

## PERIODONTICS ISSUE

APRIL 2009

### Chairman's Corner: Reflections from a New Department Chair



Being a new department chair, I am indulging in a bit of reflection based on my tenure so far:

- I took the job voluntarily
- It is important to be organized and efficient otherwise the work will never end
- I like to be able to keep my eye on the big picture but do not necessarily find the minutiae as exciting
- Different people handle stress differently and learning these patterns helps me handle my

own stress

- Giving honest feedback is difficult
- People who choose not to share their knowledge and gifts, seem to hurt themselves more than others
- I have a lot to learn
- Not everything that happens is urgent or a crisis
- Being overwhelmed is part of the learning process
- If I want to take action, I will most likely have to fill out paperwork and follow the approval process
- I am a slave to e-mail
- Some days are better than others
- Previous and Established Academic relationships have to change as the roles have changed now
- I have a higher appreciation for people in administration now that I have joined their ranks
- I am hoping the 'adage' about fine wine also applies to Chair people
- When making a decision, I will probably offend some people.

However that goes with the territory

- It can be a fairly 'thankless job'. However I probably did not thank Dr. Hancock enough
- I am looking forward to continuing this journey

This issue of our newsletter is titled '**The Periodontics Issue**'. The focus of this newsletter deals with different aspects of the field of Periodontics. In this regard, I have asked three of our faculty Dr. Blanchard, Dr. Kim, Dr. Towns and a former resident and currently faculty at the Medical College of Georgia, Dr. Ranjitha Krishna to write articles.

In addition we have many returning features including our resident case of the month as well as our faculty and staff profiles. I hope you enjoy the newsletter as much as I enjoyed putting it together.

I would like to thank Dr. Sivaraman Prakasam (2nd year resident) for help with the formatting of the newsletter.

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Editor: Dr. Vanchit John  
Design and Layout: Dr. Sivaraman Prakasam

## Perspectives of an ABP Examiner

### Steven B. Blanchard, DDS, MS



For the past three years, I have had the honor to be an examiner for the American Board of Periodontology Oral Certifying Examination. The Board oral exam format has changed substantially since 2004 when it began the current format. The oral format consists of two 90 minute examinations with each exam consisting of 3 clinical scenarios with 30 minutes allowed for each scenario. The scenarios are taken from all aspects of clinical periodontics and surgical implant therapy. Each candidate is assessed by 2 examiners for each of the two oral exam sessions. Each scenario is scored in the following six areas: Diagnosis, Etiology, Prognosis, Treatment Plan, Therapy, and Evaluation of Results/Maintenance. Scores for each area range from 1 to 4—unsatisfactory, marginal, satisfactory, and outstanding. Thus, each candidate receives a total of 72 independent scores (6 areas/scenario x 3 scenarios x 4 total examiners). Each examiner scores each area indepen-

dently for each scenario and scores independently of the other examiner. All scores are then compiled and adjusted based on the difficulty factor of the scenario and the difficulty grading factor for each examiner. The Board has established a “benchmark score” for successful completion of the exam based on previous exam scores and, remarkably, the pass rates have remained constant between 82-85% without altering this benchmark score. The ABP has spent considerable time and money working with test construction experts and has calibration sessions with all Board directors and examiners immediately prior to the oral exam testing. This has resulted in a highly calibrated and extremely fair examination format.

It has been a distinct pleasure to participate in this examination process. I have found all of the directors and examiners to be both highly professional and cordial during the examination process and feel honored to call these individuals friends due to my close interactions over the last 6 examination sessions. Candidates that come well prepared for the oral examination find the process to be thorough and complete but may be frustrated in that they feel they may not be able to fully express their full knowledge of the material to the

examiners because of the time constraints involved having to cover 3 scenarios in only 90 minutes. Candidates need to be well versed in all aspects of periodontics and surgical implant therapy including dealing with aspects of conscious sedation, drug interactions and medical emergencies, alveolar ridge and sinus augmentations, all types of periodontal plastic surgery, immediate and delayed implant placement, and traditional non-surgical and surgical periodontal therapy. Candidates that are well versed in the scientific literature to support their treatment decisions tend to do better overall than those who seem less familiar with the literature but this is probably more of a reflection of their more thorough preparation for the exam than anything else. My experience has been that recent graduates right out of training typically have little problem with the scenarios involving implant therapy, sinus and ridge augmentations, and subepithelial connective tissue grafting for root coverage but sometimes struggle with more traditional periodontal surgical procedures. Candidates that have been in practice for longer periods are better adept in dealing with potential clinical complications that may be presented in the scenarios as they have likely encountered

