Is Prophylactic Removal of Wisdom Teeth A Public Health Hazard?

Evidently!

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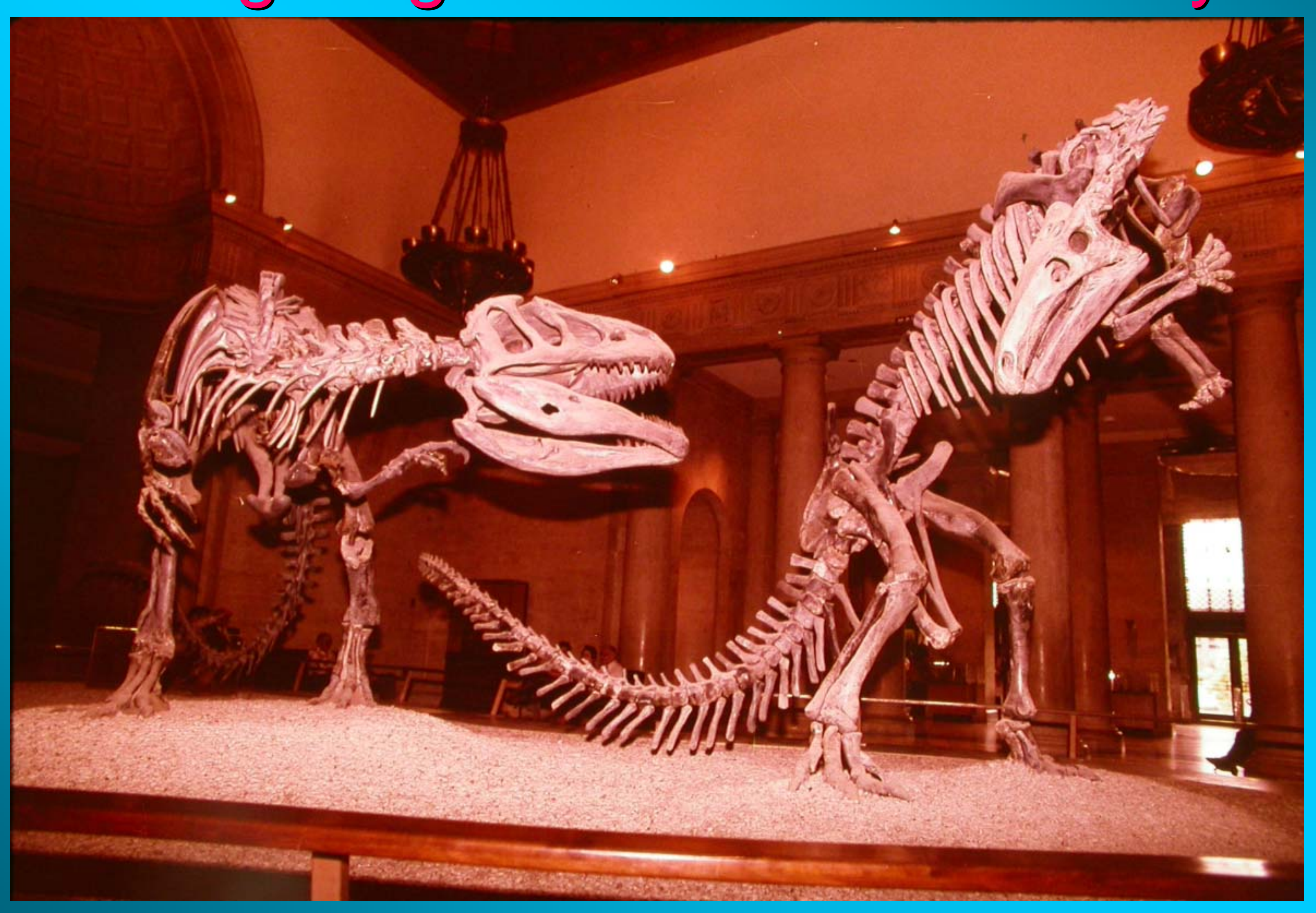
Evidence Based Practice
Relegating Predators to Posterity



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The Public Needs to be Informed

We have an obligation – as public health and consumer advocates – to inform the public of the hazards of treatment that is not Evidence-based.

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The Most Common FUN (*Functionally Unnecessary*) Extractions

Removal of normally erupting, erupted or unerupted asymptomatic, nonpathologic third molars.

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Creating & Perpetuating The Myths

AAOMS at Work

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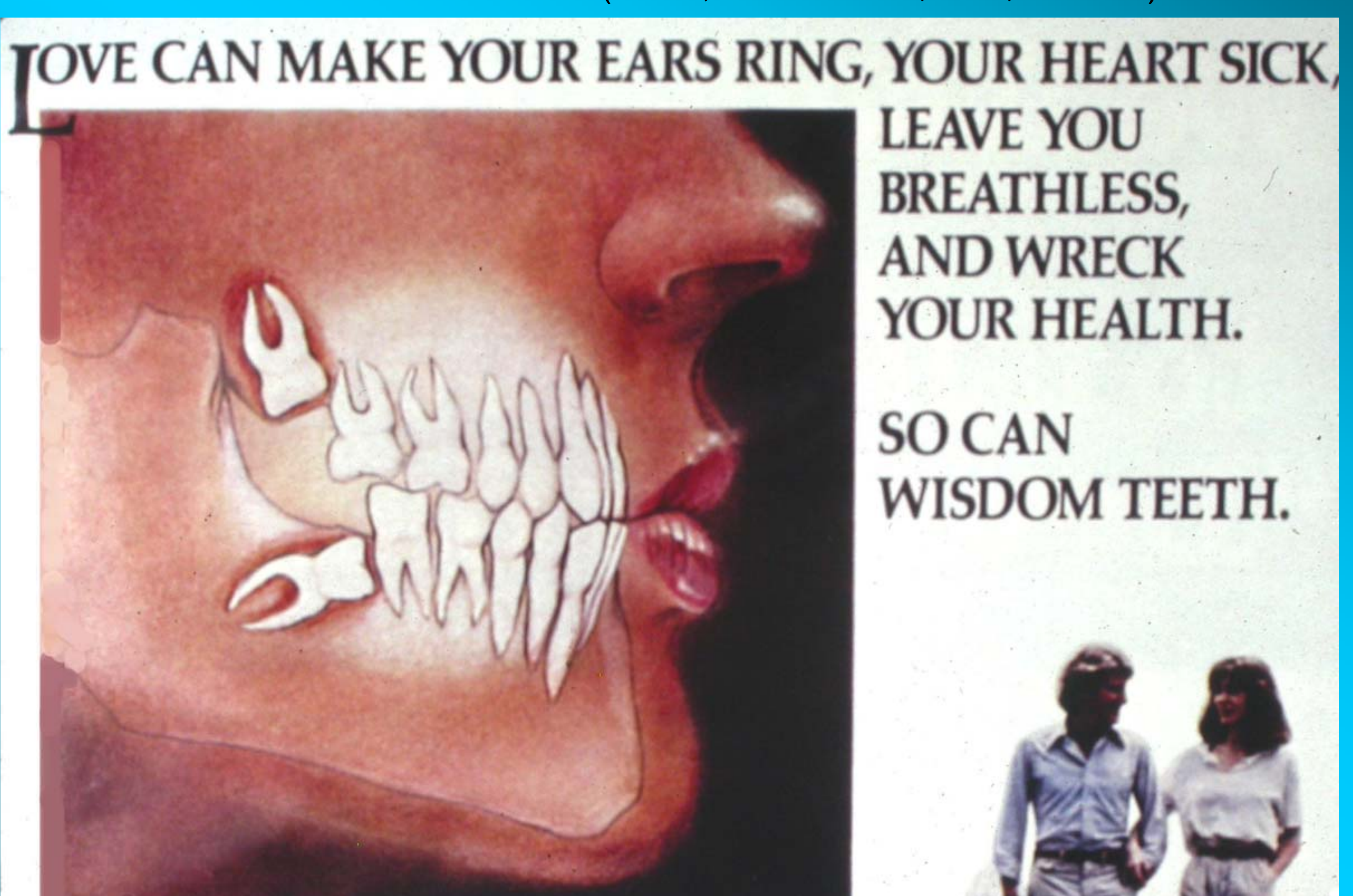
“Trouble with a Capital T”

AAOMS Advertisement (Time, Newsweek, etc., **1981**)



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Time Bombs

"Most wisdom teeth are like little time bombs. The question isn't will they go off,

it's when."

