view of improving their future opportunities. The center opened its doors in 2009 in response to the needs of local people; nowadays, 119 children attend every day outside school hours to receive academic support and participate in a variety of activities, including healthy habit education. This is where we make the difference, our team that has been part of this endeavor since 2010, among them two other ADI fellows.

Prevention is performed the whole year round at the center, but the best day for all of us is when we provide clinical dental care. Once a year, a bus brings all the children to our dental office, and the 25 members of our staff work voluntarily to perform all kinds of treatments. Los Tréboles changes the lives of these children, and we feel we have been an important part of this sustainable endeavor through the years.

If you want to volunteer in the jungle, please do it! Your help is much appreciated. And if you aren’t willing to go so far, just look around your neighborhood; I’m sure you will find someone to help.

Report of the ADI Middle East Section presentation at AEEDC 2018

Dr. Shiva Mortazavi, Regent, Middle East

As in other years, the ADI had a booth and convocation at the AEEDC in Dubai on February 6–8. From four months in advance, I had been in contact with Dr. Dina Debaybo to establish the UAE Chapter. However, despite her strong desire and our regular email and phone call exchanges, the dream of a UAE ADI chapter again was not to come true. I sent emails to the current fellows from Qatar, Saudi Arabia, and Pakistan requesting nominations of fellows from these countries. However, I received no responses despite my many reminders. I have started some communications with Afghanistan.

I met with some other Emirati colleagues, and I talked to Dr. Madarati (Saudi Arabia) too. I was invited to Dubai Health City to visit the University of MBRU and the faculties. I hope to be able to build a good relationship between the Academy and the Emirates, as we have done for Iran and India.

We registered for the ADI booth on February 6, and we (Dr. Neda Esmaieili, Ms. Fariba Namdar from Iran, and I) were in the booth all three days. We had prepared banners and brochures in advance in Iran, and fortunately the brochures sent by Central Office arrived on time. This year, the booth space was small; however, we managed well to make ADI visible, and we had several visitors come to our booth knowing about the Academy in advance.

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Tonga CDO Dr. 'Amanaki Fakakovikaitau arranged a one-month refresher course on dental equipment maintenance and repairs between the Dental Department of the Tonga Ministry of Health and Dr. David Goldsmith, from Ballarat, Australia. This is a continuation of a well-established dental equipment training and installations programme that dates back to 2001 as a partnership between Mr. Sioeli Manu, Australian dental equipment engineers Peter Copp and Cale Ziola, and myself.

Mr. Manu (Joe) has made several visits to Australia to update his skills as a part of this programme, but the latest one was back in 2006. There have been many changes in dental equipment over the past 10 years, so this was a welcome opportunity for Mr. Manu to upgrade his skills.

This maintenance twinning arrangement has been enormously successful and was followed up by unpaid volunteer team visits to Tonga in most of the years between 2001 and 2014. This collaboration with Mr. Manu and particularly PHF Mr. Peter Copp has resulted in the supply and installation of something like 20 dental chairs with the upgrading of several dental clinics, a dental caravan, prosthetic facilities, and other dental infrastructure on the islands of Tongatapu, Ha’apai, and Vava’u as well as the supply of tools and spare parts over a period of many years.

This has resulted in the smooth running of the dental department’s equipment needs throughout Tonga, including some of the outer islands, by the only such trained indigenous dental biomedical engineer in the South Pacific. Being largely self-sufficient in this area is something Tonga can be justly proud of and something that has saved the MOH in Tonga a large amount of money and equipment downtime.
and ensured continuity of dental services to the community. A less tangible but important and satisfying result has also been the goodwill and friendship that has resulted from these twinning visits, which date back to 1995.

This visit was arranged with accommodation close to Cale Ziola’s Dentequip company’s premises in Werribee, Victoria. This was ideal as the programme involved travelling around a large number of geographically diverse dental practices in Victoria, so they were able to travel together. Messrs Cale Ziola and Joe Manu work well together, so the visit proved to be not just instructive but also very harmonious. The days were long and the work quite intensive, but this has proven to be the best way to gain much useful experience in the short time available.