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the same problems during their practice of clinical periodontics. The Board oral examination experience does not have to be daunting or overwhelming and those candidates that are well-prepared find it to be a rewarding experience. I have had several recent graduates state they found the oral boards to be less stressful than our traditional resident case defense examinations. I would encourage those who have been in

practice for a number of years and have not taken the ABP exams to give serious consideration to doing so. Pass rates for graduates from our program have been higher than the national average so I feel we are preparing our graduates well for challenging the ABP exams. Like most things, you get out of it what you put into it. One cannot be over-prepared for the oral exam process but certainly one can be under-prepared. The best advice I can

give to anyone contemplating challenging the ABP Certifying Examinations is to take them at the earliest opportunity and to come well-prepared for the exam process. I think that all will find the preparation for the exam and the exam process itself to be one of the best professional experiences of their periodontal career.

Comments for Dr. Blanchard? He can be reached at [stblanch@iupui.edu](mailto:stblanch@iupui.edu)

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## To use or not to use 'Antibiotic' in the management of Periodontal Disease, that is the question!

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### Seok Jin Kim, DDS, MSD

The fact that our mouth is not a sterile place is well known. In fact, it is a very septic environment harboring more than 500 species of bacteria. In addition, every teaspoonful of saliva contains millions of germs. These bacteria are responsible for dental caries and periodontal diseases. Accordingly, the use of antibiotics has had a long history in the practice of dentistry and specifically when it comes to periodontal disease management. The pharmaceutical indus-

try has seen great marketing potential in the often repeated statement, "Periodontal disease is one of the most common diseases in humans." In our practicing careers, we have witnessed several products being brought to the market. Many of them have 'died off' due to lack of positive changes in our patients, but some survive. However "surviving" is not the word these companies usually settle for. Companies are continuously giving blood-transfusions, more correctly "infusions of money" and their "endorsements" to their products so that they not only survive but eventually prevail.

Recently Dr. Gordon J. Christensen (February issue of 'Dentistry Today') talked about the 'future of dentistry'. He talked about the use of digital radiography, digital impression, lasers, etc. In his vision for den-

tistry's future, he envisioned "conservative periodontal therapy performed by general practitioners". He emphasized the need for more general practitioners involvement with periodontal care based on periodontal disease affecting a large portion of the population. It would make sense for more involvement from general practitioners, if they are currently shying away from the treatment of the gingivitis or the mild forms of chronic periodontitis. However clinical practice indicates that this is not the case as a large number of general practitioners are already involved with the management of periodontal disease. In this article, he explains that conservative periodontal therapy includes, frequent scaling and root planning along with the use of "ANTIBIOTIC rinses, sub-antimicrobial doses



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of medication as well as the use locally delivered ANTIBIOTICS."

If ANTIBIOTICS are indeed the right choice for treating periodontal disease, why have we not conquered this yet?

Hmmm, how can I answer to this question in simplest form? Here is my answer;

"IT SIMPLY DOESN'T WORK THAT WAY!"

Periodontal disease is a very complex disease with so many different variables. Explaining this complexity here would be like 'preaching to the choir'. However, I want to share my thoughts by using the following analogy.

Dropping a bomb in the enemy's trenches every 3 months would not get rid of the enemy. At first, some of them would

survive by chance. But eventually they will learn how to survive from the bomb, and they wouldn't hesitate to share these survival tactics with their allies. And this is the very same mechanism by which bacteria develop the resistance to antibiotics. To simplify periodontal disease management and suggest that a 'pill' or a 'gel in a tray' would cure the condition would be irresponsible. However we are seeing this form of treatment being advocated more and more by so called 'leaders in the field'. In every corner of the scientific community, concerns about the frequent use of antibiotic arise. We hear of horrifying stories about septicemia and the disastrous outcome of dealing with bacteria that are resistant to antibiotics. The concern about MRSA (Methicillin Resistant Staphy-

lococcus aureus) is very serious and is happening every day. We hear reports of bacteria resistant to Vancomycin and the newest generation of antibiotics. As members of the Health Care Community, we as dentists share a similar responsibility in this matter. I am deeply worried that the unregulated and repeated use of antibiotics in dentistry is contributing to the overall crisis with regards to antibiotic resistance and the consequences that result from this. We in academia have the opportunity to make sure that future generations of dental students leave IUSD with information that will not only help their practices but also shape the dental practice landscape for years to come.

