‘Everyone can have a celebrity smile’

By Fred Michmershuizen, Online Editor

In an interview with Dental Tribune, Dr. Emanuel Layliev, director of the New York Center for Cosmetic Dentistry, talks about his high-profile practice in Manhattan, his passion for cosmetic dentistry and how he is able to make a difference in people’s lives — and what it’s like to work with famous celebrities.

Please tell our readers a little bit about yourself and your background.

I am one driven to create healthy, beautiful and memorable smiles, with a sincere focus on the well-being of my patients’ outcome, using the most up-to-date and innovative technology producing high-quality results in a compassionate, caring and gentle atmosphere.

As one committed to this, it’s important to be extremely meticulous with special attention to the intricate nature involved in the field of cosmetic dentistry. I have earned noteworthy distinctions in my field. As one committed to this, it’s important to be extremely meticulous with special attention to the intricate nature involved in the field of cosmetic dentistry. I have earned noteworthy distinctions in my field.

I am an active member in local and national professional associations, am currently the president of the New York Academy of Cosmetic Dentistry and am awaiting publication as an author in a cosmetic dentistry textbook on the subject of conservative composite bonding.

I went to New York University for undergrad and graduated from NYU College of Dentistry in 2001. I completed a full year in a hospital general practice residency and worked in multiple practices for five years before settling down to narrow my focus on cosmetic dentistry.

I have been at my practice as a

Dental advertising on the Internet

All states have laws prohibiting false, deceptive or unsupported statements in dental advertisements, and this includes those found on the Internet. The same guidelines that apply to advertising in newspapers, magazines, telephone books, brochures, radio and TV also apply to advertising on the Internet. (Photo/Gert Frey, www.dreamstime.com)

Healthy gums may lead to healthy lungs

Maintaining periodontal health may contribute to a healthy respiratory system, according to research published in the Journal of Periodontology. A new study suggests that periodontal disease may increase the risk for respiratory infections, such as chronic obstructive pulmonary disease (COPD) and pneumonia. These infections, caused when bacteria from the upper throat are inhaled into the lower respiratory tract, can be severely debilitating and are one of the leading causes of death.

The study included 200 participants between the ages of 20 and 60 with at least 20 natural teeth. Half of the participants were hospitalized patients with a respiratory disease such as pneumonia, COPD or acute bronchitis, and the other half were healthy control subjects with no history of respiratory disease. Each participant underwent a comprehensive oral evaluation...
partner at a distinctive and reputable office for nearly five years. I am married to a dental hygienist, and I am the father of two boys with another one on the way.

What made you choose cosmetic dentistry as a specialty area? I adore the craft behind the detail-oriented nature expected in general as a dentist and expanding that to focus on the cosmetic aspect to ensure precision and quality. I grew up loving to draw and engaged in arts and crafts and hobbies of all sorts. I love the need to work with my hands to produce controlled results. To create dramatic smile enhancements that immediately transform one’s appearance is very rewarding, and to do so in a pleasant and gentle manner is very enjoyable.

What do you like best about cosmetic dentistry? Just about all of it. I like having the ability to have a tremendous impact on a person’s life, self-esteem and ability to have a tremendous impact on their appearance is very rewarding, and being able to transform clients from around the world. Patients respect the location and enable us to deliver the best in treatment.

You have been treated a number of well-known patients. What is it like to work on famous smiles? It is very rewarding to acknowledge the trust and confidence they have in us. They are friendly folks with established smiles that set the bar for trends in society. People look up to them as public figures and want to emulate their look and style, and it’s my job to uphold that and to meet their expectations with excellent quality and expertise.

Can everyone’s smile be improved upon? Absolutely! Everyone can have a “celebrity smile” in today’s age. There are various options to enhance. It can range from the dramatic to the ever so slightest change; small changes these days can have great effects. As long as the simple rule of golden proportion is followed, we can create an amazing result by imparting a look of balance and symmetry.

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Interview

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Dental advertising on the Internet

Website advertising must comply with the American Dental Association’s Principles of Ethics and Code of Professional Conduct

By Stuart J. Oberman, Esq.