Mr. Manu also met with Peter Copp, continuing a long-established connection dating back to the 1990s, and obtained a useful collection of donated spare parts suitable for Tonga. Cale Ziola added to this targeted collection, which is now on its way to Tonga in a Rotary shipping container.

These are some of the experiences Cale has identified that Mr. Manu will have benefitted from as a result of this visit:

1) Better understanding of the complete network of hydraulic, pneumatic, and electro-valves internally covering a vast array of dental equipment.
2) Improved troubleshooting techniques and testing procedures.
3) Isolation of faults and corrective repair measures.
4) Preventative maintenance across a vast array of different types of dental equipment.
5) Involvement in the design and planning of surgery set ups.
6) Discussions on future equipment needs for Tonga, especially for some planned outer island clinics.

We are very grateful to Cale Ziola and Dentequip for the time and expertise so generously donated to the project, to Peter Copp and to Dentequip for spare parts donations, and to Kava Tu’imeiuuta and his family for their help with accommodations during the attachment.

Thank you to the Dental Department and the Tonga Ministry of Health for sponsoring Mr. Manu’s visit; we look forward to further cooperation in future.
Creating Smiles Vanuatu!

David Goldsmith, BDS, LDSRCS, FICD, FADI

The Rotary Club of Ballarat West has provided a dental prosthetics facility for indigenous NiVan people in Vanuatu to offer an affordable, professional removable denture service by:

1. Identifying a great need for such a service on previous visits by dental volunteers in Vanuatu.
2. Designing a dental laboratory to provide a removable denture service, both clinical and technical.
3. Obtaining through donations a comprehensive range of specialist prosthetic equipment.
4. Taking a new shipping container, air-conditioning it, and installing fitted cabinetry, lighting, boiling water, specialist electrical wiring and plumbing, a compressor, and quick release air and gas fittings.
5. Utilising Rotary facilities (RC Ballarat South shed) as a base for the outfit of the shipping container.
6. Having all work provided by licensed tradesmen to Australian standards.
7. Providing many years of supplies and consumables to make the project sustainable in Vanuatu.
8. Shipping the container to Vanuatu via Rotary DIK and gaining customs-free clearance in Port Vila.
9. Installing the laboratory on cyclone-proof footings in a permanent position with adjacent complementary dental facilities.
10. Commissioning the lab—all equipment and materials tested by two advanced dental prosthetists.
11. Making dentures in the lab for NiVan patients at no cost by professional Australian dentists and prosthetists—any complementary surgical work was carried out in the adjacent Rotary Dental Truck.
12. Having all the design and fitting out done by past and present members of the Rotary Club of Ballarat West.
13. Getting valuable initial and ongoing support from Rotary Clubs of Grassroots Vanuatu and RAWCS.
14. Getting landscaping, roofing, painting, and Rotary logos added by Grassroots Vanuatu Rotary and PCV.
15. Having work in hand for a business plan and training plan for an indigenous prosthetist to make the lab sustainable into the future.

We took this shipping container.

With input from dental prosthetist Bill Davies and others, we designed a lab and drew up scale plans and elevations. Volunteer Rotary tradesmen plumbed, rewired, equipped, air-conditioned, and fitted out the container to convert it into a modern custom-built dental facility.

We added donations of dental equipment and supplies (several years’ supply).

Then, we shipped it via DIK to Vanuatu, connected services, and installed it on a permanent, fully serviced site.
Handover ceremony and blessing by Presbyterian Church Vanuatu’s Pastor John.

In October 2016, dental prosthetists Bill Davies and Colin MacKay and dentist Dr. David Goldsmith went to Vanuatu to commission the lab and construct dentures for indigenous NiVan people as the culmination of this 18-month Rotary project.

Dr. David Goldsmith with PCV Secretary Richard Tatwin.

Results
Some before and after pics!

Full upper denture/Lower partial denture

Upper partial denture

Immediate upper partial denture

Some of the happy patients with renewed confidence in their smiles.

Prosthetist Bill Davies with a patient in the lab.
Dentistry for Every Village Foundation (D4EVF) completed its third dental outreach mission last October in the mountainous region of Porac, Pampanga, targeting the indigenous Aeta people and their neighboring Christian villages.