Comments for Dr. Kim? He can be reached at skim1@iupui.edu

## My Periodontal training at Indiana University



### Ranjitha Krishna, BDS, MPH, MSD

tal training at IUSD was what then seemed as an unreasonable choice for me. My husband and I were both working full-time and were happily settled in Atlanta. During the course of my fellowship at the Centers for Disease Control, I was intrigued by all the research going on with periodontal health and systemic association and considered the possibility of pursuing a postgraduate training in periodontics.

I started making phone calls to some of the periodontal training programs off of the AAP website asking them about their application pro-

cess. When I dialed the number for IU perio, I was taken aback when a deep male voice answered the phone and said 'This is Dr. Blanchard'.

I considered hanging up for a second. I wasn't prepared to talk to the program director. After overcoming my first impulse to hang up, I explained my situation to him and he encouraged me to go ahead and send in an application as soon as possible. I later learned that the only reason I got to talk to Dr. Blanchard that day was because Ms. Judy Doyle was out of office due to back surgery. I am so glad I didn't hang up.

Author Robert Fritz once said, "If you limit your choices only to what seems possible or reasonable, you disconnect yourself from what you truly want, and all that is left is a compromise."

Pursuing my periodon-

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Once I interviewed and was accepted into the program, there were a lot of decisions to make. IU is one of the most expensive periodontal training programs in the country.

At the same time, IU is also associated with some of the legendary names in dentistry like Dr. Shafer, Dr. O'Leary, Dr. Hancock, and Dr. Zero. We had to think about ways of paying the tuition, relocating, my husband finding a job in Indianapolis, and above all that, we had just found out that I was pregnant.

In spite of all this, I decided to pursue my periodontal training at IU and looking back, I would not have had it any other way.

The Periodontics department at IU is committed to thinking of the welfare of its residents. One example for this is the choice of implant systems that we have. Most schools are committed to using one or two implant systems in their program. IU gives its residents the choice of using multiple implant systems.

Although the department/school could make a lot of money soliciting one or two implant companies, it is in the best interest of the residents not to do that and to enhance their learning experience by giving them a choice of the many available systems. The department also has great working relations with the prosthetic department as well as the undergraduate clinics. Covering the undergradu-

ate students gives us an opportunity to interact with the students, thereby helping them provide not only a better care to their patients, but also increase our referral base.

The biggest strength of the periodontal program is their faculty. The department has a good mix of full-time and part-time faculty and each and every faculty member brings their strength to the program, be it part-time or full-time. As a first year resident, my only fear in life was being late to a seminar and have Dr. Hancock sitting there looking at his watch.

I learned not only about periodontics in his seminars, but also the importance of being on time and being respectful to the presenter. These are not things that are part of the periodontal curriculum but probably some of the most important life lessons.

How great it is to have Dr. Town's fancy office across the street and to learn from his private practice experience, Drs. Gossweilers' broad perspective about systemic conditions, Dr. Kim's critical thinking, Dr. Blanchard's availability and dependability as a program director (I recall the numerous occasions I ran into his office with my problems and got very direct and comforting answers), Dr. Wolfe's friendly and approachable personality, Dr. Gray's willingness to help us out in even in the direst of situations, Dr. Newell's wonderful case presentations and experiences, Dr. Gillette's

classic 'classic-lit' seminars, Dr. Kowolik's help with research, Dr. Swenson's ability to stay young and supportive of the program forever, and last but not the least, Dr. John's never ending energy and enthusiasm to make things better.

We probably didn't thank you all enough when we were in the program, but I know that I speak for most of the alumni in saying that you all mean a lot more to us than you can imagine. THANK YOU!

Today, as a full-time faculty member, I only aspire to someday be at least half as good as some of you guys.

My experiences at IU cannot be complete without mentioning my wonderful co-residents and the staff. I consider myself very lucky to have had some of the best co-residents. Although some of the staff gave us a hard-time when we were there, I can tell that most of them had our best interests in mind. I have after graduation called a few of them on different occasions asking for help, and they have been as willing to help me now as they were when I was a resident. Our lives are nothing but a creation of the choices we make. Every decision we make throws our life in a new direction and opens a whole new world for us. I am really glad about the choice I made in choosing IU for my periodontal training.

Comments for Dr. Krishna? You can contact her at RKRISHNA@mail.mcg.edu



## PERIODONTAL PLASTIC SURGERY

### Case Treated by Dr. Enrique Cruz Third Year Resident

55 year old male with medical history within normal limits. Patient presented for evaluation of the mucogingival defect on the buccal aspect of #3 which previously had a soft tissue grafting procedure done 7 years previously. The patient's chief complaint was tooth sensitivity.