The Same Advertisement

AAOMS Advertisement (Time, Newsweek, etc., **1981**)

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"Trouble with a Capital T"

"nine out of ten wisdom teeth come in only partially, and worse, crooked….

- Not to mention serious gum infection…
- unnecessary ailments…
- ringing in the ears…
- all the way to heart disease."

The Same Advertisement

AAOMS Advertisement (Time, Newsweek, etc., **1981**)

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2005

AAOMS Pamphlet*: **“Wisdom Teeth”**

“No one can predict when third molar complications will occur, but when they do, the circumstances can be much more painful and the teeth more difficult to treat.

It is estimated that about

85% of third molars will eventuallyneed to be removed.”

*Wisdom teeth [pamphlet]. Rosemont, Ill:American Association of Oral and Maxillofacial Surgeons, 2005.

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AAOMS 1 of 4-page Advertisement
USA Today (Sept. 28, 2007)

[AMOS Special Advertising Section
Advertising Supplement to USA Today
September 27, 2007]

American Association of Oral and Maxillofacial Surgeons

Oral and Maxillofacial Surgeons:

The Wisdom Teeth Experts

Oral and Maxillofacial Surgeons treat conditions, defects, injuries, and the esthetic aspects of the mouth, teeth, jaws, and face, including the chin, nose, cheeks and bones around the eyes.

They complete four years of dental school and a minimum of four years of training in a hospital-based surgical residency program that includes extensive inpatient and outpatient anesthesia training.

Their specialized surgical expertise, along with a thorough understanding of both esthetics and function, uniquely qualify Oral and Maxillofacial Surgeons as wisdom teeth specialists.

INSIDE

A GUIDE TO WISDOM TEETH HEALTH

Wisdom Teeth ~ RESEARCH

Pain free does not necessarily mean disease free.

What are impacted wisdom teeth...
and why are they a health problem?

Top Ten Health Reasons
to remove your wisdom teeth

Peace of Mind.

Normal and impacted wisdom teeth

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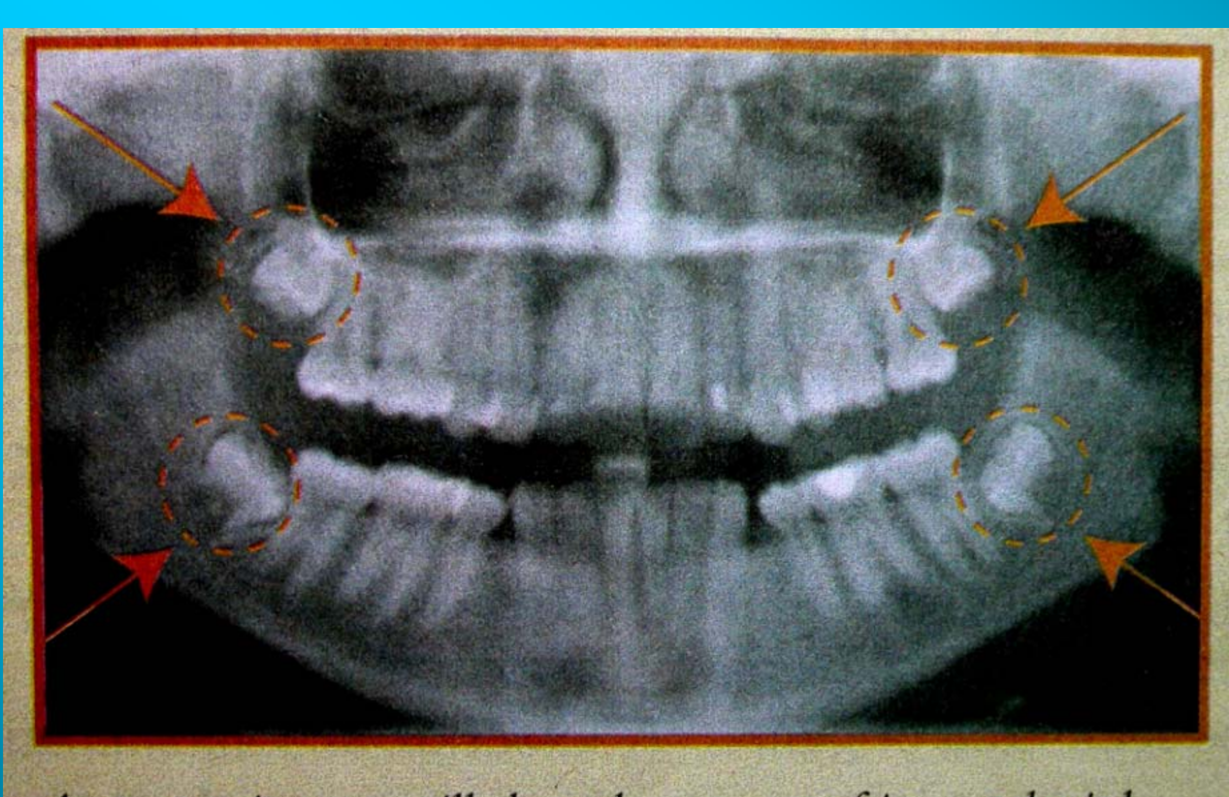
Same Adv: True & False

A Pan will show Impacted Teeth- But These are not Impacted!!



A panoramic x-ray will show the presence of impacted wisdom teeth and any problems they may present for neighboring teeth, the jawbone and other structures.

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AAOMS Adv Page 1 Sidebar (Sept. 28, 2007)

Top 10 Health Reasons to Remove Wisdom Teeth

10. “difficult to keep clean”
9. “contribute to…low birthweight”
8. “rarely…meaningful function”
7. “develop…cysts and/or tumors”
6. “With age...[extraction] complications increase”
5. “receding gum tissues, deterioration of the jawbone and tooth loss”
4. “contribute to crowding of nearby teeth”
3. “breeding ground…contributing to…diseases”
2. “early removal…faster and easier recovery”
1. **“Peace of Mind”** [emphasis added]

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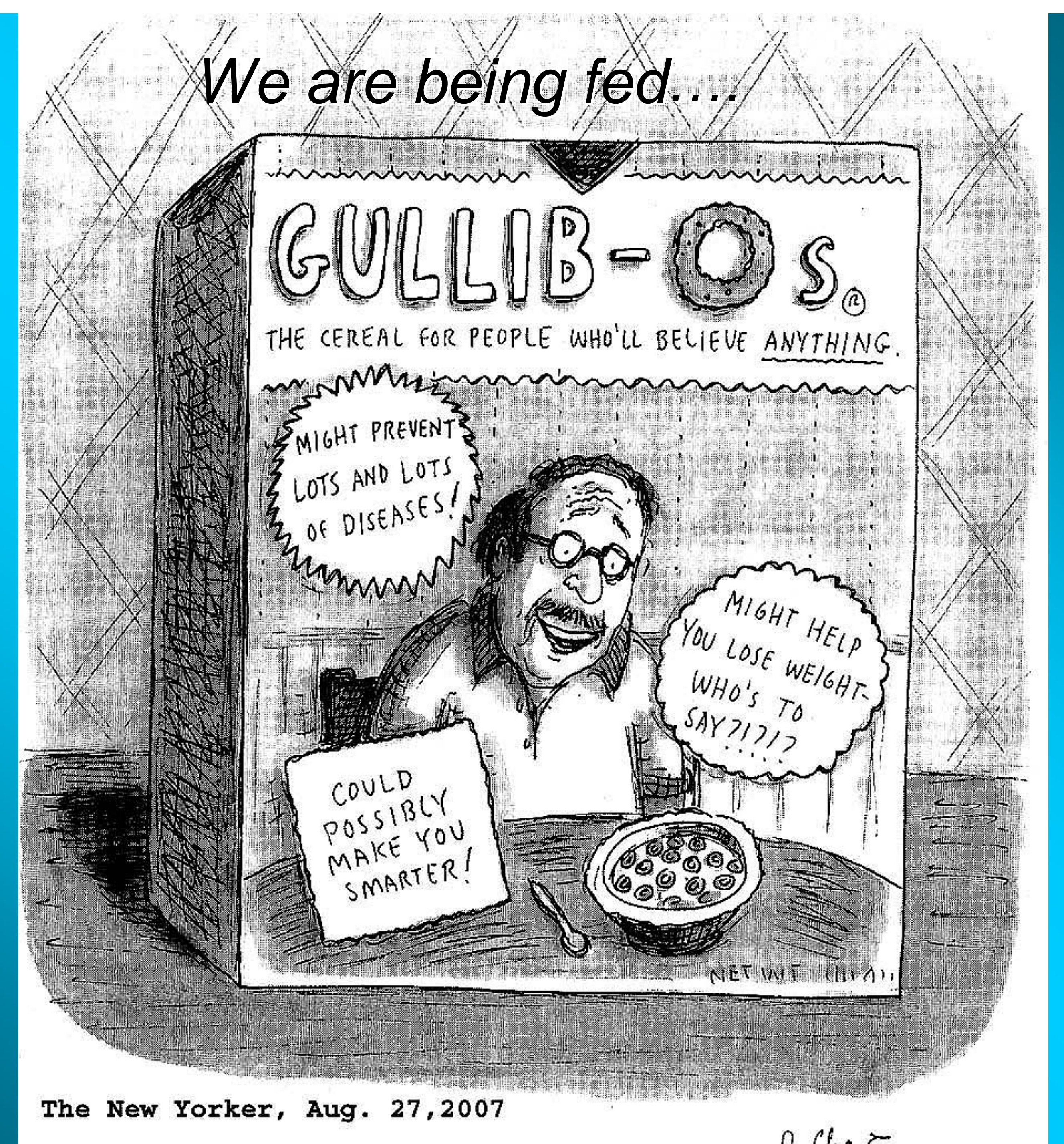
We are being fed….