The mission was held at the Antioch Mission Church in the outskirts of Porac, Pampanga, in the main island of Luzon in the Philippines. The mission was made possible through the intercession of Mr. Roger Stone, an American bible translator based in the area.

The Aetas were the former dwellers on Mt Pinatubo until the volcano erupted in 1991, destroying their ancestral domain and forcing the government to relocate them in several provinces: Pampanga, Bataan, and Zambales.

Leading the large group of dentists was ADI fellow Ed de la Vega of Canoga Park, CA. Providing the main support were the stalwarts of the Group A Dental Associates of Las Pinas City. This group led by Drs. Amry Jane Chavez, Florabelle Tan-Frondozo, Luz D. Villanueva, and Cecily Rios Vera Cruz has supported all the projects of D4EVF since its inception in 2015.

Also present to lend a hand was Dr. Maritone Olaer of Los Angeles and her husband Jojo Olaer. They donated two huge boxes of food packs that were distributed to everyone who came to the mission site.

Four dental auxiliary persons and an equipment technician also came along to ensure that all the equipment worked as expected.

Also present to assist were members of the local section of the International College of Dentists based in Manila. Ten fellows from that group came on the second day of the mission.

The Porac mission was the first time D4EVF was able to utilize a portable, hand-held x-ray machine and its corresponding software. The setup gave the dentists a better way to diagnose and treat the more than 250 patients who came to the mission.

The x-ray system created a sort of gold standard. No other of groups of dentists doing missions in the far-out villages in the Philippines had brought such a system before due to the prohibitive cost of the unit and the x-ray sensor.

D4EVF also has a rotary endodontic unit, allowing the group to do simple root canal procedures,
particularly on the anterior teeth, work made easier by the availability of the x-ray system

The group also has expanded its inventory of equipment. It now has three portable air compressors that drive all their air-driven high- and slow-speed dental units. They have acquired more ultrasonic prophylaxis units, allowing the volunteers to do scaling and prophylaxis. They have acquired two portable vacuum systems as well. In addition, more portable LED curing lights were added to the inventory, allowing more cavities to be filled instead of the teeth simply being extracted.

The number of hand surgical instruments was increased as well, with the group now boasting more than 100 assorted forceps and several elevators and periotomes, the standard instruments in oral surgery.

As D4EVF matures, its systems and procedures continue to evolve. Thanks to many supporters and donors, particularly the DLV Family Trust, more and more equipment and supplies are being purchased, giving the group of volunteers the ability to expand their services to many more recipients.

Lest we forget, United Laboratories of the Philippines provided boxes of postoperative pain medications as well as antibiotics and bags of rice for the patients. El Camino Pharmacy of North Hollywood, CA, gave pediatric antibiotics.

Of course, the constant supporters of D4EVF, the ICD Global Visionary Fund and the Henry Schein Cares Foundation, again came through with huge dental supply grants that made it easy to provide more restorations. SunStarAmericas and Dr. Luz Villanueva gave hundreds of toothbrushes that were distributed to villagers as well.

The ladies of the village cooked lunch for the patients and all the volunteers that came with funds provided by D4EVF.

The Academy of Dentistry International is also a huge supporter of the D4EVF. They never fail to provide a grant every time a request is made, something that the D4EVF will treasure and remember forever.
“I don’t see how it can work,” was the reply from Gay Thatcher-Herrera, the executive director of the Amigos de los Niños in Cabo San Lucas. Dayna Dayton—the hygienist from my Olympia, Washington, practice—and I had just outlined our plans to create a volunteer program for the children of Cabo. Gay continued, “So, you want to see children who have never been to a dentist, have never seen an American, speak no English and do dental work on them. I don’t see how it can work.” Thus began the project that has grown to the point that we now see and provide comprehensive pediatric care for 500 children per year.

