

AP NEWSLETTER

A Publication of the Academy of Prosthodontics

Volume 91, Number 2

Fall 2009

Scientific Highlights - Chicago

by Harold Preiskel & John Zarb

The 2009 meeting in Chicago, Illinois, will be remembered for its eclectic range of topics and its unified high standard of presentations. Stem cell and digital technology featured in the presentations of Gerard Scortecchi, David Gratton and Matts Andersson, (a true scientist if ever there was one). Leslie Laing Gibbard covered the all too frequently overlooked topic of Sjogren's syndrome and its oral manifestations. It was gratifying to note that the removable prosthesis, so often the Cinderella of prosthodontics was not overlooked. Indeed, Steven Sadowsky, Carl Driscoll, John Zarb and Harold Preiskel all dealt with this important aspect of prosthodontics with overdentures featuring strongly.

Lawrence Brecht presented a 10 year follow-up on cleft palate techniques that made us humble at the life changing results achieved with his surgical colleagues. It is also encouraging to see the variety of methods available for the treatment of edentulous patients, ranging from Harel Simon, David Felton and Carl Driscoll's review of the edentulous patient restored with implants.

Those undertaking implant placement or minor surgical techniques may well be concerned by the bisphosphonate spectre. Geza Terezhalmay was able to place this problem in sensible perspective. As for the initial placement of implants, it is only one stage in prosthodontic therapy as

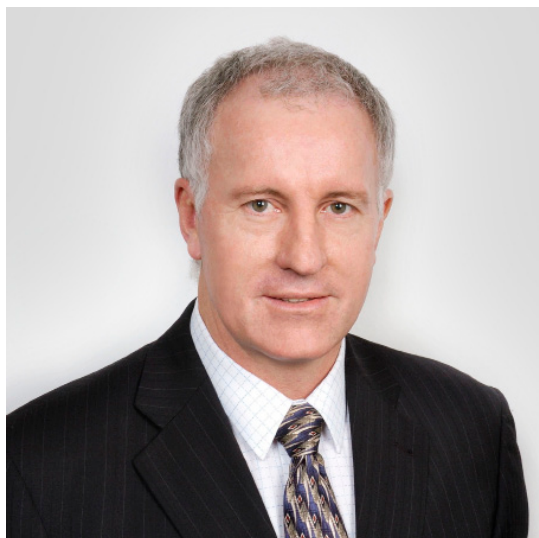
Lyndon Cooper pointed out in his discussion of peri-implant tissues.

No prosthodontic program would be complete without a display of beautiful fixed prosthodontics. Avishai Sadan and Francesco Chiappelli are to be congratulated in this respect.

There were several excellent individual papers, but the highlight of the meeting was that it showcased the current status of prosthodontics. We are now in a position to take a rational view of our latest advances, marry them with improved technology, and bear in mind the challenges facing us in the treatment of an aging population. Colleagues who attended the gathering cannot but help to have benefited from the information they received and to have enjoyed the meeting in the process.



A Crisis of Consensus



It is truly remarkable what modern prosthodontics is achieving for edentulous patients. With the recent advances that the science of dental materials, cellular biology and digital technology has forged, it has permitted even more remarkable interventions for edentulous patients. At the same time, it remains a concern that while marvelous things are achieved for what could be globally described as a privileged cohort of edentulous human beings, for all of the technology, skill and knowledge that exists, we fail to do remarkable things for the vast majority of disadvantaged people in the world requiring a prosthodontic intervention. Because of geographic remoteness, political and social disruption, poor financial resources

and limited access to professional oral health care resources; prosthodontics on a truly global level fails miserably to provide even rudimentary prosthodontic care for so many. Is prosthodontic care to remain the exclusive province of the financially and socially advantaged? Will the specialty of prosthodontics be relegated to relative global irrelevance due to its inability to address this worldwide need?

