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SAN DIEGO COUNTY DENTAL SOCIETY PRESENTS

Facets

MAGAZINE

THE SPIRIT OF *Service*

Advancing ORAL HEALTH THROUGH SERVICE & VOLUNTEERISM

WELCOMING 2026

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SELF-CARE SUNDAY, SEE EVENTS RECAP PAGES 22-23.

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EDITORIAL

Becoming a "Change Agent"

EDITORIAL

Written By:
Eric Shapira, DDS, MAGD, MA, MHA, Facets Editor

CHANGE is constant.... As TIME is infinite and never stops....

Dentistry is a complicated and involved profession and allows us, in all our wisdom and knowledge, to care for the needs and wants of patients with respect to their oral cavity, which includes the diagnosis of pathology, repairs, esthetics and function. But most of all, we are caring for another Human Being and one that depends upon us to assist them with their wants and desires, as well as the overall process of keeping them healthy, essentially orally and physically as well.

All in all, it is not our total responsibility to monitor what our patients do with respect to home care, diet, recall appointments and putting off needed treatment in the scheme of things. The oral cavity is not an isolated system in the sense that there is no change that occurs daily, a fallacy as it does change every moment. On the contrary, the oral cavity undergoes constant changes every 24 hours due to the ingress and growth of bacteria, fungi, viruses, and various injuries, as well as the spread of these entities into the bloodstream and other parts of the body. In turn, these organisms can cause further havoc. But how many of our patients are not aware of this process and these facts? And how many of our patients are prudent about the oral care they may or may not give themselves in the light of this information, if they have it at all? Dental disease does not have to "hurt" to be deleterious to one's overall health! Think about it....

The average human mouth hosts billions of bacteria and a diverse array of other microbes, including approximately 700 different bacterial species, as well as fungi such as Candida and bacteriophages, which are primarily viruses. The exact amounts are impossible to count and number, but what is there in the oral cavity is a complex microbiome, with many species of organisms playing a beneficial role, but an imbalance of which can lead to oral health needs, as well as whole body disease and possibly life-threatening issues, especially without effective diagnoses.

Yes, think about it. What part do each of us play, as practitioners of oral health, in the process of maintaining our patients' oral and systemic health? WE can do so, and in turn become effective "Change Agents" in the process, that not only cure oral health issues and educate our patients but may save our patients' lives as well by diagnosing issues that the patient was not aware of in the long run... hence, saving a life! This means everything!!

I have saved many lives over the past 50 years of practicing dentistry. I know in my heart and mind that I have practiced what I preached in being a good student, teacher and utmost, a good practitioner.

You may ask, "What is a change agent?"

A Change Agent is an individual or a group that drives and facilitates change within an organization, business such as Dentistry, or system, acting as a catalyst for improvement by promoting new processes, structures, or ways of working. They can be internal employees or external consultants who are responsible for educating and influencing others, overcoming resistance, and ensuring that the change is successfully adopted and sustained. In the case of our being, so-called "dental experts", it is our challenge and responsibility to become a Change Agent for our patients and staff through educating ourselves continuously, subsequently teaching our staff, and then our patients overall.

"Making a difference to those we serve will ultimately change the world, one person at a time."

One of my favorite and germane quotes about what I have written here is from Gandhi. However, it is an offshoot interpretation of what he really states: "We but mirror the world...if we could change ourselves, the tendencies in the world would also change." This was his original quote in 1933. However, the one meaningful quote that came out of this was what I was trying to convey in my editor's message: ***"Be the change you want to see in other people!"***

WE all must practice what we preach. Being a good practitioner means being a good teacher to our staff and patients alike, and in turn, becoming an effective "Change Agent" who will make a difference in each of our own Universe of dental practices.

Making a difference to those we serve will ultimately change the world, one person at a time. The reality of this action is that in the scheme of things, we only have a short time to achieve this goal.

Carpe Diem. EZS

Remembering Joel With a Smile

Written by: Dr. Tom Olinger

I first met Joel while we were both serving in the Navy Dental Clinic — where drills, dedication, and dad jokes were all part of the job. Joel rose through every rank he touched: Captain (O-6) in the Navy, President of the San Diego County Dental Society, Trustee for the California Dental Association, and Co-Chair of CDA Cares — caring deeply for the underserved. He was also a proud member of the Tucker Gold Study Club, where his craftsmanship and camaraderie truly shined.

Joel led with professionalism, humor, and just the right dose of mischief — turning meetings into moments and colleagues into lifelong friends. His trademark blend of candor and good fun made every gathering brighter.

Above all, Joel was a devoted family man — a proud father of Michael and Lisa and an extremely proud grandfather of five. His eyes lit up whenever he spoke of them, and his pride was contagious.

Joel will be deeply missed — though we're pretty sure he's already forming a Study Club in heaven and reminding everyone to floss.

Fair winds and following seas, Captain Joel — may the laughter sail with you.

In Memory of Dr. Joel Berrick

MESSAGE FROM SDCDS *PRESIDENT*

NOVEMBER

VIRGINA MATTSON, DDS

As the Seasons Change...

Life moves in seasons, each with its own beauty, and my journey in Dentistry has been no different. I remember the spring of my career vividly—the day I first opened the doors to my dental practice. There was excitement, anticipation, and the weight of responsibility, but also the thrill of possibility. Much like the first blooms of spring, everything felt fresh, new, and full of promise.

Summer arrived as the practice grew and flourished. The days were full, the waiting room was alive with conversation, and my patients became more than patients; they became friends, even family. My team shared both the challenges and the triumphs, and together we built something lasting. These were the years of energy, growth, and deep connection, a time of abundance and fulfillment.

Then came autumn, when it was time to harvest the fruits of that work. Selling my dental practice was a bittersweet decision, but one made with gratitude for the journey it represented. At the same time, stepping into leadership with the San Diego County Dental Society became its own season of purpose. Serving as President has been a profound honor, allowing me to give back to the profession and community that gave so much to me. And I know that next year, as I transition into the role of past president, I will carry forward not an ending, but the joy of having been part of something greater than myself.

Now I step into winter, the season of retirement. It is not a quiet fading away, but rather a time of reflection and new ways of serving—through mentorship, volunteering, and cherishing the peace of a career well-lived. There is comfort in knowing that my work, my leadership, and my relationships will continue to ripple forward in the lives of others.

Dentistry, like Life itself, is not defined by one season, but by the journey through them all. Each chapter—practice ownership, leadership, and now retirement—is a celebration. And as I look back, I do so with gratitude, joy, and excitement for what lies ahead...

MESSAGE FROM SDCDS *EXECUTIVE DIRECTOR*

NOVEMBER

ANGELA LANDSBERG

A Guiding Light for a Remarkable Year

Every great year starts with a clear vision. This guiding light helps us find our way through challenges, celebrate progress, and focus on what truly matters. For us at the San Diego County Dental Society (SDCDS), that light has been our strategic plan, guiding us toward growth, connection, and impact.

One of the highlights this year was launching our Mentorship Program, which brings together seasoned dental professionals and those just beginning their careers. The energy and encouragement shared through these relationships have been inspiring, helping build confidence and connection across generations of dentists.