The New Yorker, Aug. 27,2007

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False & Misleading Advertising?

Should not the same Truth in Advertising apply to all health professions?

Not one word on Risks of Surgery.

Commercial Advertisements For Drugs, in Print/TV list adverse effects and contra-indications.

Why Not AAOMS?

Because… **money, money, money,,,,**

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2007 Update: The American Association of Oral and Maxillofacial Surgeons:

"…if there is insufficient…space to accommodate normal eruption….***removal of such impacted third molar teeth at an early age is a valid and scientifically sound treatment rationale based on medical necessity***." [emphasis added]

What Scientific Evidence?
What Medical Necessity?

Statements by the American Association of Oral and Maxillofacial surgeons Concerning the Management of Selected Clinical Conditions and Associated Clinical Procedures: The management of impacted third molar teeth. Rosemont, Ill: American Association of Oral and Maxillofacial Surgeons, 2007.

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Definition of Impaction

A tooth that has failed to grow into its functional position in the dental arch beyond the time normally expected for its eruption.

Normal eruption period for 3rd Molars

Age ± 16 to 25

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When an Impaction Is not an Impaction

"It seems inappropriate to define impaction as a stationary event because many impacted [sic] third molars may become erupted to the occlusal level after age 19."

Mesioangular inclination	5-10 degrees --	**76% uprighted in 4 years**
	15-20 degrees --	**64% uprighted " " "**
	25-30 degrees --	**14% uprighted " " "**

Hattab FN, et al. Third molar dilemma: an overview. Dental News 1999; 6 (3):43-47.

Hattab FN. Positional changes and eruption of impacted mandibular third molars in young adults: a radiographic 4-year follow-up study., Oral Surg Oral Med Oral Pathol Radiol Endod 1997;84:604-608.

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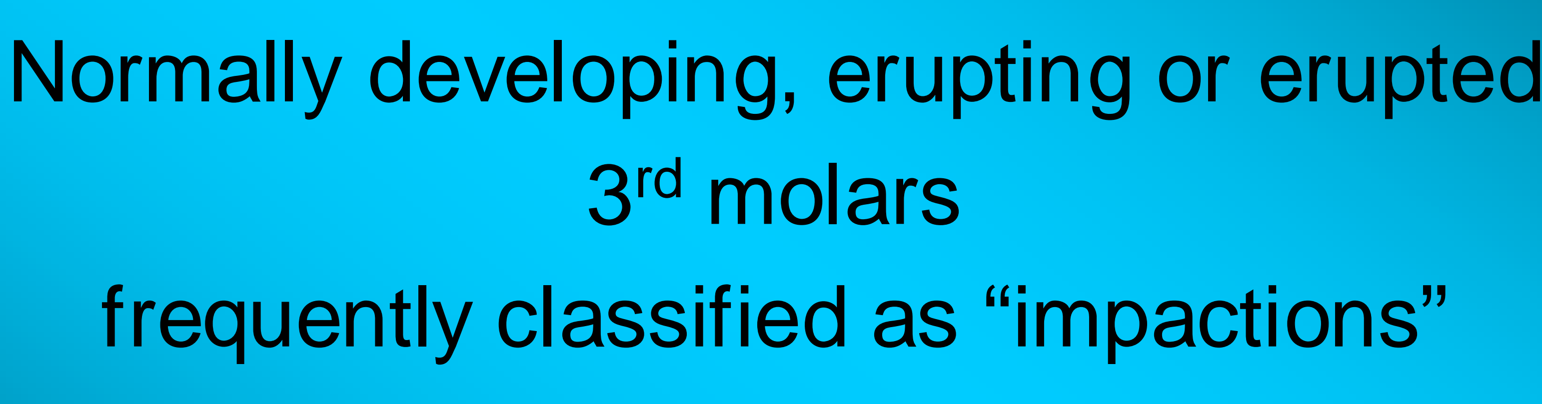

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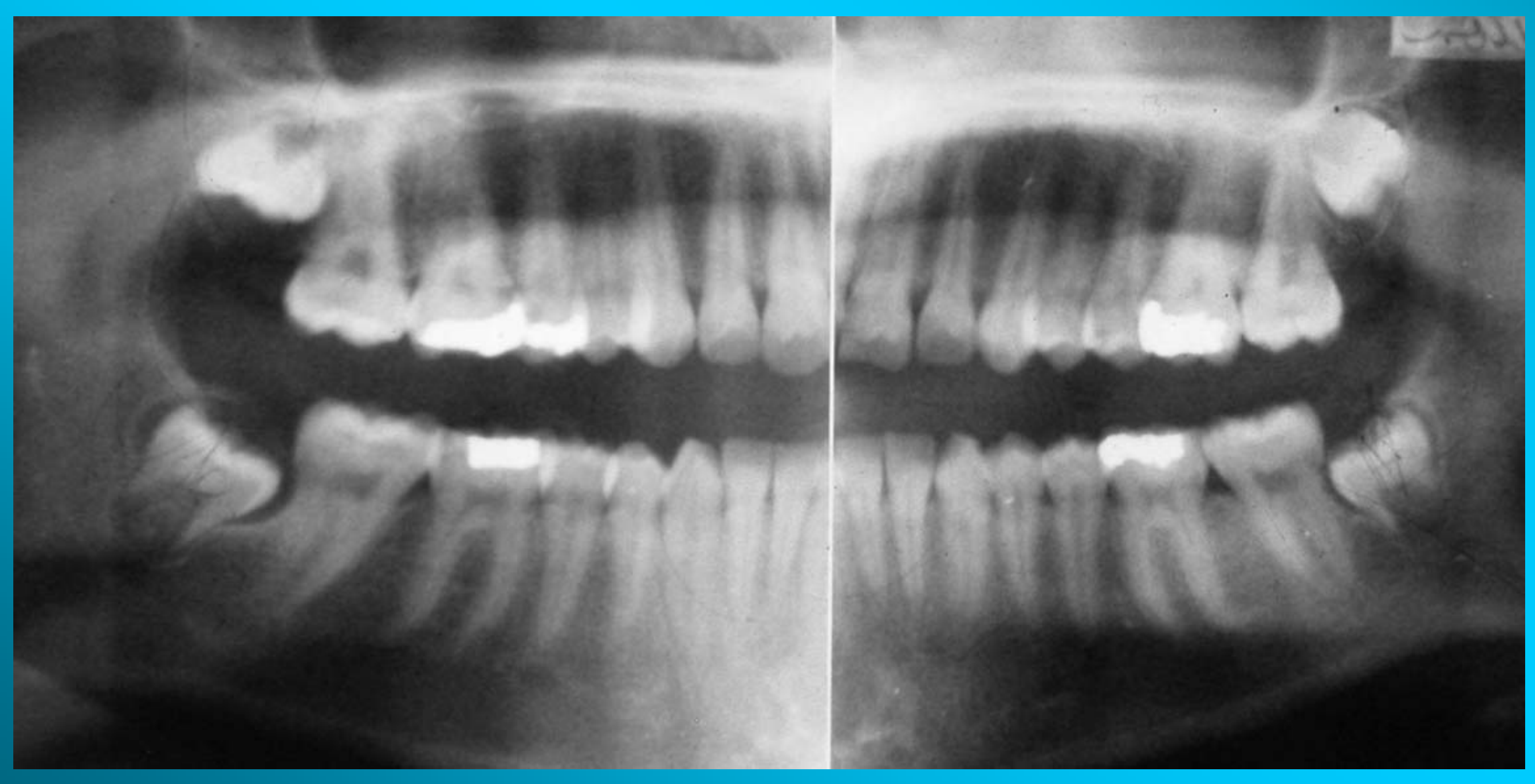
Normally Erupting Third Molars