Ophthalmic surgeons with desire and will can provide cataract surgery to the needy masses of remote and disadvantaged communities and restore sight for as little as \$25 per patient (hollows.org.au). In these circumstances, one could reasonably assume that if sight restoring surgery can be provided for resource poor and disadvantaged communities, surely it is possible for prosthodontics to respond to the challenge of providing world standard care to edentulous persons who live in remote and disadvantaged communities.

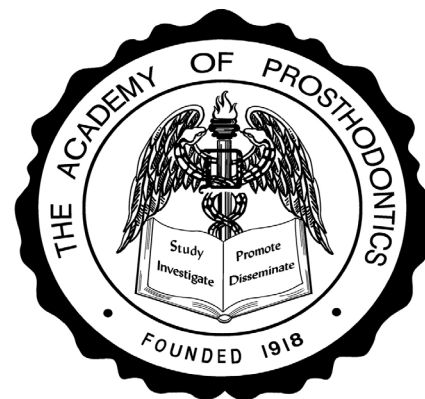
At the International College of Prosthodontists meeting held in Cape Town in September 2009, Owen and MacEntee

presented a reinvigorated protocol for the provision of complete dentures in three clinical sessions employing a mix of interdependent clinical and technical procedures. Owen while discussing the notion of standard of care has previously addressed this global challenge (IJP 2009;22:328-30)

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Secretary-Treasurer Notes

by Sreenivas Koka



I would like to thank the Fellowship for the privilege of being elected as the Secretary-Treasurer of the Academy. In the years ahead, I hope that I can repay your trust in me and give the Fellowship no cause to regret this decision. I would like to offer special thanks to Steve Eckert who preceded me as Secretary-Treasurer and Recording Secretary for his continuous guidance as I have assumed these two positions. I am very fortunate to have his advice which will hopefully lead to me making fewer novice mistakes and for this I appreciate his generosity and wisdom.

There are two main Secretary-Treasurer related goals for the upcoming year. First, is a move towards credit card payments

for dues and meeting registration fees about which more is discussed below. The second pertains to the cost of our annual meetings and taking on a general philosophy to run a mostly “balanced budget” meeting, by which I mean that our main dinner and outing costs are essentially covered by the registration payments of Fellows and guests. I use the term “mostly” because some meeting costs like the

spouse’s hospitality breakfasts, coffee/sodas/snacks for the breaks, breakfasts for the New Fellows, the Life-Associates luncheon, etc are absorbed by the Academy and not passed onto individual Fellows. A significant advantage of balanced budget events is that all corporate sponsorship monies could be put towards enhancing the financial position of the Academy and supporting activities that are foundational to the mission of the Academy. One disadvantage of balanced budget events is that sponsorship monies would not be used to defray costs associated with dinners and outings. However, I believe that the recent economic crisis has made it clear that reliance on sponsorship monies to cover meeting costs is more risky than is best for the

Academy. I also believe that being fiscally prudent, and not becoming too comfortable with the thought of using corporate monies to partially fund our activities, is an important goal. To that end, negotiations will take place with meeting hotels to keep costs down so that Academy Fellows need not be overly burdened with meeting expenses. It is my hope that the Hyatt Tamaya will be an example of balanced budget dinners and outings while ensuring that costs to participate in these events are no higher, and perhaps a little lower, than the

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AP Foundation

Contributions and
memorials should be made
to the

Academy of Prosthodontics Foundation

and sent to:

Clifford VanBlarcom DDS MSD
6834 Linden
Prairie Village, KS 66208

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and recommended a Minimum Acceptable Protocol (MAP) for all prosthodontic interventions which describes a set of principles that allow resources and therefore treatment to be adapted to those principles. Owen goes into detail to separate the distinction between his advocated MAP and the internationally confusing term “standard of care”. Prescribing a specifying treatment intervention as a “standard of care” for a particular disability has been previously demonstrated by Fitzpatrick to be potentially harmful for patients and practitioners alike. (JPD 2006;95:71-8) Recommending a universal and specific treatment regimen for a particular disability does not consider patient preference, financial and professional resources, cultural and geographic variation and implies that alternative interventions are inferior or possibly harmful and therefore negligent. Embracing the principles of MAP more closely approximated the universally accepted principles of evidence based practice which in part states; “Evidence-based dentistry (EBD) is an approach to oral health care that requires the judicious integration of systematically relevant scientific evidence,