Start the SDCDS Mentorship program.

for mentors *for mentees*

We also celebrated a major milestone with the opening of the SDCDS Academy of Learning Dental Assisting School—a huge step in creating new career pathways and addressing the workforce needs of our dental community.

Join the interest list for the SDCDS AoL Dental Assisting School.

With the debut of our Peak Performance Program, we've taken meaningful strides in supporting the well-being and balance of dental professionals.

Connection has been at the heart of everything we've done. From lively networking events to our first-ever two-day Dental CE Conference, our members came together to learn, collaborate, and celebrate what makes our community so special.

None of these accomplishments would have been possible without the incredible dedication of our volunteers and board members. Your passion, time, and teamwork are what make SDCDS thrive, and we're so grateful for each of you.

As we look ahead, we do so with excitement and gratitude. This year reminded us that when we move forward with purpose and vision, amazing things happen. Our guiding light continues to shine bright—and together, we'll keep building a strong and connected future for SDCDS.

Members earlier this year hiking Torrey Pines, a Peak Performance Program activity.

Winning Healthy Smiles Through Sports Dentistry

Written By:
Zeynep Barakat DMD, FAGD

It's Saturday afternoon. You're running errands when you get a call from an injured patient, also a basketball player. She was hit in the mouth while reaching for the ball, has broken teeth and says one feels out of place but she wants to wait until tomorrow to come in. How do you respond?

Practitioners may be familiar with sports medicine but few are aware of what sports dentistry is and how it can be integrated into sports medicine. The evolution of sports dentistry is beyond the scope of this article but a brief introduction to this field can help generalists and specialists be aware of the relationship between sports and dentistry. The Academy for Sports Dentistry (ASD), founded in 1983, was established "to be a forum for dentists, physicians, athletic trainers, coaches, dental technicians, and educators interested in exchanging ideas related to sports dentistry and the dental needs of athletes at risk of "sports injuries". However, concepts in sports dentistry are not exclusive to team dentists who treat professional athletes; rather, they can be applied to athletes at all levels—from varsity high school to recreational sports. Additionally, training in the management of traumatic dental injuries assists dentists in treating even non-athletes, such as trip and fall cases or bicycle accidents.

AWARENESS

Sports dentistry is currently defined as: "involving the prevention and treatment of dental injuries in sports, but also related oral diseases associated with sport." It can be perceived as focused primarily on traumatic injuries, but sports dentistry encompasses the diagnosis, treatment, and management of dental conditions that result specifically from training, competition, and the psychological aspects of competition. Athletes can present with chronic conditions—such as dental erosion, caries, bruxism, sleep apnea and oral lesions—depending on their sport and level. Different sports carry different dental risks; an ultramarathoner will have unique dental conditions to be aware of, given their frequent intake of sugars and carbohydrates combined with episodes of dehydration, while a weightlifter may exhibit signs of excessive clenching, such as fractured teeth. In addition to assessing the risk of dental disease as a consequence of sport, a dentist caring for athletes is expected to conduct pre-season screenings to eliminate the risk of being sidelined due to a preventable dental condition, such as partially impacted third molars or advanced caries. In another example, erosion among swimmers or athletes with eating disorders may also result in an increased risk of dental erosion and caries.

The role of the sports dentist is to work with these athletes to reduce their risk without hindering their performance.

RISKS

Sports, such as basketball, field hockey, rugby, lacrosse, baseball, softball and football, are known for their high risk resulting in acute traumatic dental injuries, either due to collisions and contacts with other players or impacts from objects. Girls field hockey, for example, has the highest risk of orofacial injuries among the contact sports at the high school level. Sports such as water polo, cheerleading, and wrestling can also cause orofacial injuries.

The number of Americans involved in sports has been on the rise, and sports-related injuries run the gamut from concussions to TMJ injuries and everything in between.

We're familiar with the type of dental injuries that include fractures, concussions, luxations, and avulsions. An excellent review can be found in The Essentials of Traumatic Injuries to the Teeth by J.O. Andreasen/ F.M. Andreasen, leaders on this topic, and current international guidelines are available by the International Association of Dental Traumatology.

Many of these injuries typically overlap and require thorough documentation, including photographs and the appropriate imaging. The extent to which they will be managed will depend on the training and skill level of the dentist. However, basic preparation can facilitate swift care simply by following a checklist and understanding how to stabilize a dental injury and the timeline for its management at the very least. Staying current on guidelines and research will help the prognostic outcome of traumatized or avulsed teeth (for example, considering the use of steroids in treating certain avulsed teeth prior to replantation). Additional team dentist training covers how and when to splint teeth, how to collaborate with designated team physicians, athletic trainers, specialists, parents and how to act quickly but thoroughly in such situations. In sports, athletic trainers will always be the first to evaluate an injured athlete and the team dentist is called on only after the athletic trainer has assessed the injury. Depending on the sport and level of competition—for instance, a high school versus an NCAA team—being available to manage a dental injury will involve either being on call or being on site during games or practices, and may demand certain credentialing by the governing body of the sport. Treating Team USA Olympic athletes, for example, requires additional training specifically by the United States Olympic and Paralympic Committee. Being familiar with the sport itself is useful in knowing how injuries could happen in the first place, like rebounds in basketball. Having pre-existing photos of patients' occlusion and range of motion is recommended and helpful, but will not be available at a field or courtside. In a practice setting, however, they can help determine if luxated teeth need to be repositioned with a splint. Be aware of the consequences of impacts to the mandible and the possibility of intra-articular edema and its management, even in the absence of any fractures. Also, keep in mind that athletes at the elite level are prohibited from taking certain medications and supplements, so be aware of which governing body the injured professional must abide by and what drugs they can and cannot take legally and professionally.

PREVENTION

The best way to manage a traumatic sports injury to the dentition, be it mixed or adult, is to prevent it. And the best tool for prevention of trauma is a properly fitting mouthguard. Do all mouthguards provide the same level of protection? Not at all. A review of the scientific literature and ongoing studies being conducted

on sports mouthguards and other related topics such as concussion prevention, is also beyond the scope of this article. Position statements from various organizations such as the ASD, IADT, AAPD, AAE and others, outline recommendations to wear a sports mouthguard during sports, highlight the orofacial risk associated with certain sports, and some provide guidance on what a mouthguard should include in its design and function.(3) Heat and pressure laminated (not vacuum formed) custom mouthguards, though more costly, are generally preferred by athletes due to their intimate fit and retention, which also helps the athlete's speech during play(4). In vitro studies have shown laminated custom mouthguards to be more effective than mouth-formed—also known as "boil- and-bite"—mouthguards in their efficacy in shock absorption (5,6). However, if an athlete doesn't like the fit of a mouthguard they will not wear it, regardless of whether it is custom made or mouth formed. The advantage of a heat pressure laminated custom mouthguard is that its thickness and material hardness (for example, Shore hardness) can be customized to the sport, to the athlete's preference and past history of trauma. Our weightlifter from earlier, may not require as thick of a facial coverage as would a rugby player, thus depending upon the brand of the heat-pressure laminated machine,and the layers for the desired coverage , which may be different. The key is to design a proper fitting and effective mouthguard that the athlete will commit to wearing. Fun fact: NHL hockey and NFL football players are not mandated to wear mouthguards even though a majority wear them—a testament to how educating the sports medicine team can result in a collective initiative amongst the athletes themselves: knowing that mouthguards are useful in preventing devastating oro-facial injuries during their sport. Another fun fact: according to the Academy of Pediatric Dentistry, the lifetime cost of a tooth with trauma was estimated to be $20,000, and in addition to how costly sport equipment can be, these costs can be taken into context when considering the cost of a custom mouthguard.