Classified as 4 full bony impactions when extracted by oral surgeon



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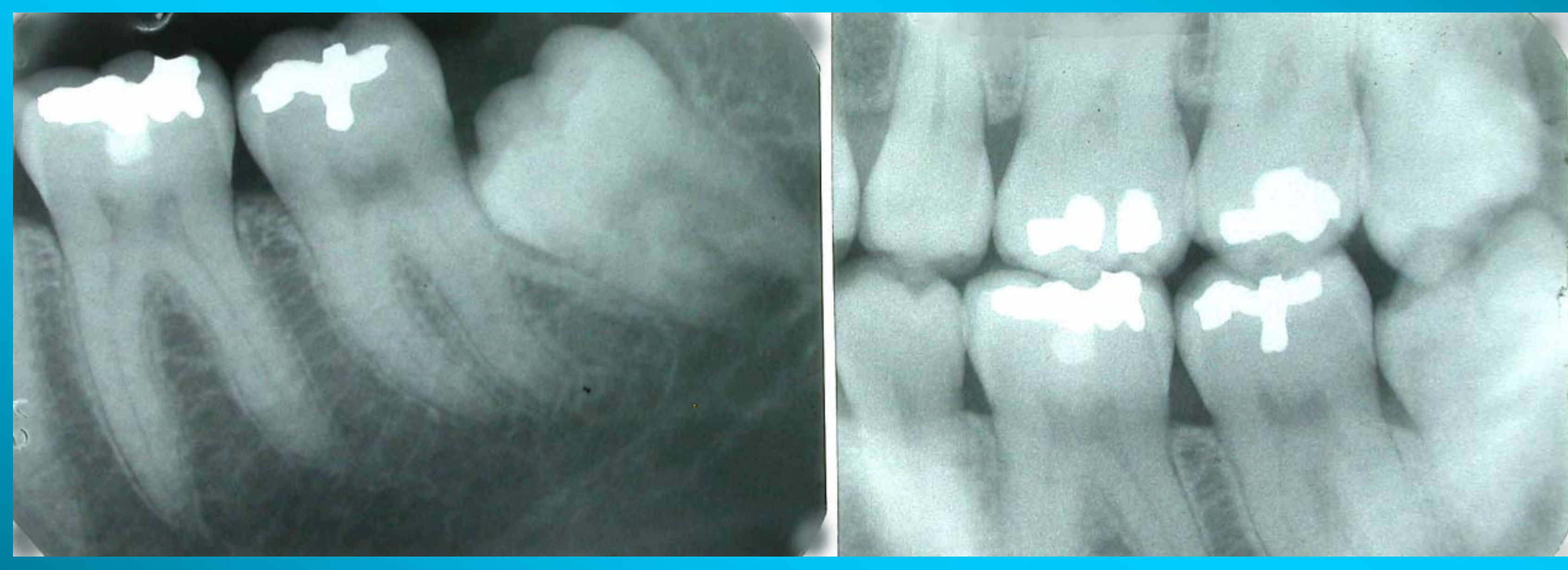
“MesioAngular” Impaction or Normal Eruption



Age 14 Age 22

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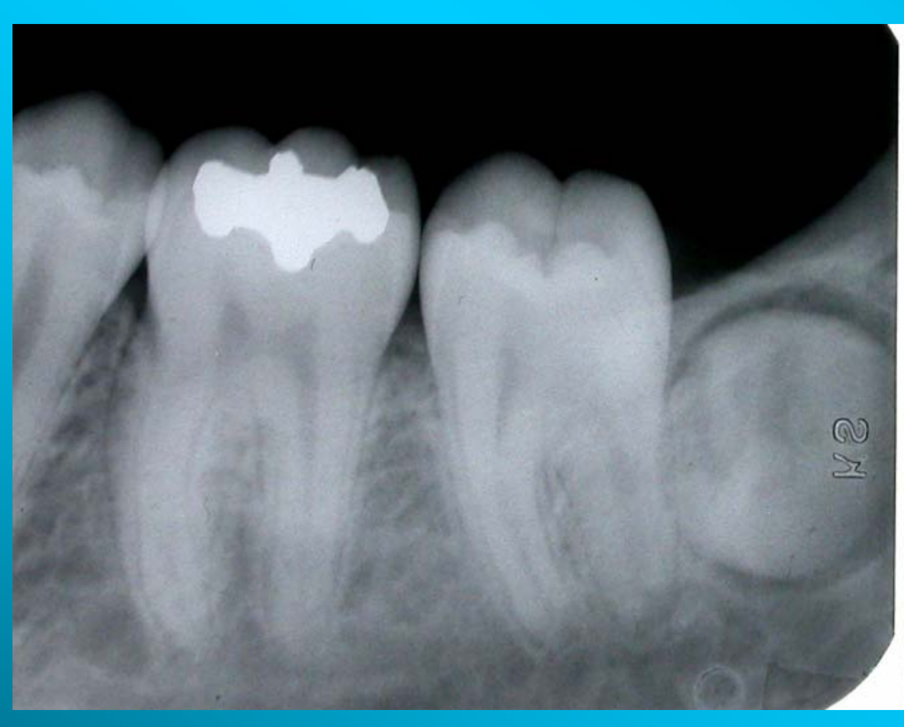
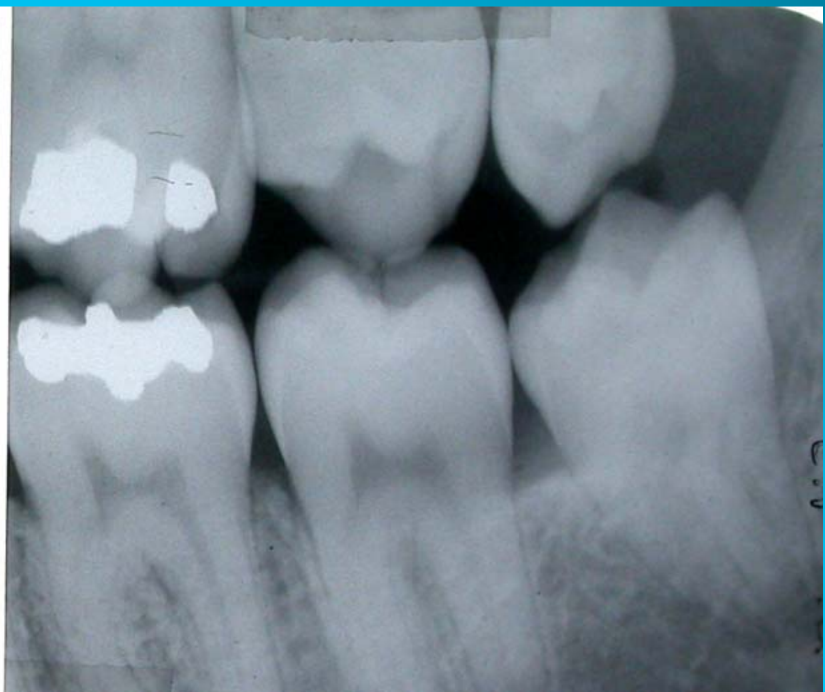
Impaction?
Wait & See