Many dentists feel that advertising their practices on the Internet is essential to competing in today’s evolving market. Before 1979, dentists were generally prohibited by law from advertising their dental services in order to avoid misleading the public. Now, dental advertisements are common, but strict restrictions are in place to ensure that the public is not mislead by dentists’ false claims.

All states have laws prohibiting false, deceptive or unsupported statements in dental advertisements. Violating these prohibitions could result in a fine, injunction and censure or in suspension, revocation or limitation of a dental license. Dentists should make a point to understand the applicable laws.

Dental websites are a very common form of advertisement, but dentists must ensure that they are complying with the American Dental Association’s Principles of Ethics and Code of Professional Conduct. Dentists must remember that the same guidelines that apply to advertising in newspapers, magazines, telephone books, brochures, radio and TV also apply to advertising on the Internet.

The rules apply to any statement, oral or written, that offers to perform dental services either directly or indirectly. The rules apply to advertising of any kind, regardless of whether it is paid advertising or free advertising. Ultimately, the dentist will be the party held responsible for the dental practice’s webpage, the owner of the dental practice must be involved in the content of the materials posted on the Internet.

Every dentist has a duty to advertise truthfully. Section five of the American Dental Association’s Principles of Ethics and Code of Professional Conduct lays out the ethical standards by stating that no dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any “material” respect.

This includes misrepresentations of fact, making partial disclosures of facts, making self-praising statements, comparing the quality of one dental practice’s services to another dental practice’s services, and making any other statement that would cause a reasonable person to be deceived.

These guidelines have been instated as a method of protecting the public from misleading advertisements inducing the patient to seek dental services at a particular office. For example, a dentist who advertises an unearned degree or who falsely advertises that the dental practice specializes in a certain area of practice would be guilty of misleading patients in a “material” respect.

In addition, the American Dental Association’s Code describes claims of superiority as misleading when the claims are not subject to reasonable substantiation. The licensed dentist’s name and the address of the dental practice should always be identified in an advertisement. If a dentist is advertising fees, a disclaimer should be included stating the description of the service, the specified period during which the fee is in effect and that the fee is a minimum fee only.

In addition, if a dentist advertises specialty services such as orthodontic, oral surgery or endodontic procedures, the dentist should also state whether the services will be performed by a general dentist or a specialist.

When advertising on the Internet, there are many phrases that should not be used. First, phrases of superiority such as “the best” should be avoided. Dentists should also state whether the services are “painless” or that specific results are “guaranteed.”

In addition, some states prohibit testimonials on dental websites. A
testimonial is a quote from a past patient recommending a specific dental practice. In states that do allow testimonials, phrases such as “the best” are still prohibited.

Dentists should refrain from advertising on the Internet (or in general) that their dental practice specializes in an area that the American Dental Association or state law does not recognize.

For example, because cosmetic dentistry is not an American Dental Association recognized specialty, a dentist should not advertise that the dentist specializes in cosmetic dentistry.

In order for a dentist to advertise as a specialist, the dentist should have completed a specialty program that is approved by the American Dental Association Commission on Dental Accreditation.

However, if the dentist is recognized by a specialty accrediting organization other than one that has been recognized by the American Dental Association, then the dentist should state that the referenced organization is not recognized as a specialty accrediting organization by the American Dental Association.

In addition, dentists should not advertise on the Internet (or in general) the name of any person who is not either an owner of the dental practice being advertised or a person who is actually involved in the practice.

However, you may identify the prior owner of the dental practice for a reasonable period of time if you have express written permission from that dentist. Dentists should also refrain from advertising an honorary degree or a degree awarded by an unaccredited institution. Finally, a dentist should not claim to be a member of the American Dental Association in an advertisement unless the dentist is, in fact, a member of the American Dental Association.

These regulations are designed to protect patients from misleading information projected by advertising dentists. Honest, non-deceptive advertisements of a dental practice help patients make informed decisions when faced with misleading advertisements.

Researchers suspect that the presence of oral pathogens associated with periodontal disease may increase a patient’s risk of developing or exacerbating respiratory disease. However, the study authors note that additional studies are needed to more conclusively understand this link.