SOLUTIONS

So how would you help your patient, the basketball player? Firstly, is she an elite, college, or recreational league player? Is there an athletic trainer involved? Would a 24 hour delay be acceptable? Does she need to return to play? Do you have stepwise questions to ask? Do you know how to splint and reposition teeth? Did this patient have a pre-existing occlusion that may have increased the severity of the injury? Why wasn't she wearing a mouthguard?

Clearly, depending on the level of sport at stake, management of this situation will be different. A self-assessment of your skills and knowing which providers to collaborate with in such cases, will depend upon your level of training. Sports dentists are one part of a large team of providers that care for athletes, and good oral health is a part of an athlete's overall physical and mental readiness for play and competition. San Diego residents are known to be active, athletic, and fitness focused—it is the birthplace of the triathlon, after all—so our knowledge on how activities and sports are related is not limited to professional athletes. Just because a basketball player in a recreational league isn't a player in the WNBA, that doesn't mean she shouldn't be educated on how to play safely to protect her teeth, and how to lower her risk from chemical erosion when they hydrate. So the next time your patient or patient's child mentions they took up a sport, discuss their level of involvement, protection, and risk. You just practiced a little part of the world of sports dentistry.

SOME USEFUL TIPS FROM SPORTS DENTISTS

Subscribe to journals such as Dental Traumatology and IADT to keep abreast of the latest studies on dental trauma and prevention.

Encourage your patients to download the "Tooth SOS" (available in multiple languages) app on their phone. This app also has a direct link to dental traumatology guidelines for dentists with direct links to guidelines on dental trauma management.

Be prepared with your materials and necessary forms, either on-site or in your practice.

Take pre-existing photos or scans of athletes before a season starts. Review pre-existing occlusion and other intrinsic risk factors with them.

Establish a relationship with athletic trainers to educate them on prevention and trauma management of their players and encourage pre-season dental screenings if they don't conduct them.

ORAL HEALTH FEATURE

Molecular Iodine Offers New Hope to Periodontal Patients: How Does it Compare to Chlorhexidine?

Written By: **Herb Moskowitz, DDS; Janice Goodman, DDS, MSc Oral Medicine and Orofacial Pain**

Chlorhexidine gluconate (CHX) was first introduced into clinical practice in 1954[1]. In its more than 70 years of clinical use, it has become a standard of care in infection control, globally. CHX oral rinse has earned the American Dental Association's Seal of Acceptance and has been a valuable adjunct in the control of periodontal disease for decades. But, has it outlived its usefulness? Let's compare the features and benefits of CHX to a current state-of the-art antiseptic agent, molecular iodine (I_2), that is currently being introduced into Canada so that you can answer that question.

Just because an antiseptic agent has earned prominence as a standard of care, doesn't mean that it will always retain that distinction. For example, during the 1930's and early 1940's, sulfa drugs were considered the standard of care as antibiotic agents. With the large-scale introduction of penicillin in 1945, sulfa was no longer considered the antibiotic of choice[2]. Consider your own practice today. When was the last time you prescribed sulfa for an infection?

So, how do CHX and I_2 really compare in parameters that are important to our patients and to our practices? Let's first look at their relative antimicrobial efficacy.

CHX has excellent biocidal activity against periodontal bacteria, but I_2 is considerably more effective. In table 1, seven of the most commonly used professional periodontal rinses were compared for their biocidal efficacy against two key periodontal pathogens (Fusobacterium nucleatum and Prevotella intermedia). At 30 seconds exposure time, I_2 was the only rinse found to be fully effective. It was 28 times more effective than CHX against Fusobacterium and 730 times more effective than CHX against Prevotella. It was also far more effective than every other rinse tested. This is no small feat, since all the testing was done in the presence of fresh, human whole saliva, which neutralizes most antiseptic rinses[3].

We are not just concerned about periodontal bacteria. How effective are CHX and I_2 against cariogenic bacteria? Table 2 shows the relative biocidal efficacy of CHX and I_2 against Strep mutans, a principal caries-causing pathogen. Within 15 seconds, I_2 completely destroyed all bacteria present with a 6+ log reduction. CHX achieved a 0.18 log reduction against Strep mutans in the same time frame. That 0.18 log reduction by CHX is the equivalent of starting with 1 million viable Strep mutans bacteria, exposing it to CHX for 15 seconds, and having 810,000 viable bacteria remain unscathed$_4$. A meta-analysis of 5 human clinical studies shows that fluoride + iodine is significantly more effective in preventing tooth decay than fluoride, alone (ioRinse AC Anti-cavity oral rinse).[5]

Let's turn to viruses. How effective are CHX and I_2 against important viruses? Table 3 helps to answer that question. Four different rinses were evaluated for their efficacy against SARS Co V-2. The testing was conducted at the Institute for Antiviral Research at Utah State University. Only one rinse was fully effective, a molecular iodine rinse. It was fully effective at just 30 seconds exposure time. None of the other rinses, including CHX were fully effective. Not at 30 seconds and not even when the exposure time was doubled to 60 seconds[6].

Let's try another virus. Rhinovirus is a common upper respiratory virus responsible for most cases of viral pharyngitis. It is a difficult-to-kill non-enveloped virus. Table 4 compares the antiviral efficacy of CHX to I_2 against Rhinovirus. Within 30 seconds, I_2 completely destroys Rhinovirus. In that same time frame, CHX has no biocidal efficacy, at all[7].

What about their effectiveness against fungi? Table 5 compares the relative efficacy of a 300 ppm molecular iodine solution to a solution consisting of 2% CHX and 70% isopropyl alcohol. Both the molecular iodine solution and the CHX/alcohol solution were tested against Aspergillus brasiliensis, one of the most resilient fungi known. The I_2 solution completely inactivated the fungus within 15 minutes. The CHX/alcohol solution took one full hour to achieve the same result[7].

What about safety? Which product is safer to use? Iodine is an essential nutrient required in the diets of humans to avoid iodine deficiency diseases[3]. That's why our salt is iodized. Iodizing salt is an inexpensive public health measure to help us avoid iodine deficiency diseases (including birth defects and mental retardation)[8].

Not only does I_2 have an excellent safety profile, it is perhaps the most effective antimicrobial agent for human use as well as being amongst the safest to use. It can be used safely, each and every day by patients, literally for the rest of their lives.

CHX, unfortunately, has serious health concerns. It is a potential carcinogen. Every bottle of CHX oral rinse sold in the U.S. is required by FDA to include a safety data sheet which states that it "may cause cancer" (see Figure 1 below). It is categorized by FDA as a class IA carcinogen, meaning that the evidence supporting that classification is based on actual human data[9].