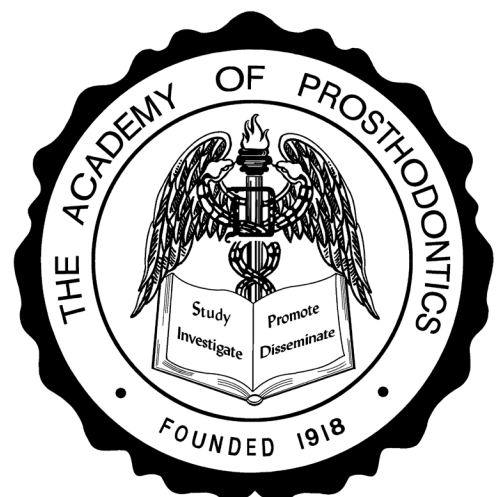
relating to the patient’s oral and medical condition and history, with the dentist’s clinical expertise and the patient’s treatment needs and preferences.” (www.ada.org/prof/resources/positions/statement/evidencebased) Fitzpatrick (2006) and Owen (2009) challenged the McGill Consensus Statement (IJP 2002;15:413-4) on the mandibular two-implant overdenture on these grounds. Recently the York Consensus Statement (BDJ 2009;207:185-6) reinforced and effectively restated the McGill statement. Benevolence and a strong sense of paternalism can be perceived behind these consensus statements and standard of care determinations by the authors of each document. However, in each instance the statement fails to define the population it purports to serve, in what circumstances the recommended intervention be applied and does not account for patient circumstances or preference. These consensus statements were each released by small invited focus groups following a symposium on the efficacy of implant-supported mandibular overdentures in the edentulous mandible.

Implant overdentures introduce elevated risk due to the need for surgical intervention and increased

cost, each of which is clearly going to eliminate a large cohort of edentulous patients in any community from access to this specific intervention. Unless prosthodontics can rise to the challenge presented by our ophthalmic surgeon colleagues and reduce cost and surgical risk to compelling levels, large numbers of edentulous citizens will be denied access to a mandibular two implant-supported overdenture as a first choice intervention regardless of its proven efficacy in specified cohorts of patients.

The McGill and York symposia did not study the disability of mandibular edentulism but rather focused exclusively on a specific intervention (mandibular two implant-supported overdentures) designed to restore function and quality of life for persons with this affliction. Each statement resulted from a thorough review of the relevant

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Secretary-Treasurer Notes

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previous year. This ambitious goal is somewhat challenged by the resort nature of our meeting site where one always pays “a premium” for the resort experience. Nevertheless, we have a target at which to aim and let’s see if we can attain it.

Secretary Notes:

Fellowship:

New Fellows/Fellowship issues: At the second business meeting in Chicago, the following individuals were voted to new Fellowship categories:

New Life Fellows: None

New Active Fellow: Brian Fitzpatrick

New Associate Fellows: David Bartlett, Radek Mounajjed, Thomas Salinas and Arun Sharma

Updating contact information:

Please send all change of address or contact information to me at koka.sreenivas@mayo.edu so that our database may be updated. Simultaneously, please send the same information to Peter Stevenson-Moore at stevenson-moore@shaw.ca so he may update the AP website.