“Pulmonary diseases can be severely disabling and debilitating,” says Donald S. Clem, DDS, president of the American Academy of Periodontology. “By working with your dentist or periodontist, you may actually be able to prevent or diminish the progression of harmful diseases such as pneumonia or COPD.” This study provides yet another example of how periodontal health plays a role in keeping other systems of the body healthy. Taking good care of your periodontal health involves daily tooth brushing and flossing. You should also expect to get a comprehensive periodontal evaluation every year,” he said.

(Sources: American Academy of Periodontology)

About the author

Stuart J. Oberman, Esq., has extensive experience in representing dentists during dental partnership agreements, partnership buy-ins, dental MSOs, commercial leasing, entity formation (professional corpora
tions, limited liability companies), real estate transactions, employment law, dental board defense, estate planning and other business transactions that a dentist will face during his or her career.

For questions or comments regarding this article, visit www.gadentalattorney.com.

SOURCE: American Academy of Periodontology

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PLAQUE BUILD-UP
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Biofilm is a dirty word
Thousands of bacteria strains deep down in the periodontal pocket are responsible for the development of various diseases. The magnitude is enormous and so is the need for periodontal disease management.

No need to mention the increased risk factor on systemic diseases such as diabetes, stroke or premature birth.

Swiss-based Electro Medical Systems (EMS) is well known for Air-Flow®, the original method for supragingival air polishing. Yet, too few dental professionals are aware of the unique subgingival application of this mix of powder and air.

“Air-Flow goes subgingival,” says EMS, and brings the point home. A unique nozzle delivers the air-powder mixture deep into the pocket where rinsing water washes out the eliminated biofilm. The device and consumables go hand in hand for extraordinary results without any stress or risk for the patient, according to the company.

The patented single-use Perio-Flow nozzle has been especially designed for use in deep periodontal pockets (up to 10 mm). According to EMS, it creates optimum but gentle turbulence in subgingival areas and prevents soft-tissue emphysema via three horizontal nozzle outlets for air-powder mixture and one vertical nozzle outlet for water.

Abusive — a bad idea?
There is also the Perio-Flow Method, and the company has specific features for its periodontal use. The glycine-based grain is extra-fine (25 µm). In addition, the grains have a particularly low specific density (d 50).

As a result, the original Perio-Flow Method is highly effective.
when it comes to abrading harmful biofilm, but will not do any harm to the tooth surface or dentin, explains the company.

According to EMS, it is important to lay this misconception to rest: abrasion is not wrong, as long as, from the gingival crest to the deepest periodontal pockets, it has no adverse effects on the tooth.

A representative from EMS said that the company is very enthusiastic about the growing market acceptance of the Perio-Flow Method and that the company is proud to go beyond the boundaries of conventional periodontal disease management.

If your patients only knew
The wound surface of moderate periodontitis in the entire oral cavity equals the size of the palm of a hand. No wonder it affects the entire immune system, often with dramatic effects on the body as a whole.

Four out of five patients suffer from a form of periodontitis (50 percent severe).* If they knew that periodontitis is the most common cause of tooth loss, wouldn’t they ask for a way to prevent it?

Implants, too, come loose with the withdrawal of bone tissue. According to EMS, regular prophylactic treatment with the original Perio-Flow Method is proven to prevent peri-implantitis and its costly aftermath.

Thus, the implant patient is and continues to be a patient, too.  

Kids World Productions President Dr. Don M. Newman emphasized that with the prevalence of childhood cavities and the effects on overall health, it is vital that dental health professionals and parents take action.

“It is well-documented that primary tooth decay increases the occurrence of decay in the secondary teeth,” he said. “Prevention is the best way to stop tooth decay.”

Dental practices can use the dental health tools shown here to develop rapport with young patients. (Photo/Provided by Patterson Dental)
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Two-stage esthetic crown lengthening

By Michael Sonick, DMD, Stephen Rothenberg, DMD and Debby Hwang, DMD

A smile that is perceived as unattractive mars confidence, sociability and self-regard. For some patients, the lack of visual appeal stems in large part from a “gummy smile,” which a layperson begins to consider disharmonious when there is 3 to 4 mm of gingiva displayed. Management of such a complaint often entails both periodontal and restorative therapy, if not also orthognathic surgery and facial plastic procedures.

The following report showcases two-stage esthetic crown lengthening and prosthetic rehabilitation for the treatment of a gummy smile.