Table 1

	Log reduction at 30 seconds	
Antiseptic rinse	***Fusobacterium nucleatum***	***Prevotella intermedia***
ioRinse Ultra	**6.0 -** complete inactivation	**6.0 -** complete inactivation
Chlorhexidine gluconate 0.12%	**4.8 -** 28x less effective	**3.3 -** 730x less effective
Cetylpyridinium chloride 0.07%	**0.2 -** 820.000x less effective	**5.3 -** 7x less effective
Chlorine dioxide	**0.71 -** 361.000x less effective	**3.9 -** 190x less effective
Povidone iodine 10%	**1.8 -** 28.000x less effective	**1.3 -** 73.000x less effective
Hydrogen peroxide	**0.4 -** 640.000x less effective	**0.52 -** 532.000x less effective
Stabilized chlorine dioxide	**0.04 -** 964.000x less effective	**0 -** no biocidal activity

Note: All testing conducted in the presence of fresh, human, whole saliva at Prime Analytics Laboratory, Concord, California

Table 2

Microorganism	**Molecular Iodine (Iz)**			**Chlorhexidine Gluconate**		
	Strength	**Log Reduction**	**Time**	**Strength**	**Log Reduction**	**Time**
Strep mutans	100 ppm	6.49 complete inactivation	15 sec.	0.12%	0.19	15 sec.

Source: BioScience Laboratories, Bozeman, Montana

Table 3

Oral Rinse	**Log Reduction**		**Observed Cytotoxicity**
	30 Seconds	**60 Seconds**	
1.5% hydrogen peroxide	<1.0	<1.0	1/10,1/100, 1/1000 dilutions
0.2% povidone iodine	2.0	3.0	none
0.12% chlorhexidine gluconate	<1.0	1.0	1/10,1/100 dilutions
Molecular iodine formula 100-S	>3.6 Complete inactivation	>3.6 Complete inactivation	none

Source: Utah State University, Institute for Antiviral Research; August 3, 2020

Table 4

Microorganism	**Molecular Iodine (I_2)**			**Chlorhexidine Gluconate**		
	Strength	**Log Reduction**	**Time**	**Strength**	**Log Reduction**	**Time**
Rhinovirus	25 ppm	4.0 complete inactivation	30 sec.	0.12%	0.0	30 sec.

Source: BioScience Laboratories, Bozeman, Montana

Table 5

Antiseptic Agent	**Time Required for Complete Inactivation (4.0+ log reduction)**
CHX 2.0% (17x stronger than 0.12% CHX oral rinse) + Isopropyl Alcohol 70%	60 minutes
Molecular Iodine (300 ppm)	15 minutes

Sources: 1. Yoshida Pharmaceutical Company. In-house testing, May 2017. 2. Care Fusion U.K. ChloraPrep Summary of Product Characteristics. January, 2016

References

1. FIScT, T. S. P. C. (2024, April 21). Skin deep: Chlorhexidine - history and efficacy. https://www.linkedin.com/pulse/skin-deep-chlorhexidine-history-efficacy-tim-r9g8e/
2. History of antibiotic development – Antibiotics – ReAct. (2024, September 17). ReAct. https://www.reactgroup.org/toolbox/understand/antibiotics/development-of-antibiotics-as-medicines/
3. Keena, T. (2023, May 5). The need for objective, evidence-based efficacy testing of Oral Rinses. Registered Dental Hygienists. https://www.rdhmag.com/patient-care/home-care/article/14291458/the-need-for-objective-evidence-based-efficacy-testing-of-oral-rinses
4. BioScience Laboratories, Bozeman, Montana: Antimicrobial Efficacy comparison of Oral Rinses Against Strep Mutans, April 2024
5. Gupta A, Nishant, Sharda S, Kumar A, Goyal A, Gauba K. Comparing the Effectiveness of Topical Fluoride and Povidone Iodine with Topical Fluoride Alone for the Prevention of Dental Caries among Children: A Systematic Review and Meta-analysis. Int J Clin Pediatr Dent. 2020 Sep-Oct;13(5):559-565. doi: 10.5005/jp-journals-10005-1844. PMID: 33623347; PMCID: PMC7887176.
6. Moskowitz, H., & Mendenhall, M. (2019). Comparative Analysis of Antiviral Efficacy of Four Different Mouthwashes against Severe Acute Respiratory Syndrome Coronavirus 2: An In Vitro Study. International Journal of Experimental Dental Science, 9(1), 1–3. https://doi.org/10.5005/jp-journals-10029-1209
7. Moskowitz, H. (2019, July 1). CHX: We don't like it! why are we still using it? Registered Dental Hygienists. https://www.rdhmag.com/career-profession/article/14036891/chx-we-dont-like-it-why-are-we-still-using-it
8. Office of Dietary Supplements - iodine. (n.d.). https://ods.od.nih.gov/factsheets/Iodine-HealthProfessional/
9. Darby Dental Supply. (n.d.). Safety Data Sheet: Chlorhexidine gluconate 0.12%. Retrieved January 15, 2025, from https://chemmanagement.ehs.com/9/60BBB-CFA-FE39-4844-A79D-86123E2EAD1B/pdf/MSZ873
10. U.S. Food and Drug Administration. (2017, February 2). FDA drug safety communication: FDA warns about rare but serious allergic reactions with skin antiseptic products. Retrieved January 15, 2025, from https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-warns-about-rare-seri-

FDA has also issued a safety warning for CHX in response to a rising number of allergic reactions[10]. These reactions can be so severe that life threatening anaphylactic shock from the use of CHX has been reported on multiple occasions.11 CHX also allows bacterial resistance to develop. The medical literature is replete with references to bacterial resistance development associated with CHX use.[12] The rapid increase in patients becoming resistant to antimicrobial agents has become alarming. In a study conducted at Temple University Dental School it has been shown that within the 20-year time span ending in 2020, 16 times as many periodontal patients became resistant to Clindamycin at the end of the study as compared to the beginning and 28 times as many patients became resistant to Amoxicillin[13].

Iodine does not cause microbial resistance[14]. Nowhere in the medical literature is there any evidence of microbial resistance development to iodine. Because of safety concerns CHX is only indicated for short-term, episodic use, not to exceed two weeks.[15] Because CHX is not effective against certain resilient bacteria, FDA has also issued multiple recalls for CHX because of microbial contamination by bacteria living within the CHX rinse bottles[16,17].

Antimicrobial efficacy and product safety are critically important attributes of our antiseptic agents, but there are other important product characteristics that can spell the difference between treatment failure and treatment success. Table 7 shows important product characteristics for both CHX and I_2 oral rinses. CHX interferes with both soft tissue repair and bony regrowth because of its inhibitory activity against fibroblasts and osteoblasts[18]. Periodontal pocket depth reduction and clinical attachment gain are impeded by this inhibitory activity. Unlike povidone iodine and chlorhexidine gluconate, molecular iodine rinses do not stain[19]. It has been shown that CHX degrades the biocompatibility of titanium surfaces. It is therefore contraindicated for use with titanium implants because implants that are no longer biocompatible, cause local tissue reaction leading to peri-implant mucositis and also peri-implantitis[20].