After a week of cool rainy weather the clouds cleared and allowed the Academy to enjoy a wonderful architectural boat tour exploring the Chicago River with many of Chicago’s famous old buildings forming the gallery walls of this historical open air river art gallery. The trip started below the Michigan Avenue bridge and a narrator took his audience on an historical journey of the Chicago skyline. Our historian discussed the many styles and eras of highrise architecture in Chicago for which it is internationally renowned. Highlights were the Sears Tower and Hancock Building, each the tallest buildings in the world at one time. The tour proceeded up and down the river before venturing toward the lock that permits access into Lake Michigan. The boat passed through the lock into a calm and windless Lake Michigan with the entire Chicago skyline unfolding before us as the boat retreated from the shore.

While most guests retreated to the warmth of the lower cabin, those more intrepid who ventured to the open upper deck with beverage in one hand and the other thrust deep into a jacket pocket, were richly rewarded for embracing the chilly clear atmosphere. The cool served to heighten one’s senses to the beauty of this internationally famous skyline. The boat cruised up and down off the city shoreline of Lake Michigan before passing the Navy Pier to return up the river for a bus trip to the Chicago Zoo. At the Lincoln Park zoo the group enjoyed drinks and dinner in the famous “cat house” amidst the roars of lions, tigers and other big cats. None of the cats seemed overly disturbed by our presence and a unique experience was enjoyed by all who availed of the organizational hard work of the local arrangements committee. Once again much thanks to the diligent work of the creative local arrangements committee.



AP Outreach - Short History

by Eric Rasmussen

In 1940 the Academy embraced the words; study, investigate, promote and disseminate as a succinct mission statement. These words were proposed for inclusion on the Academy seal where they still resides today. The principals have guided the organization throughout the years. In 1995 in Crystal City, VA the Academy of Prosthodontics revisited and developed a mission statement that continues to serve us today.

The Academy's missions are:

1. to promote the art and science of prosthodontics to the profession and the public and disseminate knowledge concerning prosthodontics throughout the profession,
2. to encourage study and investigation of the various phases of prosthodontics and related subjects
3. to provide and conduct outreach services to the community in need.

This third statement led the Academy to establish a community outreach committee. The Executive Council decided to provide prosthodontic services to a population that demonstrated extreme need. Those fellows familiar with public health dentistry through their years of service at The Indian Health Service suggested a possibility. A proposal was presented to The Indian Health Service for volunteer prosthodontic care and there was immediate response from The Carl Albert Health Center in Ada, OK. The staff prosthodontist informed the Academy that there was a population of nearly three thousand patients that had to wait more than three years to get an appointment for denture service. This Indian Health Center is the location of the regional dental laboratory which made this project site more desirable.

In August of 1993, 8 academy fellows and 1 guest technician were invited to provide clinical care to 30 patients. Sixty complete dentures were completed in one week with the help of their very dedicated dental technicians. The initial success has been built upon to bring us to 16 consecutive years of volunteer service. The Indian Health Service facilities were chosen for this type of service because they fit the criteria and permit the foundation to perform these services efficiently. Criteria include:

1. Need was demonstrated.
2. Temporary credentialing for oral health care workers was possible without involving an intra-state licensure.
3. Each health center has modern facilities and usually some dental laboratory space.
4. Most importantly, there was a possibility for expense sharing while delivering these denture services by providing accommodation and meals for workers at these sites.

Costs:

Initially, the entire expense of the outreach archives were born by the Academy of Prosthodontics Foundation with seed money coming from the foundation, the Editorial Council of the Journal of Prosthetic Dentistry and donations from individual fellows of the academy. The average cost of an outreach project is \$5,000. Accounting for all the projects has been difficult. Some IHS clinics reimburse the AP participants on a per diem basis and arrange airfares through government booking agencies. Other clinics reimburse the APF after the project is completed based on the participant's incurred expenses. When the APF receives the total reimbursement check, it pays the participants

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literature on the efficacy of the implant-supported mandibular overdenture in the edentulous mandible. Rather than coming to a measured scientific conclusion that endorsed the efficacy of the intervention, each claimed that the evidence supports the conclusion that a two-implant supported overdenture should be the minimum offered to edentulous patients as a first choice of treatment. Each consensus statement then reached a little further by referring to this intervention as the first choice standard of care.