Age 15



Age 17

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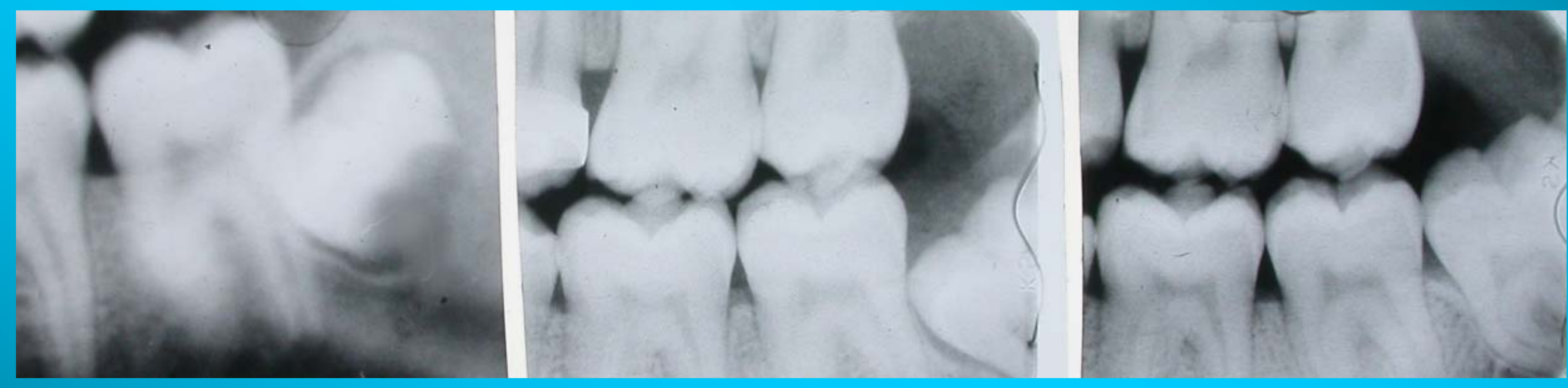
From “Impaction” to Eruption



Age 13 Age 16 Age 18

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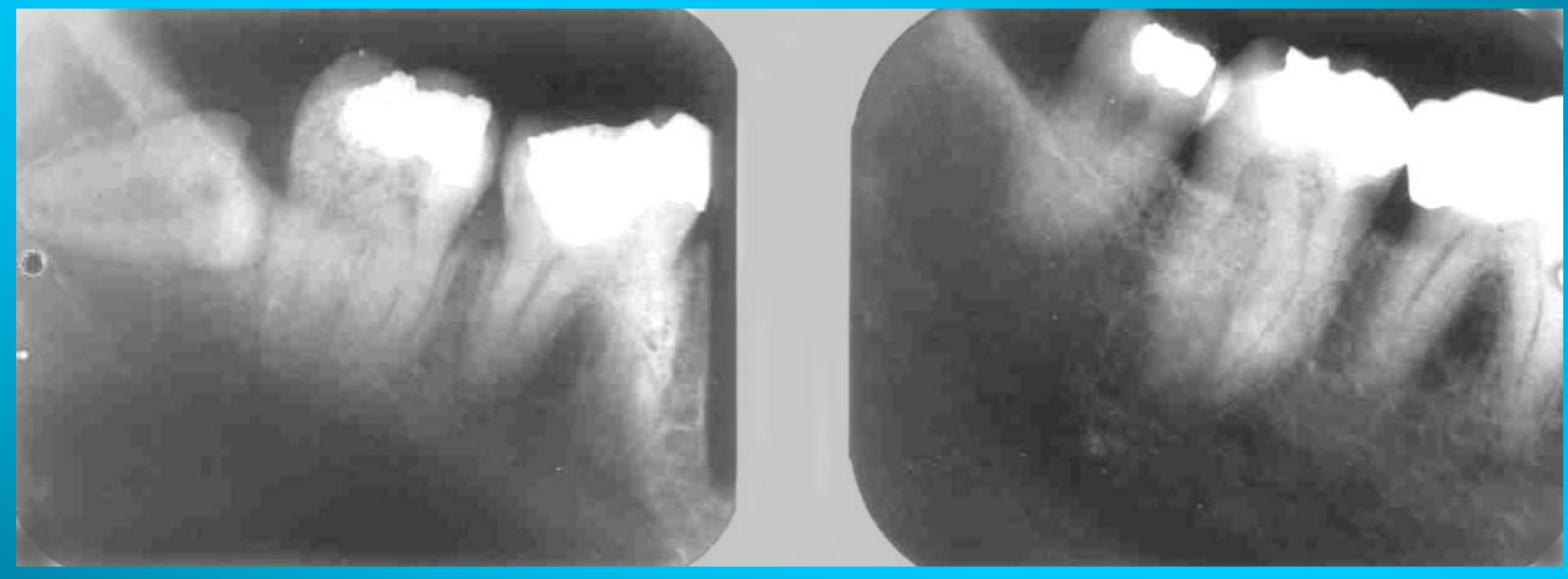
Really Delayed Eruption

Courtesy of Harold L. Clarke, DMD, circa 1984



Age 26 Age 55

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Myth: Third molars should be removed to prevent future pathology.

Confuses *incidence* *of pathology as it presents in the dental office*
with prevalence in the population.

Without relating incidence to the population at risk, it is not possible to assess the extent of the disease.

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FACT: Pathological conditions are far more commonly associated with teeth other than third molars.

Should we remove them all?

It was once a "Coming of Age."

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The Evidence
Minimal Pathology

" [Only] **12 %** of impacted teeth had associated **pathology**… [excludes pericoronitis]

"**no surge [in pathology] with increase in age**

"similar to 10 % risk of appendicitis and 12 % incidence of cholecystitis, [yet]

"**prophylactic appendectomies and cholecystectomies are not advocated**."*

Why, then, prophylactic 3rd molar extractions?

Leonard MS. Removing third molars: a review for the general practitioner. JADA 1992;123(8):77-86.

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I - Pathology Associated With 3rd Molars

12%

Internal Resorption	0.85%
Cysts	1.65%
Periodontal Bone Loss	4.72%
Resorption on Distal of 2nd Molar	4.78%

(Excludes Pericoronitis)

Stanley, et al. Pathologic sequelae of “neglected” impacted third molars. J Oral Pathol 1988;17:113-7.

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II - Pathology Including Pericoronitis

Three Studies -- 6%, 8% and 10% Incidence of Pericoronitis

Assume an Average Incidence of 8%

Maximum 3rd Molar Pathology

20%

6% - Hold on to your wisdom teeth. Consumer Reports Health 1993;5(8):84-85.

8% - Osborn T, et al. A prospective study of complications related to mandibular third molar surgery. J Oral Maxillofac Surg 1985;43:767-9.

10% - Von Wowern N, Nielsen HO. The fate of impacted lower third molars after the age of 20. A four year clinical follow up. International J Oral and Maxillofac Surg 1989;18:277-80.

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Oral Surgeons Fight Back With Third Molar Clinical Trials

[circa 1999 to present]

Disclosure: Sponsored by AAOMS

*"third molar periodontal pathology is a major contributor to chronic oral inflammation… **potentially** contributing to systemic inflammatory response with negative consequences for overall health."*

White, RP. Progress report on third molar clinical trials. JOMS, 65:377-83, 2007.

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AAOMS Finding

25% of 300 healthy people aged 14-45 had at least

1 probing depth ≥5mm on a 3rd molar [75% Didn't!]

Spreading → Periodontal & Systemic Disease.

Is that justification for extracting 85% of 3rd molars?

Should all teeth with PD ≥5mm be extracted?

Good Grief! Periodontists would become

Exodontists!

Blakey, GH, et al. Periodontal pathology asssociated with asymptomatic third molars. JOMS. 2002:1227-33.

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Periodontal Defects after Lower 3rd Molar Extraction

"Given healthy periodontal status preoperatively, **48%** had **worsening** of their [M2] periodontal measures after M3 removal…."

Richardson DT, Dodson TB. Risk of periodontal defects after third molar surgery: An exercise in evidence-based clinical decision-making. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 2005;100(2):133-7.

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Myth: Prevent Carcinomas & Cysts

Impacted third molars should be removed to prevent future associated carcinomas.