Patient history
A medically and periodontally stable 40-year-old female presented with excessive, asymmetric gingival display of 5 to 7 mm upon smiling, short clinical crowns and incisal wear from tooth #4 to #13 (Figs. 1, 2).

Due to attrition and the relationship between the dentition and periodontal drape, the anterior teeth appear square-shaped and “masculine.” Diagnoses included (1) Coslet Type IA altered passive eruption, evidenced by a wider-than-cust omary dimension of keratinized gingiva and an alveolar crest at least 1.5 apical to the cementoenamel junction (CEJ); and (2) vertical maxillary excess. The patient also shows a thick tissue biotype.

Treatment plan
• Consult with oral and maxillofacial surgeon regarding orthognathic surgery
• Consult with facial plastic surgeon regarding lip lowering therapy
• Consult with restorative dentist regarding ideal tooth shape setup and fabrication of surgical guide
• Two-stage esthetic crown lengthening from tooth #4 to #13
  • First stage: osseous recontouring
  • 6-week healing period
  • Second stage: gingivectomy
  • 3-month healing period

Fig. 1a: Initial facial presentation of patient, who exhibits a gummy smile (up to 7 mm of soft-tissue display) and vertical maxillary excess.

Fig. 1b: Initial view of maxillary anterior teeth upon smiling. The clinical crowns appear short and demonstrate attrition.

Fig. 2: Excessive keratinized gingiva, a thick soft-tissue biotype and asymmetric gingival contours exist.

Fig. 3a: The maxillary diagnostic model.

Fig. 3b: Ideal wax-up created on the diagnostic model.

Fig. 4: Surgical guide in place in the mouth. The ideal tooth contours are shaded in white.

Fig. 5: Initial full-thickness flap reflection at first stage surgery. Note the apical level of the alveolar crest compared to the cemento-enamel junction.

Fig. 6a: Final bone contours after osteotomy.

Fig. 6b: The final osseous contour lies at least 3 mm from the anticipated restorative margins, as outlined by the surgical guide.

Fig. 14: Facial view six years post-treatment.
Clinical

- Final porcelain veneer restorations for teeth #4 through #13
- Delivery of maxillary occlusal bite guard

Treatment plan rationale
Ideal treatment for the patient with vertical maxillary excess embraces a host of dental and medical specialties.

In such a case as this, in which the patient demonstrates up to 7 mm of gingival display, LeFort I maxillary impaction may further refine results if conventional crown lengthening insufficiently elevates the periodontal margin, creates an unacceptable crown-to-root ratio or precludes achievement of a natural-seeming emergence profile due to exposure of excessive radicular structure. 1

Likewise, neuromuscular relaxation of the upper lip by botulinum toxin type A (BTX-A) depresses the lip, and thus masks any mucosal surplus left after periodontal surgery. 4

As the patient declined orthognathic and facial plastic therapy, the treatment rendered to alleviate her gummy smile and reestablish tissue and dental symmetry included a two-stage crown lengthening procedure followed by delivery of porcelain veneers from tooth #4 to #13.

A biphasic crown lengthening approach minimizes the 1 to 3 mm coronal gingival shifts common after one-stage procedures detected especially in patients with thick soft-tissue biotypes (such as the patient featured in this report). 2

By first reshaping only the osseous crest and letting healing commence, it is possible to correct any coronal rebound of the soft tissue seen after healing at the second, gingivectomy-only, surgery. Once the attachment apparatus fully remodels post-gingivectomy, which takes roughly three months, final restorations may be cemented.

Restorative consult
From the diagnostic models, the patient’s prosthodontist created an ideal dental wax-up, upon which a vacuum matrix was applied to generate a surgical guide (Figs. 3, 4).

Osseous recontouring (first stage)
The first stage of biphasic crown lengthening of teeth #4 through #13 involved only osseous resection. The patient took 0.25 mg oral trizolam and 600 mg ibuprofen one hour before surgery.

Anesthesia with 2 percent lidocaine with 1:100,000 epinephrine and 0.5 percent bupivicaine with 1:200,000 epinephrine was given via local infiltration.

A buccal sulcular incision was made extending from tooth #4 to #15, and vertical incisions were dropped at the mesio-buccal and disto-buccal line angles of teeth #4 and #15. A full-thickness flap was elevated (Fig. 5).