At clinical evaluation tooth #3 had recession of 7 to 8 mm and was classified as a Miller Class 3 defect.

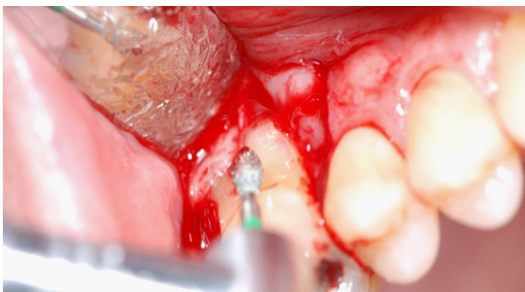
A connective tissue graft procedure was planned and performed. Patient was happy with the post-operative outcome.



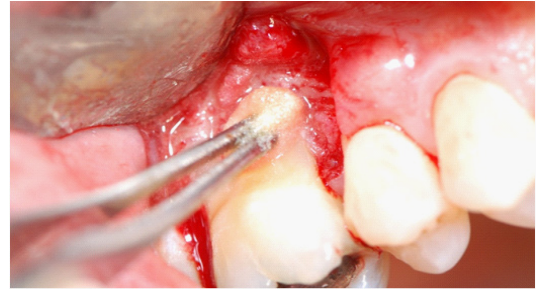
**INITIAL PRESENTATION: A Miller Class 3 defect was present in the mesial buccal root extending around 7 to 8 mm of tooth #3. Pocket depth's ranged from 2 to 3mm and visible plaque accumulation. There was evidence of mild horizontal bone loss in the area.**



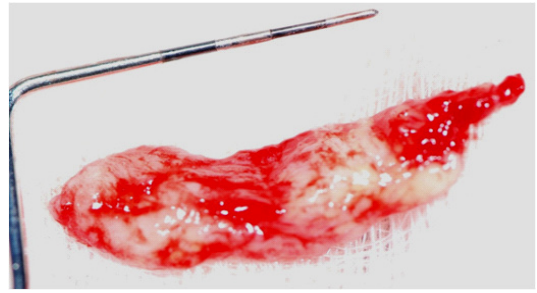
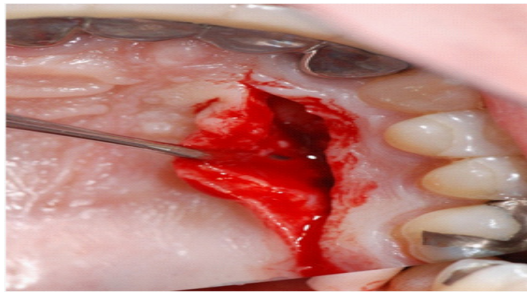
**Incisions were performed with a micro blade including intra-sulcular and two vertical incisions extending to adjacent teeth and to the buccal fold. A split thickness flap was reflected and a well demarcated convexity was found on the mesial root.**



**Football shaped diamond bur was used to smooth. Root planning of the area**



**A measurement to confirm approximate size of the graft was made. Roots were treated with tetracycline**



A straight incision of aprox 20 mm was performed to obtain the graft. Thickness of connective tissue was around 1.25 to 3mm and length of 20mm



Fixation of the graft was obtained with 6.0 plain gut, using simple sutures, and release of the periosteum was necessary to achieve better closure. Papillae was sutured together and Flap was positioned mesially and coronally whit a combination of suturing techniques, including Internal mattress sutures, sling sutures and simple sutures using 5.0 goretex suture

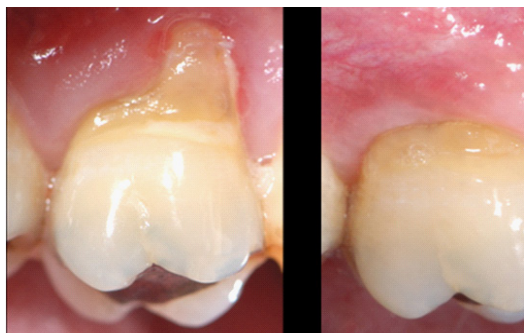


At seven days POT patient reported no pain or sensitivity, tissues appeared inflamed.; and 1 month POT