Koka (Editorial – IJOMI 2008:23(2);179-80) made the point that; *“Patients routinely rely on us to provide them with information that represents evidence-driven best practice. Given that the scientific dental literature is growing rapidly and presents a daunting challenge to assimilate, this responsibility is potentially overwhelming. We are at the mercy of the peer-review process to provide an adequate level of scrutiny to meet appropriate scientific standards.”* Koka goes on further to state; *“.. despite the best of intentions, papers will occasionally be published that reach too far with their conclusions. If such a paper were to receive considerable attention without challenge, the consequences for clinical practice could be detrimental for patients and practitioners making decisions regarding therapy.”*

The McGill Consensus Statement has received considerable international attention and has been widely referenced in the literature and accepted as a “true” universal statement by many professional organizations, providers of oral healthcare, third party healthcare funders and by legal practitioners in courts of law. Consensus statements fall low on the hierarchy of scientific evidence. Such statements fall into the category of opinion and should be weighted accordingly by those who choose to use this information when making clinical decisions or recommendations. Simply because the persons or organizations offering such opinions based on a selected review of the scientific literature are remarkable and esteemed, does not necessarily elevate the science supporting these opinions to a higher level on this established hierarchy.

A consensus statement is a comprehensive analysis by a panel of experts (i.e., consensus panel) of a scientific or medical issue. A consensus statement is developed immediately after a consensus conference at which presentations are made on the issue under review. The statement represents the panel’s collective analysis, evaluation, and opinion based, in part, on the conference proceedings. In reviewing the background and parameters of investigation for each of the McGill and York Consensus Statements and in light of the far reaching conclusions that were drawn, bias was immediately introduced since each symposium did not review the disability of mandibular edentulism or all available treatment interventions. Further bias exists by virtue of the fact that each group is a self appointed focus group without a global mandate to represent all prosthodontic stakeholders (gradu-

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It is no longer a secret!



Academy of Prosthodontics 92nd Annual Scientific Session

Hyatt Regency Tamaya
Resort and Spa
Santa Ana Pueblo, New Mexico

11-15 May 2010



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ate students, clinical prosthodontists, prosthodontic researchers and edentulous patients). Consensus by recruitment cannot be universal which the York Consensus Statement readily acknowledges in the abstract. Each statement has passed the rigor of the peer review process, the authors are substantially remarkable clinicians and researchers and each statement has been published in prestigious journals thus ensuring considerable attention.

The entire notion of a consensus statement is a response to general confusion regarding a scientific topic for which high level science is lacking as a clinical direction indicator for clinicians. The need for a consensus statement arises when clinicians or scientists desire guidance on a subject for which there is a relative deficiency of comprehensive evidence that might otherwise allow for a more definitive statement to be made. All conclusions must therefore be based on the evidence reviewed and avoid the temptation to “*reach too far*”.

One must assume that the authors of the McGill and York Consensus Statements acknowledge these facts and accepted this as a prime motivating factor behind the organizers’ recruitment of the experienced clinicians and researchers responsible for producing each statement. In each instance, there is sufficient evidence to form the view that the authors have “reached too far” in their conclusions and recommendations.

In order to avoid the potential for harm to flow from such unchallenged “consensus statements” and “standard of care” determinations, each of these issues requires universal agreement with approved guidelines in relation to the boundaries for such statements and their conclusions. For this to occur within the sphere of prosthodontics, a mandate needs to be sought by organizations that have a proven reputation of global credibility and are structurally capable of seeking and meeting this obligation. Organizations such as the Academy of Prosthodontics and the International College of Prosthodontists could meet these criteria due to demonstrated track records in these areas. The AP has developed a glossary of prosthodontic terms which has received global acceptance and the ICP has the infrastructure to represent prosthodontists from a global sphere of research, teaching and clinical experience. Each organization also has a significant stake in two of the professions’ major international prosthodontic journals.