A molecular iodine oral rinse checks all the boxes in being as nearly perfect as an antiseptic rinse can be. Because molecular iodine has such broad-spectrum activity, wouldn't it be expected to destroy nitric oxide-producing bacteria in the mouth, as well? Wouldn't a lower nitric oxide level then lead to negative changes in vaso-activity and ultimately heart disease? The answer may surprise you.

Yes, molecular iodine will destroy nitric oxide-producing bacteria along with pathogenic bacteria, but the limited production of nitric oxide produced in the mouth has only a negligible effect, if any, on vaso-activity. A joint study by John Hopkins School of Medicine and the University of Virginia Medical School demonstrates conclusively that the key production of nitric oxide involved in vaso-regulation is located in and around the blood vessels themselves, not in the mouth. They also point out that nitric oxide is produced almost everywhere in the body (skin, skeletal muscle, nose and sinuses, liver, blood cells, epithelial cells, nerves and all

Figure 1

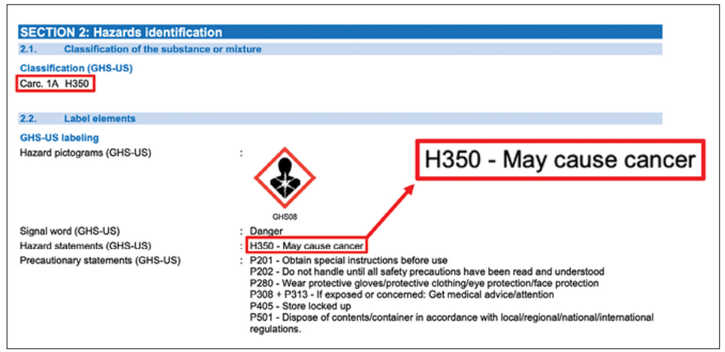


Table 6

Antibiotic	Change in number of resistant perio patients Year 2000 >> Year 2020
Clindamycin	16x greater
Amoxicillin	28x greater

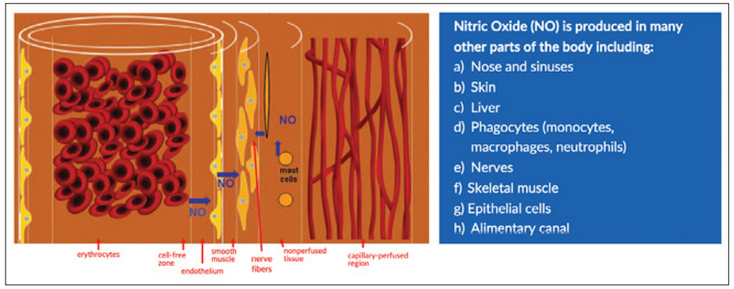
Source: Emergence of Antibiotic-Resistant Porphormonas gingivalis in United States Periodontal Patients. Rams, T. Antibiotics 2023 Nov 1, 12(11) 1584

Table 7

Product Characteristics of CHX and I Oral Rinses		
Characteristic	**CHX Oral Rinse**	**I_2 Oral Rinse**
FDA safety warning issued	Yes	No
FDA recalls for microbial contamination	Yes	No
Inhibits fibroblast proliferation	Yes	No
Inhibits osteoblastic activity	Yes	No
Stained teeth and tongue	Yes	No
Promotes dental calculus buildup	Yes	No
Alters taste	Yes	No
Use limited to short term only	Yes	No
Allows microbial resistance development	Yes	No
Compromises implant biocompatibility	Yes	No

Source: Antimicrobial Agents Used in the Treatment of Peri-implantitis Alter the Physicochemistry and Compatibility of Titanium Surfaces. Journal of Periodontology DOI 10.1902/jop.2016.150684

Figure 2



throughout the alimentary canal). See Figure 2.

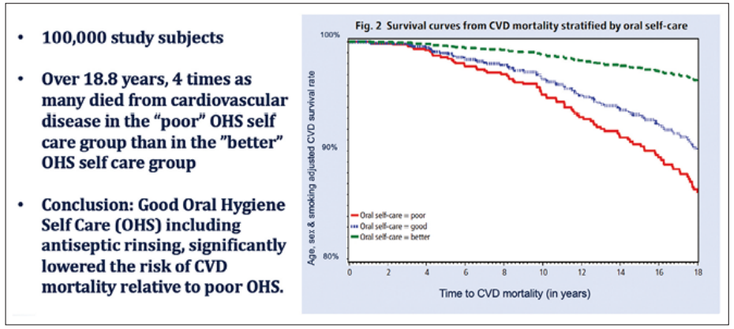
What about dysbiosis of the oral microbiome? Wouldn't inactivation of commensal bacteria by a powerful antiseptic rinse lead to dysbiosis? The mouth is never sterilized with the use of an antiseptic rinse. Residual, viable microbes, with the help of microbes from the nose, the throat, and the air we breathe, rapidly repopulate. It is postulated that repopulation of gram-positive, aerobic bacteria occurs more quickly and completely than does repopulation of anaerobic, pathogenic bacteria.[25] It is the rapid repopulation of these aerobic bacteria that crowds out the anaerobes, establishing a new microbiome favoring commensal bacteria.

We should also not lose sight of the fact that controlling periodontal disease is critical in helping to control heart disease. Periodontal disease has reached epidemic proportions, and the most effective antiseptic agents are required to help us control periodontal disease.[25]

In a recent landmark study reported in the British Dental Journal, 100,000 patients were stratified into 3 groups depending on the level of their daily, at-home oral hygiene (poor at-home oral hygiene, moderate at-home oral hygiene and best at-home oral hygiene). These patients were followed for almost 19 years, tracking the number of deaths attributable to cardiovascular disease that occurred in each group. The most significant finding was that 4 times as many patients died from cardiovascular disease in the poor periodontal health group than did in the best periodontal health group.

Is molecular iodine a newly discovered molecule? Oddly, molecular iodine or I_2 has been around as long as iodine has been around. Early Chinese physicians provided the first recorded evidence of therapeutic benefit of using iodine-rich substances more than 5,600 years ago. They formulated pastes of ground up seaweed and sea urchins, applying these pastes to the necks of patients who had goiters (enlarged thyroid glands)[20]. Although they were successful in shrinking the size of many of these goiters, they had no idea that the active agent in these

Figure 3 – Mouthwash Usage and Cardiovascular Mortality During 18.8 years of Follow-up.