- **Adenoameloblastomas & Squamous Cell Carcinomas Related to 3rd Molars**

Extremely Rare

No reliable estimates

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Incidence of 3rd Molar Cysts

Very Low

- **0.68% of 1452 impactions***
- **1.65% of 3702 impactions****
- **0.81% (!) of 2000 "neglected" impacted 3rd molars retained for an average of 27 years****

* Toller PA. Origin and growth of cysts of the jaws. Ann R Coll Surg Engl 1967;40:306-36.

** Stanley HR, et al. Pathological sequelae of "neglected" impacted third molars. J. Oral Pathol 1988;17:113-7. From: Leonard MS. Removing third molars: a review for the general practitioner. JADA 1992(8);123:77-86.

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Myth: Third molars cause crowding of anterior teeth

3rd molars in spongy cancellous bone have **no firm support against which to push 14 other teeth with roots implanted like pegs of a picket fence.**

Anterior component of occlusal force causes crowding if the jaw is too small for alignment of all the teeth.

Orthodontic relapse (crowding or overlapping) after retention is virtually inevitable if alignment of incisors is outside arc of basal bone support.

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The Evidence or Lack Thereof

"…extracting 3rd molars…for the exclusive purpose…of preventing incisor crowding is unwarranted."*

"No evidence…the impacted third molar can cause crowding and imbrication [overlapping] of the remaining teeth."**

*Southard TE. Third molars and incisor crowding: when removal is unwarranted. JADA 1992;123(2):75-79.

**Leonard MS. Removing third molars: a review for the general practitioner. JADA 1992;123(8):77-86.

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Myth: Early Extraction = Less Pain

It ain't necessarily so:

Removal of third molars before the roots are fully formed and the teeth erupt is less traumatic and painful than after eruption.

It's even less traumatic and less painful to leave them *in situ* !

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Myth: Early Extraction = Fewer Complications

"…incidence of dry socket, secondary infection and paresthesia…lower in the group aged 35 to 83 than in the 12 to 24 group."

Highest risk in the group aged 25 to 34.

Leonard MS. Removing third molars: a review for the general practitioner. JADA 1992(8);123:77-86. [Quote in reference to: Osborn TP, et al. A prospective study of complications related to mandibular third molar surgery. J Oral Maxillofac Surg 1985;43:767-9.]

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Days of Standard Discomfort or Disability (DSD)*

Based on a Delphi Study
(Estimation of 46 Clinicians)

"defined…[as] the **disability normally associated** with an **uncomplicated surgical extraction** of a mandibular third molar: namely, **pain, swelling, bruising and malaise**."

Avg = 2.27 DSD (sic & sick)

Tulloch JFC, Antczak-Bouckoms AA, Ung N. Evaluation of the costs and relative effectiveness of alternative strategies for the removal of mandibular third molars. Intl. J. of Technology Assessment in Health Care. 1990;6:505-515

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2005-06 ADA Survey of Dental Services*

Over **10 million "Impactions"**

Removed **Annually** in the U.S.

94% By Oral Surgeons

46.3 Million Total Extractions – all Dentists

62% by GPs   28% by OMS

*ADA Survey Center. 2005-06 Survey of Dental Services Rendered. American Dental Association, Chicago, Illinois. August 2007.

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Myth: Removal of 3rd Molars Is Safe and Harmless

Except for Complications

- Trismus
- Hemorrhage
- Alveolar osteitis
- Damage to teeth
- Periodontal damage
- Injury to TMJ
- Soft Tissue Infection
- Temporary dysthesia
- Permanent dysthesia
- Anesthetic complications
- Mandible/Maxilla fracture
- Oroantral communication

Tulloch, JF, Antczak-Bouckoms, Ung N. Evaluation of the costs and relative effectiveness of alternative strategies for the removal of mandibular third molars. Intl. J. of Technology Assessment in Health Care 6 (1990); 505-515.

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The Brits Have it Right

"Surgical Removal of Impacted Third Molars Should be Limited to Patients with Evidence of Pathology"

- Unrestorable caries
- Non-treatable pulpal or periapical pathology
- Cellulitis
- Abscess
- Osteomyelitis
- Internal/external resorption of the tooth or adjacent teeth
- Fracture of tooth
- Disease of follicle including cyst/tumour
- Tooth impeding surgery or reconstructive jaw surgery
- When a tooth is involved in or within the field of tumour resection
- Recurrent hyperculitis/pericoronitis if hyperculectomy is not feasible

United Kingdom National Institute for Clinical Excellence 2000. Guidance on the extraction of wisdom teeth.

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How Many 3rd Molar Extractions Annually by Oral Surgeons?*

- Average **52.7 3rd Molar Cases per Month****
- **3.8 Million Cases** (people) **per Year**
- Average **2.6 Teeth per Case**

Nearly 10 Million "Impactions" Annually

*Source: Calculated from American Dental Association, Survey Center, 2005-06 Survey of Dental Services Rendered. (CDT Codes D7220-D7241= 9.9 million "impacted" teeth)

**Moore PA, et al. Dental therapeutic practice patterns in the U.S. I. Anesthesia and sedation. General Dentistry 2006;54:92-98.

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Annual Estimates of "Impacted" Teeth Extracted by OMS*

Code	Description	Number	Percent
D7220	Impacted tooth, soft tissue	1,506,230	15%
D7230	Impacted tooth, partial bony	3,201,590	32%
D7240	Impacted tooth, completely bony	5,034,840	51%
D7241	Impacted tooth, with complications	161,470	2%
	Total:	9,904,130	

Code	Description	Number	
D0030	Panoramic radiograph	4,946,010	(sic)

5969 OMS in Active practice

Average 52.7 3rd Molar Cases/month

Average 2.6 Third Molars per Case

*American Dental Association, Survey Center, 2005-06 Survey of Dental Services Rendered.

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Prophylactic 3rd Molar Extraction Safe & Harmless?

What's the Evidence?

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Incidence of 3rd Molar Mandibular Nerve Paresthesia

(Two Studies)

Minimum* - 1.3% Temporary 0.33% Permanent

Maximum** - 4.4% Temporary 1 % Permanent

*Valmaseda-Castellon E, et al. Inferior alveolar nerve damage after lower third molar surgical extraction: a prospective study of 1117 extractions. Oral Surg Oral Med Oral Pathol Oral Radio Endod 2000;92:377-83

**Kipp DP, et al. Dysthesia after mandibular third molar surgery. JADA 1980;100:185-92.

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Conservative Estimate Permanent Paresthesia

9.9 Million 3rd Molar Exts by O.S.*

Assume 50% = Lower 3rds = 5 million (rounded)

1.3% Mandibular Nerve Injuries = 65,000**

0.33% permanent → **16,500 People inflicted with Permanent Paresthesia Each Year**

*Moore PA, et al. Dental therapeutic practice patterns in the U.S. General Dentistry 2006;54:92-98.

**Based on: Valmaseda-Castellon E, et al. Inferior alveolar nerve damage after lower third molar surgical extraction: a prospective study of 1117 extractions. Oral Surg Oral Med Oral Pathol Oral Radio Endod 2000;92:377-83

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Worst-Case Estimate
Permanent Mandibular Paresthesia

4.4% Mandibular Nerve Injuries = 220,000

1% Permanent

50,000 People inflicted with Permanent Paresthesia Each Year

BY Oral Surgeons ~~Alone~~ Combined!

*Kipp DP, et al. Dysthesia after mandibular third molar surgery. JADA1980;100:185-92.

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DO ~~NO~~ More HARM

Assume 2/3 of people having extractions had

no symptoms past or present*

and no pathology,

then AT LEAST

11,000 to 34,000 individuals are **afflicted**

EACH YEAR with **Lifetime Paresthesia**

FOR NO GOOD REASON!

*Slade GD, et al. The impact of third molar symptoms, pain, and swelling on oral health-related quality of life. J. Oral Maxillofac Surg. 2004;62(9):1118-24.

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Hysterical Distortions of a Madman?

These extrapolations are based on **their** studies.

What **if** they are **50% wrong?**

There would still be **8000 to 25,000**

People Afflicted with **Permanent**

Mandibular Nerve **Paresthesia** each Year

For No Good Reason

Maybe we should be Mad!