Osteotomy was performed using an Ochsenein chisel, carbide finishing bur and Neumeyer bur to position the alveolar crest at least 5 mm from the anticipated restorative margin at each site, as verified by the surgical guide (Fig. 6).

The bone was graduated such that no sharp edges or bulbous areas existed, and positive architecture was preserved. The flaps were replaced and sutured in sliding fashion with 4-0 expanded polytetrafluoroethylene (ePTFE) (Fig. 7). The gingival height and shape post-surgery appeared similar to that found before surgery, even 10 days after intervention (Fig. 8).

Gingivectomy (second stage)
Once the soft tissue settled six weeks post-osteotomy (Fig. 9), the second stage of biphasic crown lengthening of teeth #4 through #15 was executed. The patient was sedated and anesthetized as above.

A definitive external bevel gingivectomy of teeth #4 through #15 was performed with a #15 scalpel utilizing the surgical template to delineate the

Fig. 7: Sling sutures in place after osseous reshaping. Note the similarity in gingival height and morphology between pre-surgical and post-surgical views.

Fig. 8: Healing 10 days after first stage crown lengthening. The periodontal level still approximates the initial presentation.

Fig. 9: Healing six weeks after first stage crown lengthening.

Fig. 10a: Frontal view immediately after second stage gingivectomy.

Fig. 10b: Positional relationship between the lip and gingival margin immediately after second stage gingivectomy.
desired tooth contours (Fig. 10).

The papillae were left intact and no sutures were required. Healing four weeks after the gingivectomy revealed a harmonious gingival drape (Fig. 11).

Final prosthetics

Placement of final veneers on teeth #4 through #13 occurred three months post-gingivectomy (Fig. 12). An occlusal bite guard was delivered to protect the restorations.

In order to correct lip line asymmetry and further diminish gingival display, neuromuscular lip correction (lowering) with BTX-A was reconsidered, but the patient did not pursue treatment.

Six years after veneer placement, the patient remained satisfied with the functional and esthetic result achieved solely through periodontal surgery and prosthetic rehabilitation (Figs. 15, 14).

Postoperative instructions

After each surgical procedure, the patient was instructed to take 600 mg of ibuprofen every 4–6 hours, hydrocodone 7.5 mg/acetaminophen 750 mg every 4–6 hours as needed for pain and 100 mg of doxycycline a day for 10 days.

The patient was instructed not to brush at or near the surgical site but instead to rinse with 0.12 percent chlorhexidine or warm saline twice daily. The patient was also directed not to chew in the affected area for at least two weeks. Suture removal occurred at 10 to 14 days post-surgery. (Fig. 11a: Frontal view four weeks after second stage gingivectomy.

Fig. 11b: Positional relationship between the lip and gingival margin four weeks after second stage gingivectomy.

Fig. 12a: Frontal view of final veneers (#4 through #13) three months after gingivectomy.

Fig. 12b: Central view of final veneers (#6 through #11) three months after gingivectomy.

Fig. 12c: Right lateral view of final veneers (#4 through #8) three months after gingivectomy.

Fig. 12d: Left lateral view of final veneers (#9 through #13) three months after gingivectomy.

Fig. 13a: Smile pre-treatment.

Fig. 13b: Smile six years post-treatment.

Fig. 13c: Facial view six years post-treatment.

(All photos provided by Dr. Michael Sonick)

References


About the authors

Periodontal surgeon: Michael Sonick, DMD

Restorative dentist: Stephen Rothenberg, DMD

Dr. Michael Sonick is a full-time practicing periodontist and implant surgeon in Fairfield, Conn. He is on the editorial boards of many journals and is co-editor of the textbook, Implant Site Development.

He is currently a guest lecturer at New York University School of Dentistry and is director of Sonick Seminars, in Fairfield, Conn.
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“I salute Crest Oral-B’s recognition of the role that dental hygienists play in patient wellness. As a recipient of the Pros in the Profession award, I hope to inspire Maine dental hygienists and students of dental hygiene to share their talents wherever their paths may lead.”

