ENDODONTIC ASSOCIATES

ea news

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Memories of Dr. Melvyn Eder

By Dr. Gerald C. Dietz, Sr.

Dr. Melvyn Eder and Dr. Gerald Dietz, Sr.

Dr. Melvyn Eder, past president of OCDS and the MAE was a cornerstone to the endodontic specialty in Oakland County and pioneer for co-founding the largest endodontic practice in the nation.

In 1965 Dr. Eder called me and suggested that we drive to Ann Arbor together to attend a meeting of the Ralph Sommer Endodontic study club in which we both were members. We were not really well acquainted at that time and I was surprised when he suggested that we go together. He had something on his mind.

Mel knew that I was building a new endodontic dental clinic in Birmingham, Michigan, and asked if I would consider having him join me in practice. He wanted to move from where he was in Detroit; and I had become very busy since opening my solo practice five years earlier in Royal Oak. I knew I didn't want to continue working six days a week alone. Joining forces satisfied both our needs. So we talked, shared philosophies, and quickly joined forces in what would become Endodontic Associates, P.C.

In spite of different personalities, different backgrounds, different religions, different experiences, we grew into a wonderful partnership and friendship that only ended with Mel's death in March.

Mel was very bright and ambitious; and he was extremely hard working. He enjoyed interacting with patients and his clinical skills were outstanding. Patients felt very secure in his care and his chair side manner was excellent. As a result, he developed a very loyal group of referring dentists who wanted only Mel to treat their patients. Patients whom he

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Inside

Management of Invasive Cervical Resorption

Invasive cervical resorption (ICR) describes a relatively common, insidious and often aggressive form of external tooth resorption, which may occur in any tooth in the permanent dentition. Characterized by its cervical location and invasive nature, this resorptive process leads to progressive and usually destructive loss of tooth structure. Resorption of coronal dentin and enamel often creates a clinically obvious pinkish color in the tooth crown as highly vascular resorptive tissue becomes visible through thin residual enamel.

On periapical radiographs, ICR may barely be discernable or dramatically evident. The lesions vary from obvious, well-delineated radiolucencies to poorly defined lesions with irregular borders and sometimes a radiographic resemblance to caries. When ICR is superimposed in the pulp space, pulp space anatomy is usually evident.

When ICR is diagnosed, treatment can involve 3 choices:

- *immediate extraction
- *no treatment, with eventual extraction when the tooth becomes symptomatic
- *access, debridement and restoration of the resorptive lesion (intracanal approach or surgical approach)

Dental implants have led to the increasing use of the first 2 choices, especially for the extensive cases of resorption. However, a tooth may go many years without symptoms.

Schwartz et al, private practitioners from Texas, described 3 cases of ICR and used the Heithersay approach to debride the resorptive lesions. In that approach, the lesion is accessed, and the granulation tissue debrided with a carbide round bur in a slow-speed handpiece.

The resorptive tissue is removed until smooth, clean dentin is present, except for a few small spots that are discolored or bleeding; this represents communication of the resorption with the periodontal ligament. The dentin is then scrubbed for 1 minute with 90% aqueous trichloroacetic acid (TCA) on a cotton ball. TCA cauterizes the residual resorptive tissue, making it more obvious under magnification.

A slow-speed round bur is used to remove additional tooth structure, and the acid is applied again. This process continues until all the penetration points are eliminated (surgical approach) or perforation through the external root surface is imminent (nonsurgical approach).

For nonsurgical treatment, it is impossible to eliminate all the penetration points, and TCA must be relied upon to cauterize any resorptive tissue that remains. If invading resorptive tissue remains viable, the resorptive process is likely to continue.

When an external approach is necessary and the lesion is accessible, a rubber dam for isolation can be used because

- *The caustic TCA will cause burns if it comes in contact with gingival tissue.
- *The rubber dam provides better visualization and isolation for the restorative procedures.

For the endodontic treatment and the internal debridement approach, a rubber dam is always recommended. Dentin treated with TCA is severely demineralized and not suitable for bonding with either dentin-bonding agents or glass ionomer materials. It must be "refreshed" with a bur before bonding procedures are applied.

Dentin-bonding agents rely on a shallow demineralization of the dentin surface, which is infiltrated with a resin to form a hybrid layer with the exposed dentinal collagen matrix. Glass ionomer materials rely primarily on ionic bonding to the calcium in hydroxyapatite.

Conclusion

Proper management of ICR requires knowledge and skills in endodontics, surgery and restorative dentistry. Elimination of the resorptive tissue is performed most effectively under a microscope.

Schwartz RS, Robbins JW, Rindler E. Management of invasive cervical resorption: observations from three private practices and a report of three cases. J Endod 2010;36:1721-1730. ■

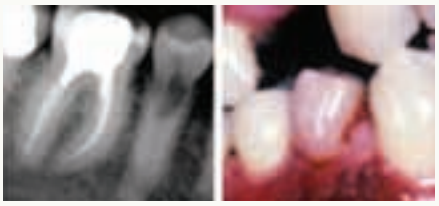

Figure 1. An x-ray (left) reveals the resorption defects, and a clinical photograph (right) shows a pinkish discoloration secondary to resorption *(photographs courtesy of Dr. Fred Barnett).*

THREE REASONS YOU NEED A FINANCIAL COACH

The difficult dental practice environment, constantly changing tax laws, and volatile investment climate have made it more difficult for doctors to achieve real financial progress over the past few years. As a result, many doctors are entering 2011 with a "deer in the headlights" look. These economic uncertainties have created paralysis in doctors' financial lives. Accordingly, many doctors are sitting with more uninvested cash earning minimal (less than 1%) returns than ever before.

Doctors using a financial advisor who provides ongoing coaching services are faring much better, for three reasons.