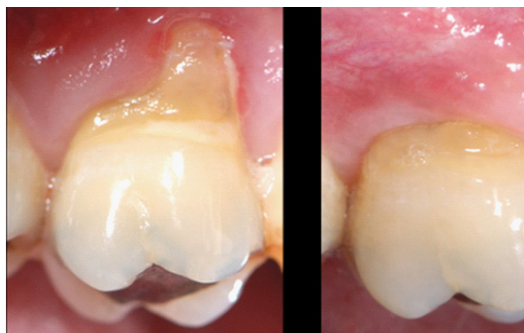


Above: At 1 year POT patient reported no pain or sensitivity, probing depths remained the same and patient was able to decrease plaque around the area  
Right: No problems were reported from patient from the donor site

Before

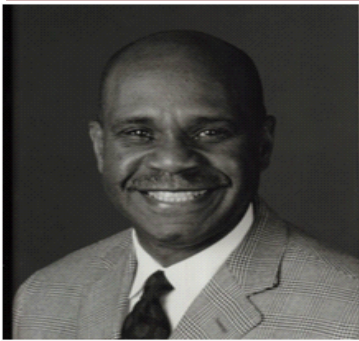


After



# Ninety Eight Years in Dentistry – A Generational Perspective

## Steven Towns, DDS



My dad recently sold his dental practice and retired after sixty three years of practice, prompting me to think retrospectively about the many changes that have taken place during both our careers. This perspective spans over ninety eight years with thirty five of those being my own. From my dad's view, the changes have been related to advancements in materials, techniques and most of all in the way we deliver dentistry in a business sense. Since I am a periodontist, I would like to share some my observations on the evolution of periodontics and what its future role may be in interdisciplinary dentistry.

The Science of Periodontics for the most part has seen a series of paradigm shifts. I guess the simplest way to look at periodontal therapy is that it's all about controlling the environment of the pocket, keeping plaque and the biofilm off the teeth. If these agents are allowed to remain in contact with the gingiva and teeth for a prolonged period of time, an entire disease cascade is set in motion that creates the diseased pocket. This process can be modified by certain

systemic diseases, medications or just plain genetics. Periodontal pockets once they are formed and reach a certain depth (>3mm) cannot be predictably cleaned by either the patient or the professional. The deeper these pockets become, the less predictable the cleaning. If we do not eliminate, control or reduce the causative agents within the pocket, it will lead to the breakdown of the attachment apparatus (bone, cementum and PDL). How we control the environment forms the basis for periodontal therapy. I realize that this is a very simplistic explanation of the pathogenesis and management of periodontal disease, but I think it communicates the basic principles. How we treat these pockets has been my thirty five year journey.

The best way to treat any disease is to keep it from developing in the first place! Remember your grandmother saying that "An ounce of prevention is worth a pound of cure". The problem is that our medical disease management model is rewarded for doing procedures and not prevention. Prevention is underrated and treatment over glorified. Unfortunately in the real world for any number of reasons, people don't take care of their mouths, get gum disease, develop pockets and need therapy to keep their teeth. How we control the environment of the pocket(s) has been a true learn-

ing experience. We can control the pockets surgically by cutting them away (resection) or getting them to fill up and close (regeneration). This may or may not get us to the magic number of 3mm or less. We can treat them non-surgically by repeated pocket debridement (scaling and root planning) or consider the adjunctive use of antibiotics. Certain antibiotics can be used either systemically or placed directly into a pocket via chips, cords, syringes, biologic carriers or trays. Many times all modalities of treatment are used. However knowing their limitations is important (see the article by Dr. Kim)

So let's start with surgical management. Resective pocket elimination has evolved from gingivectomy to osseous resection. As a young man, I remember my dad doing full mouth gingivectomies at our local Chicago hospital. The gingivectomy procedure was a very popular surgical treatment modality in the fifties and early sixties that attempted to eliminate periodontal disease by cutting away the soft tissue pockets. The procedure left patients with long sensitive teeth and since only the soft tissue pockets were addressed, recurrent pocket depth and repeated surgical invention became the norm. The post surgical healing process was legendary and could best be described as problematic and lengthy. Over time it became apparent that



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the underlying osseous defects had to be addressed along with the soft tissue pockets. Osseous resection with apically repositioned flaps was a procedure that was developed to not only eliminate the pocket but address the underlining osseous topography that created the hard and soft tissue defects. This surgical exercise then matured into what I considered to be an art form, knowing how much supporting bone could be removed without rendering the remaining supporting bone compromised. Such factors made this procedure, technique sensitive with successful outcomes being dependent on training, care, skill and clinical judgment of the periodontist. Many times this resulted in a wide range of clinical outcomes and failure to eliminate pockets.