The initial crew that launched the Cabo clinic in May 2016, including two Mexican dentists. This picture depicts what happens to volunteers when they work with me! :-)

Dayna and I convinced Gay to give it a try, and that if it didn’t work, we would never bother her again. She spoke with her own local dentist, who agreed to let us use his office for two days, and we began. Four patients into our first day, Gay, who was observing, came to us with an amazed look on her face and told us, “I can’t believe what I’m seeing.” Of course, for those of us in pediatric dentistry, this is a common response, most usually coming from parents. With Gay now on board with great enthusiasm, the program was formally launched the following year in a facility in a remote section of Cabo San Lucas. A rudimentary dental clinic had been included in a building that served as a daycare, a preschool, as well as first, second, and third grade classrooms for children who came from single-parent families. It was a one-chair office but had a compressor and all the other necessities to do restorative dentistry. For the next nine years, I would take teams of three people to work in this location, normally seeing about 50 children per session. The program was successful, and we saw some of the children from year to year. The needs of these children were great. I often felt that I could have moved to Cabo, opened a full-time practice, and still not met all their dental needs.

In 2014, Gay informed me that the Amigos de los Niños had received two “very substantial” donations and that the Board of Directors had met to discuss how to use the money. Much to my astonishment, the decision was to tear the roof off the existing administrative building, add a second floor, and construct a fixed dental clinic for me. I was stunned! The floor plan originally had space for two chairs, but by convincing them to rearrange the spaces, I determined that I could fit three chairs into the space. It would be cozy but possible. For the next year and a half, I coordinated the design, construction, equipment, and cabinetry for the clinic, primarily from my home in Olympia. It was not easy, but my vision was clear. I wanted a clinic that could be ongoing for more children.

A picture of all three chairs in use.
After many hiccups and bumps, the clinic was completed in time for a May 2016 launch. I had successfully recruited an impressive list of professionals who wanted to volunteer, primarily during a lecture I gave at an American Academy of Pediatric Dentistry meeting in Seattle. My first crew of eight consisted of two Mexican dentists with whom I work on my “other” project in Zihuatanejo; Dr. Patricia Clevenger and Jennifer Ackley, RDH (both of whom had already been on the project with me before); Chrissy Askew, RDH; Danielle DePersio, RDA; and my wife, Mary Ellen. All came from the Seattle area other than Drs. Cecilia Villavicencia and Brenda Manrique. As with any opening day, we had things to iron out, but before long, we were working efficiently and well. Since that first session, seven more teams of eight people have worked in the clinic. Volunteers have come from Bellingham, WA; Prescott, AZ; Issaquah, WA; Boone, NC; London, ON; Chicago, IL; and once again from the dentists from Mexico. Dr. Ron Fritz joined the group from Canada as well. On average, we are seeing 125 children per session, so each year we can treat over 500 children.

The children we see are from a variety of locations, among them a halfway house for children who live in unsafe homes and an orphanage. We also see children with special needs. Gay told me that no dentist in all of Baja California would see the latter children, so we are sole providers for youngsters with Down syndrome, autism, developmental delays of all sorts, and cerebral palsy. Because the ADLN began as a medical organization, they have many patients who have gotten hearing aids, strabismus corrections, heart surgeries, and cancer drug therapy. These children also become patients of our clinic.

At present, four sessions are scheduled each year, with a possible fifth session for 2019. As if this expansion of the project weren’t enough, in June 2017, I met with a man who runs a nonprofit in San Jose del Cabo, the second major population center of Los Cabos. He is building a very large facility that will include a Boys’ Club and a Girls’ Club; the first food bank in Baja California; classes for the local children in art, music, and English; and a learning center for their parents so they can qualify for jobs other than gardener or maid. He informed me that he was aware of the clinic in Cabo San Lucas and that he had apportioned a significant space for another one in his building. I drew plans for a four-chair clinic that is scheduled to launch in 2020. My sincere belief is that when both clinics are fully functioning, we will be able to offer comprehensive pediatric dental care to more than 1200 children each year. If anyone had told me five years ago that I would be writing these words today, I’m fairly certain my response would have been, “I don’t see how that can work.” With good intentions and a clear vision, I believe all things are possible.