Required Accountability

For many years, we prepared a comprehensive financial analysis and detailed written gameplan for doctors as part of our tax and business planning program. Unfortunately, there was no scheduled follow up to assure implementation. While many doctors achieved remarkable success, many others failed to make the progress they needed to make.

Several years ago, we changed the program and now provide follow up phone calls to answer questions, assist in implementation, and monitor the doctor's progress. What a difference this has made! When doctors know that someone is checking to see if they have completed their "mutually agreed upon homework", they get it done. As a result, doctors' financial progress has increased more than 50% as a result of this required accountability.

Avoid Huge Financial Mistakes

We've seen numerous very intelligent doctors make huge financial mistakes based upon decisions that seemed perfectly logical to them at the time. For example, one doctor with a small, but highly efficient office facility learned that a large adjacent lot was becoming available. Fearing what might move in next door, he bought the lot intending to resell it at a later date.

He then decided to build as large as possible medical office building on the lot so that he would know what his new neighbor's building would look like. Unable to sell it or find tenants, the doctor then decided to move his practice into the new space, abandoning his existing building. Since the new building was significantly larger, he needed to invest substantial amounts in leasehold improvements and new equipment to fill it up.

Shortly thereafter, the unoccupied operatories began to haunt him, so he hired a new associate. Once the associate was on board, his lack of busyness began to bother him, so he signed up for every managed care plan in sight to provide additional patient flow. Before he knew it, this doctor had transformed his practice from a highly efficient and profitable (50% overhead) dream operation into a high volume, high overhead, low profit/high stress operation that was making much greater demands on his time, while producing inferior financial returns.

A good financial coach can also keep doctors out of a "financial ditch". Wrong decisions like the one above can take years to unwind and cost hundreds of thousands of dollars in losses. In this low return environment, it can take a decade or longer to recover. Simply put, doctors can't afford to make huge financial blunders and still reach their retirement goals these days.

Makes You "Eat Your Spinach"

An effective financial coach can help force doctors make sound decisions that they would otherwise never make. I remember back to the early part of the year 2000. Like most other investors, my stock market returns for 1999 were "through the roof". The huge stock market gains had pushed my asset allocation well beyond the agreed upon stock/bond ration. My investment advisor, Bob Sytz, CPA, CFP, informed me that I need to rebalance my portfolio by selling some stocks and taking some profits off the table, and investing them in bonds. I remember looking at him like he had just flown in from Pluto! Who wanted to "eat spinach" (bonds) when all I wanted to do was just have more dessert (tech stocks).

Fortunately, I took his advice and sold off some stocks near the top and invested in bonds which provided much higher returns over the next decade. This advice, though unwanted and underappreciated at the time, made me more than $200,000 that I would other wise have never had.

An effective financial coach can also serve as a "lightening rod" to help diffuse marital financial problems. Rather than focusing on each spouse's financial shortcomings, an effective financial coach can help couples develop a mutually agreed upon financial gameplan for improvement. It's amazing how marital relations improve when couples achieve financial success based upon a shared financial vision.

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Craig Duhaime, New Editor of *Dental Review*

Dr. Craig Duhaime is now serving as editor of the Oakland County *Dental Review*, after serving two years on the OCDS council. Dr. Duhaime has assumed the role of editor from Dr. John Greig, who served as the Dental Review editor for 5 years. Being editor is a way for Dr. Duhaime to combine his love of writing with his interest in organized dentistry.

Currently, Dr. Duhaime is pursuing the American Association of Dental Editors sponsored courses to eventually become a *Certified Dental Editor*. "Although there is still much to learn, being editor has given me an opportunity to reach out and encourage more dentists to get involved in writing articles that help advance our local dental profession," stated Dr. Duhaime. "Oakland has a very talented, diverse dental community, and I'm proud to be a part of it."

In addition to continuing into his second year as editor, Dr. Duhaime also plans to begin teaching endodontics at the newly chartered GPR at St. Joseph's Mercy-Oakland. Dr. Duhaime has asked for continued input with regard to the *Dental Review* and can be emailed at craig.duhaime@hotmail.com by member dentists who have some news or opinions to share.

Dr. Duhaime treats patients in the Endodontic Associates Clarkston, Waterford and Commerce Township locations. ■

Memories of Dr. Melvyn Eder

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once treated often insisted on seeing him for any future endodontic problems.

Mel was also very friendly. He got along with staff, patients, referring doctors, and also many doctors who seldom referred. He had a great sense of humor and really enjoyed exchanging a good story with friends.

Endodontics in 1965 was dentistry's newest specialty. At that time there were many new techniques being developed and more and more patients became aware that they could save their teeth with endodontic procedures. Mel was always anxious to learn and grow and adopt any new advances in patient care that developed.

As Mel prospered in practice, he became increasingly active in organized dentistry. He enjoyed regular attendance at American Association of Endodontists meetings where he made many professional friends, and stayed on the cutting edge of his specialty. He is past president of the Oakland County Dental Society, the Michigan Association of Endodontists and the R.F. Sommer Endodontic Study Club.

Mel was chief of Endodontics at Sinai Hospital from 1966-1984. In 1967 he was selected as the first State Board Examiner for Endodontics in the State of Michigan. He subsequently wrote the Board exam and this format is used today.

Joining forces and having the pleasure of sharing a professional and personal life with Dr. Melvyn Eder was one of the better decisions I ever made.

It is sad that his last few years were diminished by his illness. I'm sure he is in a better place now. He is and will continue to be missed. ■

Quote of the Quarter…

"Of all the forces that make for a better world, none is so indispensable, none so powerful, as hope. Without hope people are only half alive. With hope they dream and think and work."

– Charles Sawyer

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