Surgical philosophy then began to swing to what was considered a more conservative approach, after some studies indicated there was no difference in long-term attachment levels, whether osseous resection was done or not. This approach gained favor, since it eliminated the need for difficult and time consuming technique sensitive bone resection. The Modified Widman Flap technique was developed to address these issues. The technique was considered less invasive and reduced the problems of post surgical tooth mobility and accompanying thermo sensitivity resulting from osseous

surgery. The problem with this procedure was that since it did not adequately address the underlying bony defects, soft tissue pockets returned and long term maintenance of periodontal health became a problem. So controversy continues to this day between those who believe in bony resection and those that don't. What I have had a tendency to see, are surgical flaps used to access bony pockets and diseased roots for debridement. This is followed by some attempt to establish a bony topography with conservative bony resection that the gingiva will except with minimal pocket depth. The success of flap surgery with some level of bony resection seems to have a direct correlation to when surgical intervention is instituted. The earlier we proceed with the surgical intervention, the more predictable the results.

Unfortunately resective surgery did not address advanced disease states with deep pockets, advanced attachment loss and furcation involvement. I always felt building support was better than cutting it away. Having practiced in an under served area of Chicago for a number of years, many of the cases that I treated had significant disease. The successful management of these cases required that I develop surgical regenerative skills. Regeneration in an infrabony pocket is a race between epithelial cells growing down into the pocket,

inhibiting new attachment and progenitor cells differentiating, migrating from the marrow spaces into the bony pocket to begin the regenerative process. The problem with regeneration is that epithelial cell growth is much faster, thus minimizing regenerative potential. Because of this, most grafting materials had limited success. Autogenous grafts had the best success rate since they contained viable cells and growth factors. The best donor sites were site specific and many times required extra oral harvest (hip). This truly limited the use of this particular donor source. The major paradigm shift in regeneration began with the use of membranes. Membranes blocked the down growth of epithelial cells and helped contain graft materials. This allowed for progenitor cell differentiation, migration and new attachment. The ability to treat advanced periodontal lesions became reality. Research has now provided the periodontist with more advanced membranes, new grafting materials and growth factors that signal bone growth. All of these developments have provided us with treatment modalities that 35 years ago I would have compared to going to Mars. What now concerns me is the cost of these therapies. Although we can treat many of these lesions, they are too cost prohibitive for us to treat the average patient. We may also make the assumption that due to the cost most under- served pa-



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tients will still lose their teeth.

During the evolution of periodontal surgical management, nonsurgical treatment via scaling and root planing has been an unglamorous, valuable and cost effective therapy. This procedure has stood the test of time. Although it may not eliminate a pocket or regenerate a defect; it has been shown to effectively control the environment of the pocket when done at proper intervals. I have used selective limited systemic antibiotic therapy in conjunction with scaling and root planing for a number of years. This has enabled me to manage the disease of many of my underserved patients, who could not afford the more advanced therapies. Systemic antibiotic should not be used haphazardly, due to the possibility of creating bacterial resistance. The overuse of localized antibiotic delivery systems by means of chips, cords, trays, syringes

and biologic carriers are of a major concern. My experience has been that they are only marginally effective and are only useful in isolated areas and special circumstances. They seem to be most effective with repeated use. These agents are not cost effective for generalized use and their application is being driven by the pharmaceutical industry. Remember these agents are being marketed as the silver bullet, so keep in mind "There is no free lunch".

The final significant paradigm shift that I have seen in my time is the successful use of implants and associated ridge augmentation procedures. These therapies have in my opinion completely changed the way we manage cases and has made the periodontist, a major player in interdisciplinary dentistry. Our training in periodontal-prosthesis, along with our surgical skills have prepared us well for the shift. I

feel that although implants are a major part of all periodontal practices, we must remember that we still treat gum disease and saving teeth is just as important as implants. We must always remember that many people cannot afford implants, but still want to save their teeth.

My life as periodontist has been a true journey. I have seen significant changes in how we treat disease and what my role has become as an interdisciplinary dentist. I have concerns about the role of third parties influencing our ability to deliver effective therapy, cost, treating the underserved and the influence manufacturers have on sponsoring continuing education and research.