Donations and Contributions from:
3M/ESPE
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Solmar Foundation (for housing)
Pueblo Bonito Sunset Beach (for housing)
Patterson Dental
Onpharma
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Denovo
Hu-Friedy
Treasure Tower
Oral-B
Smart Practice
Medical Center of Malehice

Dr. Dietmar Klement

It is not long now until the Mozambique Dental Help project can finally begin. A year has passed since I made contact with Sister Elisabeth Hessdörfer in Malehice. She is originally from Retzbach, a renowned wine-making area near Würzburg, and has been working for many years for the Missionary Sisters of the Precious Blood at a small locality some 200 km north of Maputo where she looks after orphans and the destitute. The locality has a small hospital and a dentist’s chair, although the nearest dentist is based miles away. Having abandoned my first African project in Zimbabwe due to the uncertain political situation, I had been wondering for some time about where in Africa I might be of some use. As a fellow of the ADI, I decided with Gerhard Seeberger, a friend and former fellow student now based in Italy, to set up a dental project in Mozambique. With this in mind, the two of us will be travelling to Malehice around the start of November to establish on the ground whether dental work is a feasible proposition.

Introducing the Medical Center of Malehice

The hospital in Malehice cares for around 35,000 people from the region. There is a surgery with a senior physician from the country itself as well as test laboratories for HIV and TB with attached advisory facilities, an outpatient unit, and a maternity ward staffed by trained specialists.

Basic Dentistry

Basic dentistry is performed by a technical assistant (a trained stomatologist) and takes the form of dental extractions. We met all the staff, explained our initiative, and asked them to help us with early detection of oral pathologies.

We installed the 26 kg portable water preparation device we had brought with us. We were able to buy a PAUL (Portable Aqua Unit for Life-saving; http://www.waterbackpack.org/) with the help of old gold donated by my patients. It can filter around 1,000 liters of contaminated water (bacteria, viruses, etc.) per day. This ensures that people always have access to really clean drinking water and helps significantly reduce cases of gastrointestinal diseases such as cholera and typhus.

Sister Elisabeth invited a number of orphans from the area where the missionary post operated, and we gave out the toothbrushes and toothpaste we had brought to around 50 orphans and those accompanying them. They all had to clean their teeth together, following Gerhard’s instructions. This was the first time in their lives they had done this with clean water.

With the help of an interpreter, Gerhard took the opportunity to tell the children about the dangers of sugar consumption (in the form of soft drinks) and energetically promoted the newly clean water as a way of quenching their thirst.

Excerpts from Dr. Klement’s blog available at www.mosambikdentprojekt.wordpress.com is intended to give people some idea of our day-to-day work with the help of words and pictures.
In 2009, I found myself one of the sponsors and chaperones for a group of high school students from Loma Linda Academy on a mission trip to Kenya. It was a new experience, although I had been a missionary for the Seventh-day Adventist church after graduating from dental school in 1975. I went to the island of Trinidad and Tobago. My six years there as a dental missionary were a wonderful experience. Although it was a third-world country and challenges were present, I had a clinic equipped with high-speed suctions, air-driven handpieces, and x-ray units.

When I arrived in Kenya in 2009, our group was tasked with three projects: first, putting the finishing touches on a school being built; second, helping out in the Mission medical clinic; and third, seeing to the dental needs of the local community. I was the only dentist on the trip, which also included my niece, my nephew, and my daughter Katie, who were all in high school at the time. When I was dropped off at the medical clinic, I asked where the dental clinic was. Taken inside the clinic, which had a tin roof and a poured concrete floor, I was directed to a door that had a black-and-white sign on it reading “dental clinic.” When I opened the door, I found two windows with no screens, one medical examination table just made from wood, and a wooden straight-back chair. There was no running water, no electricity, no lights, no autoclave, and nothing other than the sign to indicate that it was a dental clinic.

I had come prepared, however: I had 50 toothbrushes, 50 tubes of toothpaste, dental floss, gloves, masks, anesthetic carpules, disposable exam gloves, and disposable needles.

When I asked for the instruments that they had for the clinic, I was brought a metal pan with numerous extraction forceps and elevators wrapped in a towel. I got excited that this was going to be a true mission experience with dentistry like I had never experienced. But that first day, my heart began pounding; I actually felt panicked because I realized that I had nothing to help me out if I got in trouble with an extraction. But then I remembered that I had God on my side, and he would help me through anything, even if I broke off a root and I couldn’t see it.

Luckily, I had brought along some cavi-wipes and cold sterile solution. I also had my high school students, who, though not experienced, were eager to learn and help.