Our edentulous patients need to be treated with the highest levels of professional dignity and respect. Patient choice and valid consent remains the measure by which a true healthcare professional will ultimately be judged by peers, patients and dare we mention it, courts of law.

Is prosthodontics mature enough and global enough to meet such a challenge and ensure continued relevance to all stakeholders?

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from the deposited funds.

If a private company (Straumann) dedicates funds for a specific project, the APF holds the funds in escrow until the project expenses are calculated and dispersed. If unused funds remain, these are kept in reserve to be used in subsequent years.

The University of Connecticut uses department funds to offset travel expenses to AK and the APF pick up the remaining balance of expenses from other donated funds dedicated to outreach projects. Clinic staff members sometimes provide accommodation for project volunteer in their own homes or the tribal housing authority permits the use of vacant houses. Generally the expenses to the Academy are low but the future is uncertain and fund raising continues to be a necessary activity. Expense reporting to the Outreach Committee by participating teams has been unreliable even with online reporting forms available. It would be possible to manually reconstruct the complete financial history of APF deposits and disbursements with 20–30 hours of diligent paperwork. The digital book-keeping program is only a recent development and will

streamline financial reporting. The APF has retained all previous financial records and is a tax-exempt 501(c)-3 corporation (#87-6119459)

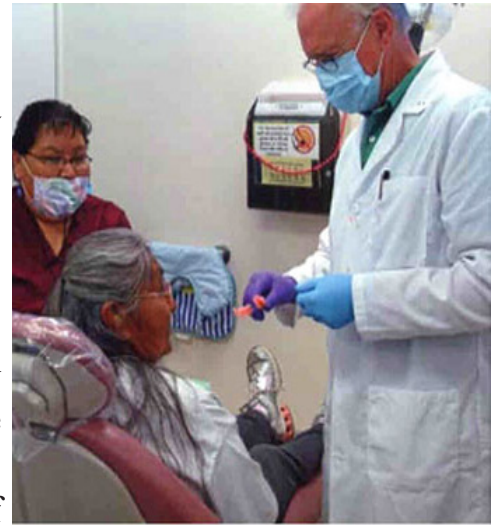
Site selection:

As the work of the AP Outreach committee progressively became known throughout the Indian Health Service, requests were made to assemble a list of other potential IHS sites. Key criteria for selecting a potential site include:

1. The foundation chose sites that allow access within a reasonable time frame and the IHS clinics were in a position to reimburse the APF for expenses.
2. The site would close most of its dental clinic to facilitate the delivery of these denture services over a one-week period.
3. The local dental staff would be available for assistance and provide the necessary clinical support for this type of project.

Recruiting:

Recruiting volunteers has been rewarding. The AP Foundation is very grateful that laboratory technicians have been able to help so consistently. The best arrangement for a one-week denture project is to have one technician for each prosthodontist. The APF receives numerous offers from academy



fellows, guest dentists, graduate students and technicians to participate in future projects.

The academy fellows continue to be very supportive of these projects with many are willing to participate on an annual basis. There are some fellows who cannot participate directly but are very generous with their encouragement and with the procurement of essential used dental equipment. Much of this type of equipment can be left at projects for future use. It is necessary to keep recruiting new volunteers to the projects to allow this fellowship experience to spread through the entire organization.

Funding:

The generosity of private foundations has helped considerably with the initiation of the project and with the ongoing survival of these denture clinics. Academy fellows have been very generous with

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their financial donations and a number of fellows have donated equipment. Private foundations namely; The Dorothy Snyder Foundation, the Editorial Council of the JPD and the APF have had a significant impact on the ability for the various projects to get started but frequently have a limited time frame for which the grants are available. Most non-profit charitable foundations offer financial support conditional on it being used as a stepping stone to increased self sufficiency.