Comments for Dr. Towns? He can be reached at [sbtowns@aol.com](mailto:sbtowns@aol.com)

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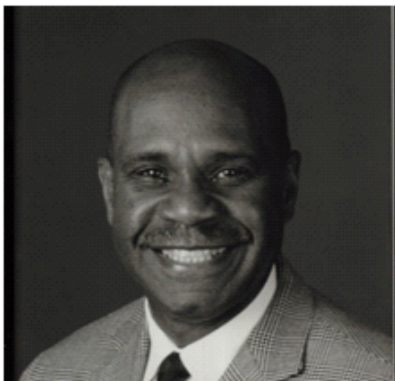
## FEATURE SECTION:

*We are featuring Dr. Steven Towns in our Faculty Profile and Jamie Fields in our Staff Member Profile.*

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### Faculty Member Profile: Steven Towns, DDS

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D. Steven Towns joined

the faculty in the Department in 2004.

He graduated from the University of Illinois, School of Dentistry, where he also received his certificate in Periodontics. He has served as Assistant Clinical Professor of Periodontics at both the University of Illinois and Meharry Medical College.

Dr. Towns has been a very active participant in organized

dentistry, on the local, state and national levels. He is past president of the National Dental Association and has been a member of the Illinois State Board of Dentistry, Central Regional Dental Testing Service and Northeast Regional Board. He has participated in numerous continuing education programs including the closed circuit television program and featured speaker for the Chi-



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cago Dental Society on two occasions; a featured speaker at the Yankee Dental meeting, the Greater New York Dental meeting and the National Dental Association annual meeting as well as for local and district

study clubs. He serves on the board of the Indianapolis Zoo and the Indianapolis District Dental Society and is the immediate past president of the Historic Meridian Park Neighborhood Association.

Dr. Towns shares a full time dental and spa practice - Sonrisa A Periodental Spa - with his wife, Dr. Holloway, a general dentist. He has two children - Jenae and Geoffrey

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## Staff Member Profile- Jamie Fields

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### Brief education background

I graduated from John Marshall High School and then went to Harry E. Wood Vocational School for Dental Assisting

Things you did in school/college that you wish you never did

I had almost perfect attendance

dental hygiene/dental assisting I think if I didn't become a dental assistant I would have liked to be a professional gardener

### Professional background and Position in the department

I am a Dental assistant in Graduate Periodontics and I have worked in the department for just about 25 years

Things you did not do in school/college that you wish you did

Something I wish I had been able to do was to play girls basketball.

### Pet Peeves

Something that really bothers me is when people don't use their turn signals

### Family Background

I have been married to Mark for 32 years and have 3 children. Jill who is 24 who is continuing her college degree at IUPUI, then there is Leigh who is 21 and is also going to IUPUI and finally there is Quint who is 18 and is in high school

### Your hobbies

Some hobbies I enjoy are gardening, needle point and sewing

### Likes/Dislikes

Things I dislike are coffee and tea. Some things I like are fresh cut flowers they liven up a room, chocolate I don't think I have say anymore about that and when you wake up on a Saturday and realize you don't have to get up and you can go back to sleep. I don't like lazy people

What would you have become (professionally/personally) had you not gone into dentistry/

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## Faculty and Staff Member(s) in the News

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**Dr. Vanchit John** was selected to participate in the ADEA Leadership Institute. Dr. John is one of 21 faculty from across the country to be chosen to participate in this leadership training program. The yearlong training program consists of 4 phases which will culminate at the ADEA meeting in Washington in February 2009

**Professor Elizabeth Hughes** was selected to attend Allied Dental Faculty Leadership Development Program (AD-FLDP) administered through ADEA

*Having 2 members from our department selected to participate in the ADEA leadership Institute speaks very well for*

*us. This is in keeping with our vision statement where we indicated that we would become the premier department in the school.*

**Dr. Sarah Herd** (MSD 2007) successfully passed the ABP oral exam and is now a Diplomate.

STAFF BONUS AWARDS: Re-

Article continued in next page.

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ipients of the school's annual bonuses are selected by a Bonus Review Committee, and staff may be nominated by either themselves or others associated with the school. Both full- and part-time appointed staff who have been with IUSD

for at least a year are eligible. The newest recipients from our department are:

**Kay Rossok**, Periodontics and Allied Dental Programs

**Diana Yates**, Periodontics and Allied Dental Programs

**Diana Yates and Kay Rossok** received staff bonus awards for all the work they do and did in 2008.

*Great job Diana and Kay. You are truly assets to our department.*

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## Papers Published by Alumni

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**This is a new section for the newsletter. Alumni, if you would like to include your publications and other professional and service accomplishments, please email the information to me.**

**John V, El Kholly K, Krishna R.** Periodontal Maintenance Therapy: An Integral Part of Dental Practice. Case Reports on Three Periodontally Involved Patients. Accepted for publication to the Journal of the Indiana Dental Association- Spring Issue 2009

**Bhola M, Cabanilla L, Kolhatkar S.** Dental Occlusion and Periodontal Disease: What is the Real Relationship? Journal of the California dental Association 2008; 36(12):924-930.