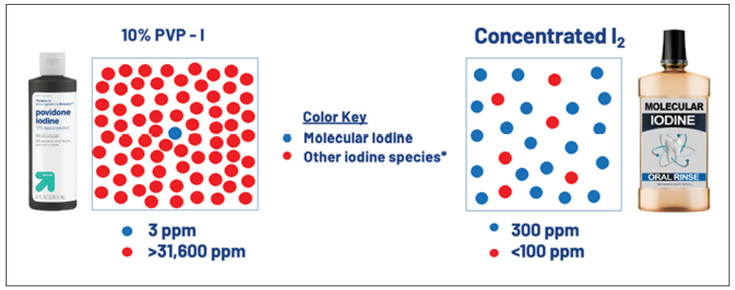
Source: British Dental Journal Feb, 2023

References

ous-allergic-reactions-skin-antiseptic#:~:text=Stop%20using%20the%20product%20containing,to%20other%20more%20serious%20symptoms

11. Weng, M., Zhu, M., Chen, W., Miao, C., Fudan University Shanghai Cancer Center, & Shanghai Medical College, Fudan University. (n.d.). Life-threatening anaphylactic shock due to chlorhexidine on the central venous catheter: a case series. In Int J Clin Exp Med (Vol. 7, Issue 12, pp. 5930–5936). https://e-century.us/files/ijcem/7/12/ijcem0002887.pdf
12. Wand, M. E., Bock, L. J., Bonney, L. C., & Sutton, J. M. (2016). Mechanisms of Increased Resistance to Chlorhexidine and Cross-Resistance to Colistin following Exposure of Klebsiella pneumoniae Clinical Isolates to Chlorhexidine. Antimicrobial Agents and Chemotherapy, 61(1). https://doi.org/10.1128/aac.01162-16
13. Rams, T. E., Sautter, J. D., & van Winkelhoff, A. J. (2023). Emergence of Antibiotic-Resistant Porphyromonas gingivalis in United States Periodontitis Patients. Antibiotics (Basel, Switzerland), 12(11), 1584. https://doi.org/10.3390/antibiotics12111584
14. Lanker Klossner, B., Widmer, H. R., & Frey, F. (1997). Nondevelopment of resistance by bacteria during hospital use of povidone-iodine. Dermatology (Basel, Switzerland), 195 Suppl 2, 10–13. https://doi.org/10.1159/000246024
15. Martino, R., DDS. (2022, July 13). Revealing the truth about chlorhexidine, and a better alternative. Decisions in Dentistry. https://decisionsindentistry.com/article/revealing-the-truth-about-chlorhexidine-and-a-better-alternative/#:~:text=Noted%20for%20its%20high%20potential,or%20other%20solution%20than%20CHX.
16. The Food and Drug Administration (FDA) recalls Paroex Chlorhexidine Gluconate Oral Rinse USP, 0.12% by Sunstar Americas. (2021, January 11). Constituent. https://www.agd.org/constituent/news/2021/01/11/the-food-and-drug-administration-(fda)-recalls-paroex-chlorhexidine-gluconate-oral-rinse-usp-0.12-by-sunstar-americas
17. U.S. Food and Drug Administration. (2023, March 7). Lohxa, LLC issues voluntary nationwide recall of chlorhexidine gluconate oral rinse USP, 0.12% due to microbial contamination. Retrieved January 15, 2025, from https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/

Figure 4



pastes was iodine. It wasn't until 1814 that the French researcher, Courtois identified iodine as an element.[21]

Figure 4 shows two schematic diagrams. The schematic on the left represents 10% povidone iodine. It contains approximately 31,600 ppm of total iodine. Of all the different species of iodine in povidone iodine, only one species is biocidal and actually kills germs. That species is molecular iodine (I_2)[6] and it is only present in povidone iodine at trace levels (2-3 ppm).[6] As almost unimaginable as it may be, those 2-3 ppm of I_2 account for all of povidone iodine's germicidal activity. The schematic on the right side of Figure 2 shows a high-level molecular iodine solution containing 300 ppm I_2. Only trace levels of other iodine species are present in this high-level iodine solution, so it does not stain.[18]

For decades, researchers have tried unsuccessfully to develop high level molecular iodine solutions while suppressing other iodine species which are toxic and staining. I_2 is unstable and quickly morphs into other forms of iodine which are not biocidal[23]. So even if it was possible to add I_2 to povidone iodine, it wouldn't stay as I_2, but would rapidly change into other non-biocidal species of iodine.

In 2016, after 3 years of painstaking research focused on this very problem, Iotech International, a Florida-based medical technology company, developed the breakthrough technology that has ushered in a new generation of stable, high level molecular iodine oral care products which have been patented globally and have a useful shelf life of 2 years[24].

These products are already successfully being used in thousands of dental offices in the U.S. and in Canada. You should now be able to answer the question, "How does molecular iodine compare to chlorhexidine?" Perhaps a more important question to ask yourself is "If molecular iodine oral rinse is available, why am I still using chlorhexidine?"

The San Diego County Dental Society is pleased to share this article from Oral Health.

About the Author: The author Dr. Herb Moskowitz is the Chairman and Co-Founder of ioTech International, a developer and manufacturer of molecular iodine oral care products.

References

lohxa-llc-issues-voluntary-nationwide-recall-chlorhexidine-gluconate-oral-rinse-usp-012-due#:~:text=0.12%25%20Alcohol%20free-,Company%20Announcement,repackaged%20from%20Sunstar%20Americas%20Inc.

18. Liu, J. X., Werner, J., Kirsch, T., Zuckerman, J. D., & Virk, M. S. (2018). Cytotoxicity evaluation of chlorhexidine gluconate on human fibroblasts, myoblasts, and osteoblasts. Journal of bone and joint infection, 3(4), 165–172. https://doi.org/10.7150/jbji.26355
19. Riad, A., Yilmaz, G., & Boccuzzi, M. (2020). Molecular iodine. British dental journal, 229(5), 265–266. https://doi.org/10.1038/s41415-020-2127-0
20. Kotsakis, G. A., Lan, C., Barbosa, J., Lill, K., Chen, R., Rudney, J., & Aparicio, C. (2016). Antimicrobial Agents Used in the Treatment of Peri-Implantitis Alter the Physicochemistry and Cytocompatibility of Titanium Surfaces. Journal of periodontology, 87(7), 809–819. https://doi.org/10.1902/jop.2016.150684
21. Lee, Chen-Hsena,b,c,e,*; Chiu, Jen-Hweyb,c,d. Goiter disease in traditional Chinese medicine: Modern insight into ancient wisdom. Journal of the Chinese Medical Association 84(6):p 577-579, June 2021. | DOI: 10.1097/JCMA.0000000000000547
22. Metrangolo, P., & Resnati, G. (2011). Tracing iodine. Nature Chemistry, 3(3), 260. https://doi.org/10.1038/nchem.998
23. Blasi C. (2021). Iodine mouthwashes as deterrents against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Infection control and hospital epidemiology, 42(12), 1541–1542. https://doi.org/10.1017/ice.2020.1356
24. Liquid gold. (2024, June 30). Incisal Edge – Strategies to Accelerate Success, p 14-16 https://www.incisaledgemagazine.com/mag/article/liquid-gold/
25. Moskowitz, H. (2024) Oral Rinses: What's Safe? What's Effective? Dental CE Academy. https://www.dentalceacademy.com/iotech-international-on-demand-webi

Dental Editors Meet in San Diego

Written By:
Harriet Seldin, DMD, MBA, CDE

For the first time I'm aware of, the annual national meeting of the American Association of Dental Editors and Journalists (AADEJ) was held in San Diego. This meeting is a rare opportunity for dentists and non-dentists who are involved with dental publications and other media to network and obtain continuing education in dental journalism skills and trends.

I attended as the Editor for the American College of Dentists' Southern California Section. The SDCDS Editor, Dr. Eric Shapira, attended on behalf of SDCDS and our Editorial Board member, Dr. Roslyn Joseph, also attended. The meeting was held September 9 - 10 at the Manchester Grand Hyatt, in conjunction with the International College of Dentists' annual meeting and also the San Diego Dental CE Conference.