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Identifying and responding to the drug-endangered child

By Sharlee Burch, RDH, MPH, EdS

As drug use and abuse has risen throughout the United States, dental professionals find themselves faced with increasing requests to assist in the identification of drug-endangered children in their communities. It is vital that dental professionals learn simple ways to identify and assist the most vulnerable of those affected by addiction, the drug-endangered child (DEC). In the end, this will allow the dental community to better serve their patients and the public.

The drug-endangered child (DEC)
A drug-endangered child is any child who is physically, emotionally, and/or psychologically harmed by an adult who is using, selling or manufacturing drugs. Some drug production (specifically the production of methamphetamine) will change the physical environments in which children reside. They are likely to inhale toxic fumes of colorless, odorless gases. Drug-endangered children often ingest chemicals through contaminated food and handling other objects. Drug-endangered children typically experience a chaotic home life with poor supervision. They are at increased risk of future substance abuse, and having been born prematurely or with low birth weight, often suffer from developmental delays and disabilities. Finally, they are at increased risk of child abuse, sexual abuse and injury.1

Seventy-six percent of all substantiated child abuse cases for children aged 0 to 18 years involve adult drug use. More than 3 million cases of child maltreatment are reported each year, and approximately 3 million adults and an additional 3 million seniors are also abused or neglected annually. Although at least 75 percent of physical abuse of children, adults

Third ‘Pros in the Profession’ winner selected

Crest Oral-B has honored RDH Mary Lynne Murray-Ryder of Hermon, Maine, with the brands’ third Pros in the Profession award. A champion for dental hygiene, Mary Lynne has improved the lives of others both inside and outside the office. In addition to her 31 years of experience as a registered dental hygienist, Murray-Ryder has served as an American Dental Hygienists’ Association (ADHA) delegate, Maine Dental Hygienists Association (MDHA) president and on several MDHA councils, while currently serving as immediate past president and continuing education council liaison.

“I applaud Crest Oral-B for the message of commitment and support the Pros in the Profession award sends to the dental hygiene profession,” said Murray-Ryder. “Further, I salute this recognition of the role that dental hygienists play in patient wellness.”

Having spent the last 10 years of her career at a private holistic practice, Murray-Ryder has a passion for providing individualized solutions to each of her patients. She expands this devotion to comprehensive care by helping put the state on the map through initiatives with Maine’s Independent Practice Dental Hygienists, which allows a RDH to go out in to the community to reach out to underserved populations.

As an RDH, Murray-Ryder shows devotion to improving the lives of others by volunteering for community service projects that focus on helping the homeless. A constant learner, she also attends and organizes continuing education classes for her fellow registered dental hygienists.

“As a recipient of the Pros in the Profession award, I hope to inspire Maine dental hygienists and students of dental hygiene to share their talents wherever their paths may lead,” said Murray-Ryder.

With this honor, Murray-Ryder will join previous Pros in the Profession winners Ann Benson and Trudy Meinburg on a VIP all-expense-paid trip to the ADHA’s 88th Annual Session in Montreal Canada.
and the elderly involve injuries to the head, neck and mouth, less than one percent of all reports of child maltreatment are made by dental professionals.2

Identifying the DEC

It is important for the dental professional to understand the legal responsibilities to identify and report suspected child abuse and neglect cases. Part of that understanding is learning the legal definitions associated with child abuse and neglect.

Federal legislation provides a foundation for states by identifying a minimum set of acts or behaviors that define child abuse and neglect. The Federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse and neglect as, at minimum:

- Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act that presents an imminent risk of serious harm.

This definition of child abuse and neglect refers specifically to parents and other caregivers. A “child” under this definition generally means a person who is younger than 18 or who is not an emancipated minor.

While CAPTA provides definitions for sexual abuse and the special cases related to withholding or failing to provide medically indicated treatment, it does not provide specific definitions for other types of maltreatment such as physical abuse, neglect or emotional abuse. While federal legislation sets minimum standards, each state is responsible for providing its own definition of maltreatment within civil and criminal contexts.

Within the minimum standards set by CAPTA, each state is responsible for providing its own definitions of child abuse and neglect. Generally, most states recognize four major types of maltreatment: neglect, physical abuse, sexual abuse and emotional abuse.3

According to the Child Welfare Information Gateway, the following definitions of major maltreatment are the generally recognized standard used by most states.