It is interesting to note that one of the questions the charitable foundations frequently ask is if 100% of Fellows provide direct support to the projects. These benefactors show greater interest in providing help if there is unanimous support for charitable work the organization is performing

Private Industry Donations:

A wide range of dental supplies is needed to produce complete dentures. Larger dental supply companies have recently changed their customary business practices and one of our largest suppliers of teeth (Dentsply) has now stated that while they believe our projects are worthwhile, they are no

longer able to provide supplies to all projects. Ivoclar International is now providing us with a number of sets of teeth for these projects and their generosity is appreciated at this crucial time in the development of these APF outreach projects.

Miscellaneous supplies have been provided to outreach projects by dental supply houses (Patterson) at cost, which has also helped to offset the expense of funding these projects.

Travel Expenses:

Travel Expenses have been the largest outlay for outreach projects. Some participants in the various teams have donated tickets and frequent flyer miles to aid these projects. The intention of the committee is to have individual teams request invitational travel expenses from each site. These funds are sometimes available depending upon the financial circumstances of the regional authority.

Urban Projects:

The APF supported one project in an urban setting at the University of Illinois in Chicago. This project worked quite well since credentialing was not necessary due to the legal ability of the university to permit guest faculty perform clinical procedures and continuing

education courses. This is an area where further work could be contemplated. However, the high cost of accommodation and meals in urban settings generally prohibits the foundation from exploring this on a regular recurring basis.

Outreach projects resemble the early style of academy meetings. There is much discussion and clinical demonstration while the various procedures are being performed. The staff at the clinics and the local professionals contribute to a very lively exchange of dental ideas. Under some circumstances, Academy Fellows with university affiliations are able to provide the participants and observers with continuing education credit. This is a noteworthy possibility the academy may consider pursuing more actively in an attempt to attract more members to participate.

ADA Geriatric Oral Health Care Award:

In 2004 the American College of Prosthodontists nominated the APF for an ADA national award to recognize the outstanding achievements of the AP Community Outreach Committee. A cash reward and a plaque were presented to the APF president at the annual ACP meeting in Ottawa.

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The Future:

To continue the projects at the present site is highly likely. With more support from local sites and additional outside support, it could be possible to increase these projects to greater than the 3-4 projects completed each year. The committee is always open to new ideas, suggestions and innovations for delivering denture service.

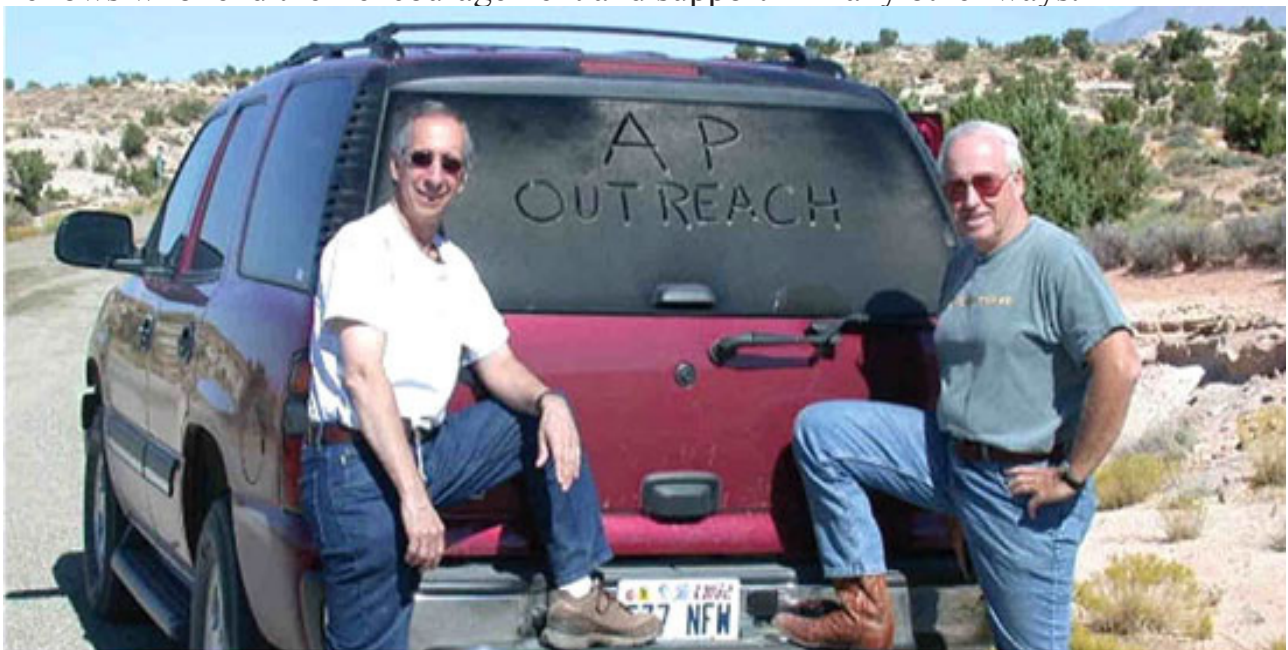
Summary:

During the past 16 years, 11 Indian Health Service clinics and 1 urban site in 9 different States have been visited. 52 individual projects have been completed providing treatment to 811 patients totalling 1,444 individual prostheses. To date 110 volunteers have participated. 37 fellows, 52 guest dentist and 21 technicians have served in a very dedicated way, some returning multiple times to help with the outreach projects.

The value of the projects can be calculated in any number of ways. If a figure of \$1,000 per prosthesis is used, 1.4 million dollars of service has been provided. The financial impact on the individual sites is significance since they would not ordinarily be able to provide this type of service for that number of patients given their budgets. The value of the service to the individual patient is intangible. The casual observation indicates it is a great boost to the individual patient, their family and also their community.

The Academy of Prosthodontics has promoted the awareness of the specialty and provided a needed service to a neglected segment of the population. We must sincerely thank the IHS clinics and their employees for their dedication and generosity in undertaking these projects.

Also we are grateful to the technicians that provide us with the essential laboratory services enabling the prosthodontists to provide more denture services per one week project. We owe a debt of gratitude to the guest dentists, graduate students and finally the fellows who participate and those fellows who lend their encouragement and support in many other ways.



AP Outreach - Historical Site Summary

Site Location & Year(s) of Visits	Number of Visits Per Site	Approximate Cost for Materi- als Donated	Number of Denture Units	Number of Treated Patients
Polacca, Arizona 07,08	2	\$5,000	56	32
Ada, Oklahoma 93,94,94,95,96	4	\$8,000	145	77
Browning, Montana 94,95,96,97,98,02,03,05,06,07,08	11	\$20,000	222	114
Fort Duchesne, Utah 95	1	\$1,800	32	16
Juneau, Alaska 95,96,97,98,99,00,01,02,03	9	\$13,500	250	132
Sitka, Alaska 04,05,06,07,08	5	\$11,000	123	64
Okmulgee, Oklahoma 97	1	\$1,200	32	16
Chicago, Illinois 97	1	\$1,000	24	12
Pine Ridge, South Dakota 98,99	2	\$2,600	92	49
Arapaho, Wyoming 05,06,07,08	4	\$13,371	136	88
Montezuma, Utah 00,01,02,03,04,05,06,08	8	\$11,000	256	159
Macy, Nebraska 05,06,07,08	4	\$10,000	76	52
All Totals to the End of December 2008				
TOTALS:	52	\$98,471	1,444	811
1993 - 2008 = 16yrs 52 Projects	37 Fellows	21 Technicians	52 Guest DDS and Gradu- ate Students	110 Total Volunteers