**Khan S, Cabanilla L.** Periodontal Probing Depth Measurement: A Review. Compendium of Continuing Dental Educa-

tion 2009; 30(1):2-9.

**Cabanilla LL, Molinari G.** Clinical Periodontal Consideration in Children and Adolescents. Journal of Dentistry for Children (Accepted April 2008)

**Kolhatkar S, Cabanilla L, Bhola M.** Inadequate Vertical Bone Dimension Managed by Bone-Added Osteotome Sinus Floor Elevation (BAOSFE): Literature Review and Case Report. Journal of Contemporary Dental Practice. (Accepted April 2008, anticipated publication July 2009)

**Cabanilla LL, Hernandez F,**

**Neely A.** The Relationship of Periodontal Diagnosis and Prognosis and Survival of Teeth Supporting Prosthodontic Restorations. Quintessence International. In Press (accepted December 2008)

**Charakorn P, Cabanilla LL, Wagner W, Foong WC, Shaheen J, Pregitzer R, Schneider D.** The Effect of Preoperative Ibuprofen on Tooth Sensitivity Caused by In-house Bleaching. Journal of Operative Dentistry. In Press (accepted December 2008, anticipated publication March/April 2009)

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## Where are they Now?

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### **Dr Robert De Poi (MSD 2002)**

Came to our program following a 14 year stint in general practice of dentistry in Melbourne, Australia. Following the MSD program, he returned to Australia and now maintains specialist practice in Moonee Ponds with two employee

periodontists and two dental hygienists. He is involved with teaching in the graduate periodontal programme at the University of Melbourne and has lectured at many continuing education courses. He is councillor of the Australian Dental Association Victorian Branch Inc., the President of the Aus-

tralian Society of Periodontology Victorian branch, a member of the American Academy of Periodontology, the Academy of osseointegration, Australia and New Zealand Academy of Periodontology, the International Team of Implantology and a fellow of the Royal Australasian College of Dental Sur-

Article continued in next page.

DPADP Indiana University School of Dentistry  
1121 West Michigan Street,  
Indianapolis, IN-46204

geons and the Pierre Fauchard Academy. You contact Robert at rtdepoi@yahoo.com

**Jason Owens (MSD 2002)**

After returning to Ireland in 2002, Dr Owens opened his private practice in Naas, Co Kildare.

He was appointed sub editor of the Irish Dental Journal in 2003/2004. He is part time faculty at the Dublin Dental School Trinity College Dublin. Dr Owens has just finished his 2 year term as President of the Irish Academy of American Graduate Dental Specialist. He

is also an active member of the Irish Society of Periodontology and the Irish Dental Association as well as the AAP. At the end of 2008, Dr Owens and his wife Roisin Brady (MSD Prevention) opened their new purpose built practice. Jason and Roisin have two very active boys Jeremy (8) and Hugo (4)! You can contact Jason at jason@periodontalsuite.ie

**Saba Khan, (MSD 2005)**, became Diplomate of the American Board of Periodontology in 2006. Following the advanced standing program (DDS) at

University of Detroit Mercy moved back to Chicago, Illinois in 2007. She is currently a part-time Assistant Clinical Professor at University of Illinois, College of Dentistry. She has started her own practice in Mount Prospect, IL in addition to the multi specialty practice in Chicago where she is an Associate. Dr Khan is actively involved in the community education & service at her local community center in Morton Grove, Il. Saba can be contacted by e-mail at sabakhan@uic.edu

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## Upcoming Dates and Events

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**April 14, 2009 - Faculty Enrichment Time- 9:00-12:00**

**April 20-24th- Case Defense Week**

**April 24, 2009- IU School of Dentistry Research Day- 9:00-12:00**  
**IUPUI Research Day 1:00-5:00 PM**

**May 1st- Indiana Society of Periodontology Meeting**

**Location: Ritz Charles on Meridian**

**12156 N. Meridian Street.**

**Carmel, Indiana 46032**

**Phone: 317-846-9158**

**Facsimile: 317-575-2253**

**FEATURING DR. LYNDON COOPER, DDS, PhD**

**May 9, 2009 Commencement for the School of Dentistry**

**May 11, 2009 Summer Session Begins**