Over the next 10 days working in the clinic, I learned that 2 x 2 gauze worked as a great suction system, that a kidney bowl was a great spittoon, that flashlights and the sunlight through the open window provided almost as much light as a Pelton Crane oral light. I also learned that if you don’t swat at them, the swarms of wasps whose nests were in the room would not sting!
In those two weeks in Kenya’s Maasai Mara, I fell in love with the Maasai people, their warmth, and their hospitality. I found people living in pain for three to six months with abscesses or broken teeth who were totally grateful for our services. I’ve been back every year since and this June will be there again.

In the years since that first trip, we’ve been able to build a real dental clinic, and now, although we don’t have running water yet, we do have electricity, which at first was a generator and now is supplied by government powerlines (that work most of the time). We have an autoclave, high-speed suction, an air compressor, a digital x-ray unit, and high-speed hand pieces. Two years ago, we were able to do our first endo procedures, so now when someone comes in with an abscessed front tooth, we can save it and not just extract it as we had to in the past. We can do both composite and amalgam fillings, prophys, scaling and curettage, and, of course, extractions.

We have been fortunate to have about four groups of dentists visit the clinics year for two weeks at a time and are able to treat between 60 and 80 patients. Occasionally local dentists from Nairobi come and give of their time as well.

In conclusion I have to say that I’ve learned a lot in my trips to Kenya, for each time when I return to the States, I feel I’ve gotten more that I’ve given! There are always challenges, however with prayer and God you get through them. Above all that, more than relieving suffering, the people feel God’s love through our hands and they know that people from the other side of the globe care about them and their health.

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The Hidden Mission in Our Backyard
SAC Health System houses one of the nation’s largest HIV dental training programs and dental clinics.

Ronald E. Fritz, DDS, MPH, FADI - Daniel Ninan, DDS, FADI - Rodney L. Turner, DDS, FADI

When most of us think of a dental mission, we picture in our minds preparing our plans and instruments, getting with the group at the airport, and flying internationally to provide dental care to needy patients who have no access to care. What we don’t hear about very often is the admirable instances where that is not the case, since people who have no access to care exist right here in the USA.

A short 10-minute drive from Loma Linda University to the city of San Bernardino, you find yourself surrounded by a community that has many people with no access to care. Back in 1996, Dr. Richard Hardt saw this need, and along with his brother, he established SAC Health System on the former Norton Air Force Base.
Dr. Rodney Turner came to town in 1995. He had been working at a San Bernardino County dental clinic treating HIV+ patients and saw an opportunity. When Loma Linda started their SACHS dental clinic, Dr. Turner obtained a position, which he has held ever since, and arranged via grants and many approval committee meetings to have these same patients seen at SACHS, formerly the Norton Air Force Base clinic until closed down by President Clinton in 1994. It is located two miles from downtown San Bernardino, the county seat of the largest county (San Bernardino) in the continental US. It covers over 20,000 square miles, extending from Los Angeles Country to the Arizona border at the Colorado River. As Dr. Turner worked with these patients who were neglected by mainstream dentistry, at times even rejected for treatment, he found that they are more appreciative of what they receive and less demanding, and they like to hug their dentist upon arrival and departure. This program is unique in that it receives federal funding as a joint venture among three entities: Loma Linda University School of Dentistry, SAC Health System, and the San Bernardino County Department of Public Health. Thanks to this combination of Medicaid and Ryan White Federal funding, these patients are no longer neglected and receive some of the finest treatment available. What Dr. Turner found out was that if these patients had poor oral health, their self-esteem was in the basement; they had no motivation to find a job and stayed away from even trying. However, once their oral problems were treated and their self-esteem and joy of life returned, they not only showed how much they loved their dentist but were now motivated to go out and get jobs and be productive.

In addition to providing high-quality dental care to those in dire need, SAC Health System has received grant money to educate future oral healthcare workers. All of the dental students, dental hygiene students, and international dental students at Loma Linda University go through rotation to learn more about how HIV behaves and how it is related to dentistry. The students are broken into small groups and learn about HIV, its oral manifestations, considerations for dental treatment, and accidental occupational exposure. Their learning experience is a combination of lecture, case-study, a group interview with an HIV-positive individual, and hands-on clinical experience.