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Estimated Annual Incidence of Paresthesia of the Mandibular Nerve by OM Surgeons*

(Based on Extraction of 3.5 million Lower 3rd Molars)

Minimum No. Persons with Paresthesia		Maximum No. Persons with Paresthesia	
1.3% Temporary		**4.4% Temporary**	**1% Permanent**
65,000	**17,000**	220,000	**50,000**
Unavoidable 33% of 3rd Molars with Symptoms or Pathology			
21,000	**5,000**	73,000	**17,000**
If 50% are FUN Extractions			
33,000	**8,000**	110,000	**25,000**
If 67% are FUN Extractions			
44,000	**11,000**	147,000	**34,000**

* **Rounded to nearest thousand**

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Not to Mention
TMD -Temporomandibular Disorder

For age 15-20, "…risk of experiencing TMD after third-molar extraction was 1.6[%] …."

Assume 25% of 3.5 million OMS 3rd molar cases are in this age group, most of whom have IV Sedation or GA

- Translates to **14,000 TMJ Injuries <u>in this age group alone</u>** <u>Each Year</u>!

Contributing Factor: "…intravenous sedation or general anesthesia … decrease a patient's protective mechanism."

Haung GJ, Rue TC. Third-molar extractions as a risk factor for temporomandibular disorder. JADA 2006;137(11);1547-1554

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Better than Implants

AAOMS: “rarely…meaningful function”*

The Value of Retained Wisdom Teeth

- **Certainly, They Have Value to Oral Surgeons**
  - **And to others ?**

*AAOMS Adv Page 1 Sidebar (Sept. 28, 2007)

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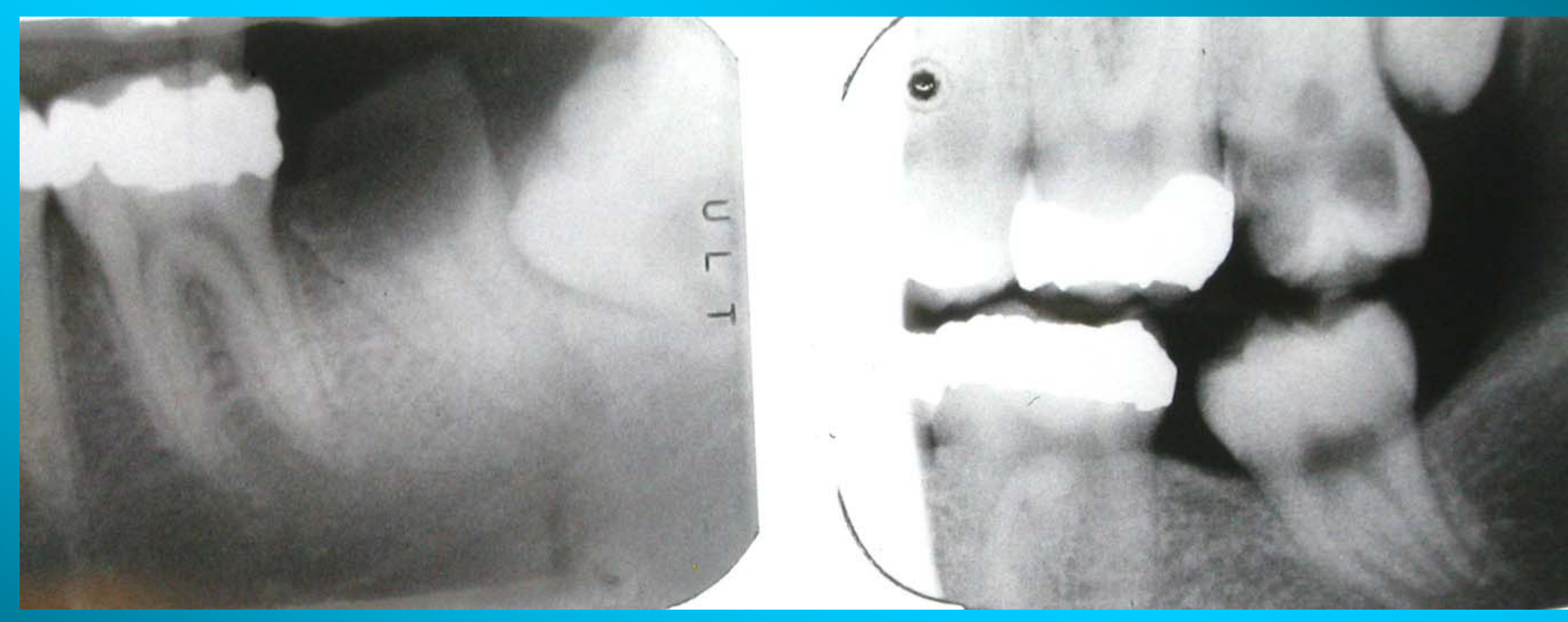
3rd Molar Erupted
Following Extraction of #18



Age 17 **Age 19**

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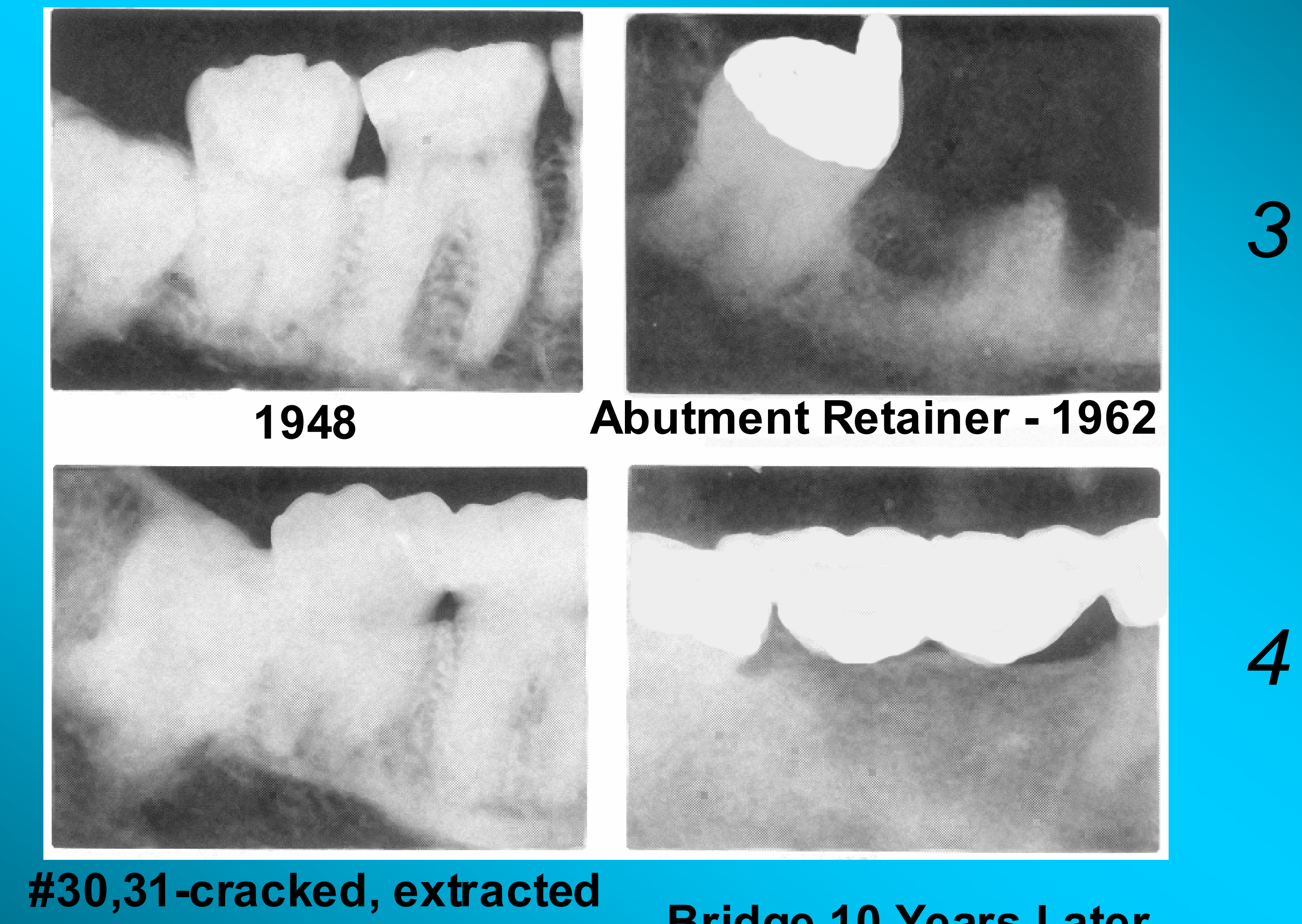
Impacted 3rd Molar Utilized as Abutment