The AADEJ meeting had great speakers. CDA Managing Editor Kristi Parker Johnson spoke on creating content like a journalist in a scientific world. Katherine Fiorillio, editor with Michigan Alum, spoke on Digital Publishing. Christopher Smiley DDS (AADEJ President and past Michigan Dental Association Editor) spoke on navigating AI in Dental Publishing, and AADEJ's guidance for authors and Editors. Barbara Gastel, MD, MPH, spoke on Copyediting. Victoria Ruhle, Publisher at Taylor and Francis (MANY association publications now publish via Taylor and Francis) spoke on Unmasking Plagiarism. Kevin Henry of Dr. Bicuspid spoke on Podcasting. AGD Editor Timothy Kosinsky, DDS, spoke about editorials. New and interesting to me, Alison DeKock from ADA spoke about the new ADA Commons and how ADA has invested in this new portal for our use. Through AADEJ's collaboration with the ADA, dental editors will soon be able to enhance their media presence. Beyond the agenda, AADEJ is the ONLY place I know where dental editors can learn from each other, hopefully to the benefit of our publications and our members. It was very special that the conference highlighted San Diego, including our luncheon speaker, Jim Cassidy, PhD, from the Maritime Museum.

Let Me Introduce...

DR. MICAH SHAW

Written By: **Rosa Le, DDS**

Let Me Introduce is an ongoing column featured in Facets to introduce us to the many members that make up the depth and breadth of the San Diego County Dental Society. We hope you enjoy getting to know your colleagues better.

What inspired you to become a dentist?

I decided to become a dentist at age four. My dad is a high school counselor and encouraged me to make life plans early. I liked going to the dentist and taking care of my teeth.

Where are you from and where did you go to undergrad and dental school?

I'm from San Diego! Raised in Lemon Grove and a Helix alum. I went to UCLA where I was in the marching band. I studied at Midwestern College of Dental Medicine-Illinois.

What's one innovation or technology in dentistry that you're most excited about, and how do you see it impacting patient care in the next few years?

I am excited to see a greater implementation of the Community Health Worker. I have started to see more patients utilizing CHWs and they really help to ensure that patients and their parents understand everything.

What are your hobbies or interests outside of dentistry?

I have been a quilter for over 20 years; I'm currently working on a quilt. I am an AMC movie pass holder - I go at least once a week and I also go to a few Broadway shows at the Civic Theater throughout the year!

What's a book, movie, or podcast you've enjoyed recently?

I love "Six the Musical!" I didn't know much about the show going in, but any expectations were surpassed. I'm going to "Harry Potter and the Cursed Child" in LA!

What's your favorite thing about living in San Diego?

I like that it feels like home. It just feels right being here... like when you're driving home, you can take an alternate route without a map, and my family is here. The ocean is a good marker for me, I felt a little disoriented without it in Chicago!

Do you have any favorite local restaurants or coffee shops you'd recommend?

Bahn Thai in University Heights - Pad thai with tofu and/or veggies.

Valentine's Mexican Food on 6th and B St has vegetarian rolled tacos and vegetarian section in their menu,

If you weren't a dentist, what do you think you'd be doing?

I think I'd be an optometrist. My optometrist was really cool, and he would try to convince me to be an optometrist! I think it says a lot about how much someone enjoys their job when they actively try to get people to pursue the same career.

What's one thing you're really looking forward to this year?

I took some time off this summer for some events, including a trip to San Francisco for a wedding. I was so excited for Comic-Con! I go with my family every year. We block off our calendars as soon as the dates are confirmed. We do a day of "Bob's Burgers" cosplay and wait in line for over 24 hours for the Hall H Saturday panels.

What's one small thing that always makes you smile?

A beautiful plant can be a great addition to the day. Not having them but simply passing by a lovely flower or tree. However, I am not a gardener. I have Lego plants, but I'm not willing to take care of real plants.

What's the best piece of advice you've received?

It was about ergonomics. A dental school faculty member stated, "The patient is in the chair for 20-30 minutes, don't bend for them because you have to do this for 30-40 years!" I work a lot in pediatrics, so that is not always realistic, but I try to keep that in mind.

Threads of Hope and Love

Dr. Benjamin Harouni was our eldest son—an intelligent, compassionate, and remarkable dentist. Ben dedicated his life to helping others, firmly believing that a beautiful smile could transform lives. He provided countless free dental services to those in need and connected deeply with every patient he met.

In February 2024, Ben began designing a unique, stylish floss—carefully crafted for texture, flavor, and cavity-fighting properties. His vision was to make the younger generation fall in love with flossing. He named it LuvLine.

Tragically, on February 29, 2024, Ben was brutally murdered while treating a patient in El Cajon, CA, in a senseless act of hate. From this devastating loss, we created Hearts Over Hate (HOH)—a nonprofit dedicated to supporting victims of violent crime and bringing people together through community events, music, and acts of love.

In my grief, I discovered the best way to honor Ben was to continue his dream. On July 1, 2025, we launched LuvLine, carrying forward both his passion for dentistry and his commitment to humanity. Each package includes a heartfelt love note, encouraging kindness and compassion. And to ensure HOH continues to flourish long after we are gone, every purchase contributes to its mission—while also providing floss donations to underprivileged patients at local free dental clinics.

In just three months, LuvLine has already donated nearly $3,000 to Hearts Over Hate and supported a San Diego clinic offering free dental care. What began as a product has grown into something far greater: a bridge of connection, resilience, and hope.

What I didn't expect was how much this project would give back to me. Each note, story, and message from someone who uses LuvLine has been like a thread of light. People share how they feel connected—not only to their oral health, but to something deeper: a choice for kindness, compassion, and community.

The dental community has always been like family to me. Together, I believe we can continue to build something beautiful—one smile, one thread, one act of love at a time.

If you are interested in supporting LuvLine, please feel free to email me at hilda@luvlinefloss.com—I would be happy to drop off brochures for your office.

We also offer bulk pricing for dental practices, while patients can conveniently purchase LuvLine directly from their dentist, on Amazon, or at www.luvlinefloss.com.

With gratitude,

Hilda Sadigh Harouni, RDH

Jack Harouni, DDS

info@luvlinefloss.com

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LUVLINE FLOSS

Dental Bites
A Slice of History

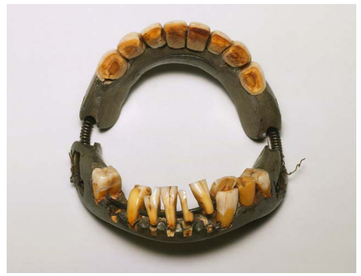
Written by: Eric Shapira, DDS, MAGD, MA, MHA, Factes Editor

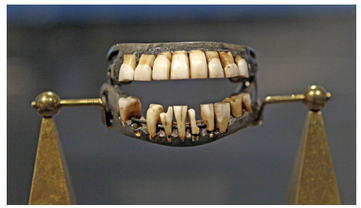
Poor Ol' George...