When Dr. Ninan attended LLU, he rotated through this program. Then, in 2010, he began working with Dr. Turner in the SACHS clinic and has found out what a great mission project this is for the community, the county of San Bernardino, and the world. Today, SAC Health Systems has five dentists in two locations, both in San Bernardino, and is actively pursuing plans to further expand dental services.
This visit, which took place from Monday 12 to Friday 16 June 2017, was the thirteenth annual voluntary surgical team mission that I have led to the Odonto-Maxillo-Facial Hospital in Ho Chi Minh City, Vietnam. The hospital is a tertiary referral centre for oral and maxillofacial surgery for the southern half of Vietnam. The hospital has recently commissioned four new operating rooms, and we were the first foreign team to use them. The three old ORs are still functioning. The hospital has over 100 beds.

During the week, the team operated on 53 cases. Over the 13 years that our team has worked at the Odonto-Maxillo-Facial Hospital, we have operated on approximately 600 individuals.

During the week, the team operated on 53 cases. Over the 13 years that our team has worked at the Odonto-Maxillo-Facial Hospital, we have operated on approximately 600 individuals.

We performed surgery all day from Monday afternoon to Friday afternoon. Some procedures were very complex, involving up to seven hours of surgery to complete. We were supported by, and worked closely with, the local oral and maxillofacial surgeons and trainees, anaesthetists, and nurses. Most of the hospital surgical staff have worked closely with our team members during all our visits to the hospital. The close and collaborative engagement between our team members and the local hospital staff has been a particularly rewarding experience for all (Figs 3 and 4).

The procedures performed on all cases were life-changing for each patient. It was particularly rewarding for all team members to experience the expressions of gratitude from all our patients, their families, and the hospital staff.

On the last afternoon of our visit, the hospital hosted a ceremony of appreciation for the Australian team members.

Our efforts to care for the local patients could not have occurred without the essential contributions of various individuals, companies, and associations. All
surgical team members were self-funded and donated their time and skills to contribute to the team’s work. We received donations of essential equipment and materials from a range of sources, including Defries Industries, Epic Pharmacy (Berwick), Johnson and Johnson, KLS Martin, St John of God Hospital Berwick, Teleflex Medical, and Waverley Private Hospital. A grant from the Overseas and Outreach Aid Committee of the Association of Oral and Maxillofacial Surgeons partly funded the costs of the nurse members. Essential surgical and anaesthetic instruments purchased with grants kindly supplied by ANZAOMS and the International College of Dentists were used by the team during our visit (Figs 5 and 6).

This trip was another wonderful and rewarding experience for all team members. We have been invited to return next year, and all members look forward to continuing the team’s special association with the hospital, the Vietnamese patients, and their families who entrust us with their care.

Fig 1. 2017 team members at the Odonto-Maxillo-Facial Hospital, Ho Chi Minh City, Vietnam.

Fig 2. Screening clinic, day 1.

Fig 3. In OR working with the local oral and maxillofacial surgery trainees.

Fig 4. Team members with hospital oral and maxillofacial surgery staff.

Fig 5. Ambu portable monitor and disposable flexible fibreoptic videoscope in use at the Odonto-Maxillo-Facial Hospital on a patient with ankyloses of the TMJ.

Fig 6. Coronal CT scan of ankyloses patient.

Editor’s Note: Dr. John Harden and Dr. Daniel Ninan are the delegated CE speakers for the USA Section meeting in Honolulu, October 17, 2018.

33 Years of Dental Anesthesiology and Hospital Dentistry

John W. Harden Jr., DMD, FADI, FACD, FICD, FPFA

I practiced general dentistry in downtown Atlanta, GA, from 1978 until 1984 after graduating from the Medical College of Georgia School of Dentistry. At this time, I was considering a residency in oral and maxillofacial surgery. A general practice residency or an anesthesiology residency is typical preparation for such an endeavor. I was fortunate to be accepted in an anesthesiology residency at Illinois Masonic Medical Center in Chicago. I went through the program with 17 physician residents. This program really changed my professional life. Actually, I was so excited about it that I even thought about going back to medical school.