“Neglect” is failure to provide for a child’s basic needs. Neglect may be: physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision); medical (e.g., failure to provide necessary medical or mental health treatment); educational (e.g., failure to educate a child or attend to special education needs); emotional (e.g., inattention to a child’s emotional needs, failure to provide psychological care or permitting the child to use alcohol or other drugs).

These situations do not always mean a child is neglected. Sometimes, cultural values, standards of care in the community or poverty may be contributing factors, indicating the family is in need of information or assistance. When a family fails to use information and resources and the child’s health or safety is at risk, then child welfare intervention may be required.

“Physical abuse” is physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap or other object), burning or otherwise harming a child. Such injury is considered abuse regardless of whether the caretaker intended to hurt the child, generally recognized.

“Sexual abuse” includes activities by a parent or caretaker such as fondling a child’s genitals, penetration, rape, sodomy, indecent exposure and exploitation through prostitution or the production of pornographic materials.

“Emotional abuse” is a pattern of behavior that impairs a child’s emotional development or sense of self-worth. This may include constant criticism, threats or rejection, as well as withholding love, support or guidance. Emotional abuse is often difficult to prove, and therefore child protective services may not be able to intervene without evidence of harm to the child. Emotional abuse is almost always present when other forms are identified.

Individual states also have different reporting laws when it comes to child abuse and neglect. Currently, every state has immunity (individuals cannot be sued or held liable following a report) for mandated reporters, which are most health-care professionals, including dental professionals. These states that do not have mandated reporting and penalties for health care professionals who fail to report are: Mississippi, North Carolina and Wyoming.4

One key to reporting child abuse and neglect is being able to recognize common indicators. A dental professional may easily identify some of these physical and behavioral indicators during routine dental care. Dental professionals should establish an office protocol for identifying drug endangered children. According to the Arkansas Office of Oral Health, there are four recommended steps in identifying a suspected case of child abuse or neglect. Those four steps include:

- General physical assessment of the child. Although general physical examinations may not be appropriate in all settings, be aware of obvious physical traits that may indicate abuse or neglect (e.g., difficulty in walking or sitting, physical signs that may be consistent with the use of force).

Behavior assessment. Judge the child’s behavior against the demeanor

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of children of similar maturity in similar situations.

- **Health histories.** If you suspect child maltreatment, it can be useful to obtain more than one history, one from the child and one from the adult.

- **Oral examination.** Look for signs of violence, such as multiple injuries or bruises, injuries in different stages of healing or oral signs of sexually transmitted diseases.

Along with the four steps to identifying a drug-endangered child, there are four steps in the child abuse or neglect reporting process that dental professionals should follow. These steps include:

- **Documentation.** Carefully document any findings of suspected abuse or neglect in the patient’s record. Don’t forget to take intraoral and extra-oral pictures.

- **Witness.** Have another individual witness the examination, note and co-sign the records concerning suspected child abuse or neglect.

- **Report.** Call the appropriate child protective services (CPS) or law enforcement agency in your area, consistent with state law. Make the report as soon as possible without compromising the child’s dental care.

- **Necessary information.** Have the following information available when you make the report: name and address of the child and parents or other persons that have care and custody of the child; child’s age; name(s) of any siblings; nature of the child’s condition, including any evidence of previous injuries or disabilities; any other information that you believe might be helpful in establishing the cause of such abuse or neglect and the identity of the person believed to have caused such abuse or neglect.

Dental professionals should realize that many drug-endangered children may not be seen in the dental office. Other areas where children can be identified include school screening days, Head Start required oral exam days and other oral and public health events.

It is well-documented that the systemic health of drug-endangered children is greatly affected long term; therefore, we can confidently assume that their oral health will be seriously harmed as well.

**Responding to the DEC**

Dental professionals can become involved in the fight for drug-endangered children in their community in several ways.

First, they have the opportunity to form or become part of an established drug-endangered child team in their community.

Secondly, by working to identify children within their dental practice who may be drug-endangered or volunteering their time to examine pre-identified DEC who are currently a part of the social services system.

Finally, they can receive more training on child abuse and neglect, eventually educating other health professionals on the need to recognize and respond to drug-endangered children.

A complete list of references is available from the publisher.
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