The first president of the United States of America was George Washington. Rumors had it that he was plagued with illness, but highest on the list were his oral health issues. Apparently, rumors abounding created myths about Ol' George wearing wooden dentures. This author has had the privilege and opportunity to see those initial teeth in the Temple University School of Dentistry's Dental Museum. They were Ivory from elephants or hippopotamuses; Metal of gold, silver, and copper; Human teeth, both his own and those purchased from others, and animal teeth from cows and horses. All fixed with gold and silver wires to help hold them in place. Mr. Washington suffered from severe dental problems throughout his life.

Ol' George apparently used dental powders of unknown origin and a toothbrush with very hard bristles to clean his mouth, but loss of his teeth continued to persist. For a person of such stature and consciousness of his appearance, his dilemma caused him great discomfort, physically and mentally throughout his lifetime. Mr. Washington was fraught with tuberculosis as well as dental disease from what we know of him. He was a great Founding Father of our Country, General of the US Army, and Stateman... but unfortunately, a dental nightmare.

Sadly, George Washington never smiled! He was very tightly lipped, possibly due to a poor self-image with respect to his smile, only showing a thin upper lip of his own. I am thinking that the motto, "Loose lips sink ships," might have stemmed from him or his dental history and not Admiral John Paul Jones of the Continental US Navy.





UPCOMING EVENTS!

LOOKING AHEAD TO **2026**

Something New COMING IN 2026

In collaboration with dental industry professionals, we are proud to introduce the Dental Business Series, a new initiative designed to strengthen the business side of dentistry. This series will cover key topics related to building and growing a successful practice, supporting the profession, and creating a sense of community through networking and shared learning.

Each series will feature a mix of continuing education and mixers. Members can enjoy food, connect with colleagues, and earn continuing education credits. Sponsors will share insights from their areas of expertise, bringing real-world experience to each discussion.

SAT JAN 10
3 CE Courses in a Day: DPA, IC, BLS
9:00 AM - 5:45 PM | Free for Memers!
Westpac Health Partners | 5280 Carroll Canyon Rd. Suite 300, San Diego

THU JAN 22
22nd Annual Dental Practice Transition Update Seminar for Future Sellers
6:30 PM - 9:00 PM | Ignite Sparked
4747 Viewridge Ave, San Diego

THU FEB 12
OSHA Webinar
6:30 PM - 8:30 PM

WED FEB 25
Dental Business Series*
Time and Location Coming Soon!

SAT MAR 07
Spring Shredding & E-Waste
9:00 AM - 12:00 PM
Encinitas Pediatric Dentistry & Orthodontics, 135 Saxony Rd. #200, Encinitas

THU MAR 19
BLS Renewal for Healthcare Providers
5:30 PM - 9:30 PM | Location Coming Soon!

SAT MAR 25
Dental Business Series*
Time and Location Coming Soon!

THU MAR 26
Cut Your Teeth
6:30 PM - 8:30 PM | Location Coming Soon!

SAT APR 25
Women's Retreat
11:00 AM - 2:00 PM | The Prado at Balboa Park

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HERE'S WHY IT SHOULD BE:

- Maximize Referrals
- Important Communications & Industry Updates
- Directory Listings
- Networking & Leadership Opportunities

ACTIVE

RETIRED

sdcdentalsociety

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Economics VS. Ethics

Written by:
Ronald Garner, DDS
SDCDS Ethics Committee Chair

I have been a member of our county Ethics Committee for 18+ years and chairperson for over 10 years. I have been in general practice for over 4 decades and am nearing the end of my career. I have seen many changes occur in dentistry over that time. I am disheartened by the extreme debt load placed upon many of our early-career dentists. It is not uncommon to see debt services ranging from $750K to over a million dollars just to start a practice and pay for dental school or buy into a group practice. Add to that the incursion of corporate dentistry on private practice, the continued downward pressures from insurance companies on reimbursements, and the ever-increasing rise in governmental regulation and costs. The pressure on young dentists to meet these debt service loads has never been seen before. The result forces dentists to produce or perish. Many times, this leads to the development of extensive and expensive treatment plans and costs that many patients cannot afford.

I see two to three patients a week for 2nd opinions, where the chief complaint is excessive treatment needed and total confusion as to why. When I offer 2nd opinions, I educate the patient rather than degrade the previous dentist. Educating the patient through explanation allows them to better understand the treatment recommended by the previous dentist. This is done by utilizing drawings, intraoral photos, etc. I also give the patient a brief explanation of how I read X-rays so they can see what I see and how I think. It also allows the patient to visually and mechanically understand why a particular treatment is required...or not. This allows the patient to be 'in charge' of their own treatment and removes doubt, ensuring the patient doesn't feel victimized. I give the patient ALL their options, and don't limit their choices to the treatment I want them to accept. I have found over the years that if I properly educate the patient, they will almost always choose the treatment I want them to have. This is an oversimplification, but it always works

Recently, a case came in for a second opinion involving a patient from a large group practice, where she and her husband were assigned. The wife went to the office because of an emergency. She was in pain and had swelling on the outside of her mouth in the lower left jaw. She filled out the necessary information and explained the reason for her emergency visit. The dentist saw her, reviewed her health history, and did an exam. She was then told that she needed a total of 17 crowns! The cost was $24,750! She was informed that if she signed the paperwork, they could start immediately. She was also told that dentistry had to be completed before they could treat her emergency. She was subsequently referred to my office and presented with 2 mandibular abscessed teeth (not part of the previous dental treatment recommendations). This is an extreme example of the many cases I see.

With all that I just mentioned, I still have to reflect on why I chose dentistry as a profession. I will direct your attention to the various subsections of the CDA Code of Ethics, ADA Principles of Ethics, and Code of Professional Conduct Manual:

Autonomy the patient has self-governance over their dental care and their bodies

Beneficence our primary objective is service to the patient and to minimize harm and maximize benefits

Compassion identify with the patient's oral health needs

Competence The ability of each dentist to identify, diagnose, and treat the patient's dental needs and refer when necessary

Integrity honor and decency of the dentist

Justice fairness and care to the patient without prejudice

Professionalism self-governance of our dentists and protection of the public

Tolerance practice within a wide cultural community and within dentistry

Veracity truthfulness, honesty, and trustworthiness

Practicing dentistry today is extremely challenging. My hat is off to all the young and early-career dentists who face a multitude of challenges. Dinosaurs like myself never had to contend with what is imposed on dentistry today. That being said, remember we do not have thriving practices without patients. Their interests are paramount to our success. No one is perfect, and how we rectify problems that arise with patient care and costs says a lot about our personal ethics

Many of you may not be aware that CDA eliminated the Peer Review Council, all component Peer Review Committees, and the Judicial Council. Some of the state components still maintain an Ethics Committee, but they have little or no "teeth" with respect to justice. Both Councils are being replaced with a new council: The Council on Professionalism and Mediation. The new 9-member council is in the final stages of vetting a slate of state dentist mediators. The new council will be able to address a wider range of patient and dentist complaints and ethical concerns, greater than the two previous councils. More to follow...

Oktoberfest






Peak Performance Program: Self-Care Sunday





3 CEs in a Day




SD Dental CE Conference




Check out page 19 for upcoming SDCDS events—you won't want to miss them!

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