I thought long and hard about this decision. I decided that I was not prepared to go back to school.
for eight more years at age 42. I decided to use this great training in the practice of dentistry. It turned out to be a fortuitous decision.

In my residency, I administered anesthesia for the general practice residents and for the oral surgeons. This is what prompted me to come back to Atlanta and begin doing hospital dentistry in 1988 as part of my general practice.

The following case was a patient with Hay Wells Syndrome (ectodermal dysplasia) who was treated in the operating room at Emory University Hospital Midtown in Atlanta in the summer of 2013. The oral surgery attending and residents extracted seven teeth, including four third molars. I followed with restorative dentistry and endodontics and treated a total of nine teeth. This was an all-day case.

I was called back to the recovery room after the case when the nurses observed edema in the patient’s lips. After consulting with thoracic surgery, we decided it was due to obstruction of lymphatic drainage in the face from the hours of facial retraction. This resolved by the next day with IV corticosteroids.

I am fortunate to practice in a teaching hospital for a major university/medical school where I can collaborate with physician colleagues. Many of these patients are extremely sick, but at this institution, no one is ever turned away, as we can handle anyone. Some of the sickest patients in the southeastern United States are treated here.

FDA’s New Pregnancy and Lactation Rules and its ramification for Dentists

Daniel Ninan, BS, BA, DDS, FADI

When we as dentists prescribe medication to our patient are we paying attention to the side effects of the medication on women especially in terms of its potential effects on conception, pregnancy, post-pregnancy stages?

The FDA is in the middle of making a major change. In June 2015 the FDA began eliminating the well-known Pregnancy Risk Category (PRC) letters from prescription drug labeling. And, by June 2020, the FDA will have eliminated the “Pregnancy” category system from all prescription drug labeling. This means that the dentist can no longer use the pregnancy risk category letter in determining if a medication is appropriate to prescribe during pregnancy.

In 1979, the FDA adopted the “Labeling for Prescription Drugs Used in Man” which outlined the A, B, C, D, X Pregnancy Risk Category system that is still in use today. For many years, this system has helped guide clinicians in making prescribing decisions. According to this system (PRC) the designations for drug selection was as follows:

- **A**: Safest drugs to take during pregnancy with no known adverse effects.
- **B**: No risks have been found in humans.
- **C**: Not enough research has been done to determine if the drugs are safe.
- **D**: Adverse reaction have been known to have been found in humans.
- **X**: Should never be used by a pregnant woman.

I used to think that selecting a medication for use during pregnancy was easy. I would simply look up the different drugs that might be appropriate for the patient’s condition. I would then select the one with the pregnancy category closest to A. This usually meant that I found a pregnancy category B medication. And, when there were multiple
medications in the same category, I would simply select the one that I thought might work the best for the particular patient I was treating. I didn’t realize that I was incorrectly using the Pregnancy Risk Categories.

One of the criticisms of the PRC system is that the single-letter representation oversimplifies prescribing decisions and does not provide adequate information to make appropriate risk-benefit decisions that are individualized to the specific patient. In light of this, and a number of additional shortcomings, the FDA chose to replace the Pregnancy Risk Categories with a new Pregnancy and Lactation Labeling Rule (PLLR).

The information pertaining to relevance to women and pregnancy does not change. However, with this new system the information is re-organized and presented in more detail which will allow for more involved discussion between the physician and the patient about risks, clinical consideration and data collection during conception, pregnancy, post-pregnancy stages.

Like any system, there are always shortcomings. One of the criticisms of the new system is that because there is not a simple single-letter summary of risk, the clinician will have to spend more time making prescribing decisions. Then when the clinician is rushed, it is possible that important information may be overlooked, which may lead to a worse prescribing decision.

While no system is perfect, it is reassuring that the FDA is continually trying to improve. It is important for the clinician to be aware of these changes so that we can provide the best possible care to our patients.

I hope to address these new changes and other considerations when providing dental care to the pregnant patient, during the CE lecture planned for the ADI USA Section Meeting in Hawaii on 17 October 2018.

The above was retrieved from https://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/Labeling/ucm093307.htm on March 18, 2018.)