(Donald G. MacQueen DDS)

J So Cal Dent Ass July 1972



#30,31-cracked, extracted 1962

Bridge 10 Years Later

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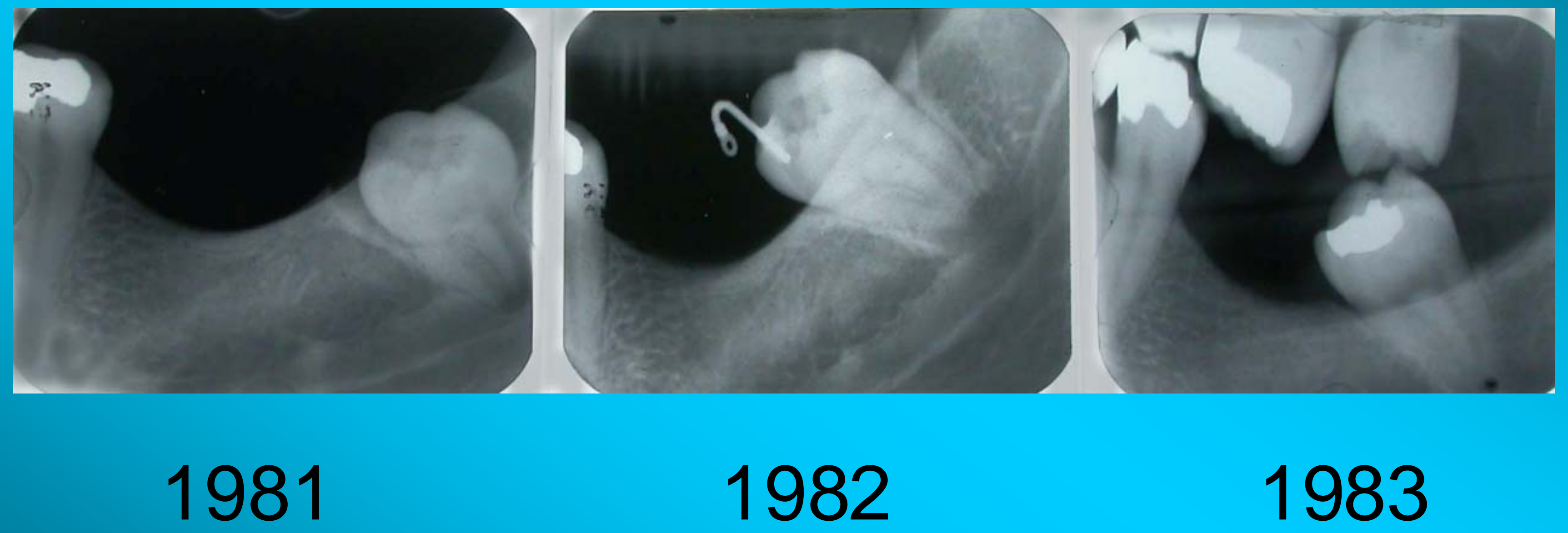
Assisted Eruption



1981 1982 1983

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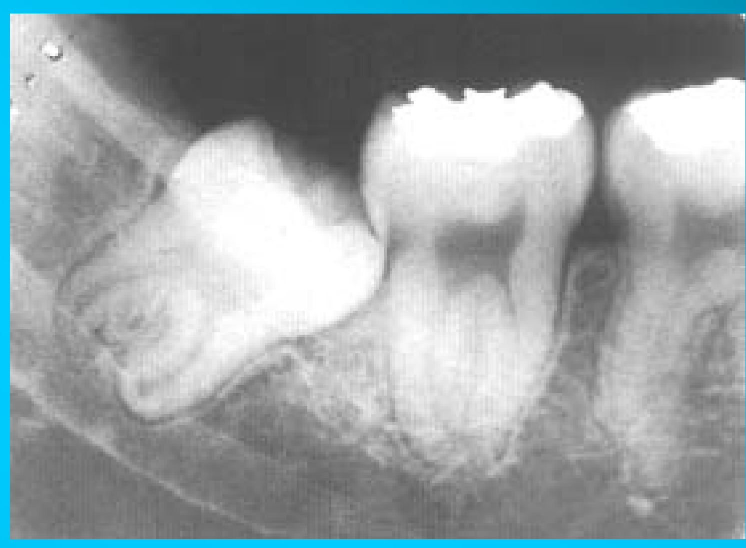
Discretion is the Better Part of Valor



Mesioangular "Impaction"

Risk of Temporary Paresthesia = 35%*

Risk of Permanent Paresthesia = 6.8%**

When Roots in Close Proximity to Mandibular Canal

*Howe GI and Poyton HG. Prevention of damage to the inferior dental nerve during the extraction of mandibular third molars. Brit. Dent J 1960;109:355-63.

**Friedman JW. Containing the cost of third-molar extractions: a dilemma for health insurance. Public Health Reports 1983; 98(4):379-84.

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Redundant Radiographs

Unnecessary Radiation Exposure & Cost

"Nearly everything a dentist needs to know about a person's oral health is revealed by full mouth periapical Xrays…dispensing with the usefulness of the routine panoramic view."*

Most Oral Surgeons take a FUN Panoramic instead of utilizing the GPs xray films.

*News Release, University of Buffalo Dental School, March 11, 2005
Re: study by Dr. Lida Radfar.

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Counting FUN Panographs

3.8 M cases @$80 = $304 Million

Assume **67% FUN Cases**

$204 Million Wasted on

Mostly Worthless Panographs

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Overcharging by Overclassification of Procedures An OMS *Specialty*

Many if not most normally developing maxillary 3rd molars are classified as Partial or Full Bony impactions.

Many if not most Routine Extractions are classified as Surgical Extractions.

Many if not most Soft Tissue Extractions are classified as Partial or Full bony Impactions.

Gilding the Lily or Fraud?

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Classification of Extractions

ADA Procedure	Description
D7140	**Extraction (routine) - erupted tooth or exposed root** (elevation and/or forceps removal)
D7210	**Surgical removal of erupted tooth** (elevation of mucoperiosteal flap and removal of bone and/or section of tooth)
D7220	**Removal of impacted tooth – soft tissue** (occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation)
D7230	**Removal of impacted tooth – partially bony** (part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal)
D7240	**Removal of impacted tooth – completely bony** (most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal)

From ADA CDT 4 (Current Dental Terminology-2005)

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Overclassification of "Impactions" by O.S[1]

Comparison between Classification by Oral Surgeons and by Dental Consultant (JWF)

Extrapolation to 2006 Data

ADA Procedure	*Oral Surgeons* 1979[3] (%)	*Oral Surgeons* 2006[4] (%)	*Consultant*[2] (%)
7220 (Soft Tissue)	1	15	→ 25
7230 (Partial Bony)	31	32	→ 44
7240 (Full Bony)	68	53	→ 31

[1] Adapted from: Friedman JW. Containing the cost of third-molar extractions: a dilemma for health insurance. Public Health Reports 1983;98:376-84.
[2] 2 California dental plans (1982) (N=6,751)
[3] Pennsylvania Blue Shield (1979) (N=100,664)
[4] American Dental Association, Survey Center, 2005-06 Survey of Dental Services Rendered.

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The Low Cost of High Savings*

Based on Reclassification and NonPayment For Normal Erupting 3rd Molars (converted to 2005 Fees)

Review of 440 **Oral Surgeons' Claims** = **37 hrs**

Review **Time per Claim** = **5 minutes**

Gross Savings: $98,800 = $225/claim

Consultant 37hrs @$150/hr $5,550 $13 /claim

Net Savings: $93,000 = $212/claim

Saving $2500/ Consultant Hour

Potential Claims Review Savings

3.8 M Claims = ± $800 Million

*Friedman JW. The case for preservation of third molars. J.Calif. Dent. Assoc. 1977;5:50-56.

**Avg estimated fees: D7140-$100; D7210-$150; D7220-$200; D7230-$300;D7240-$375

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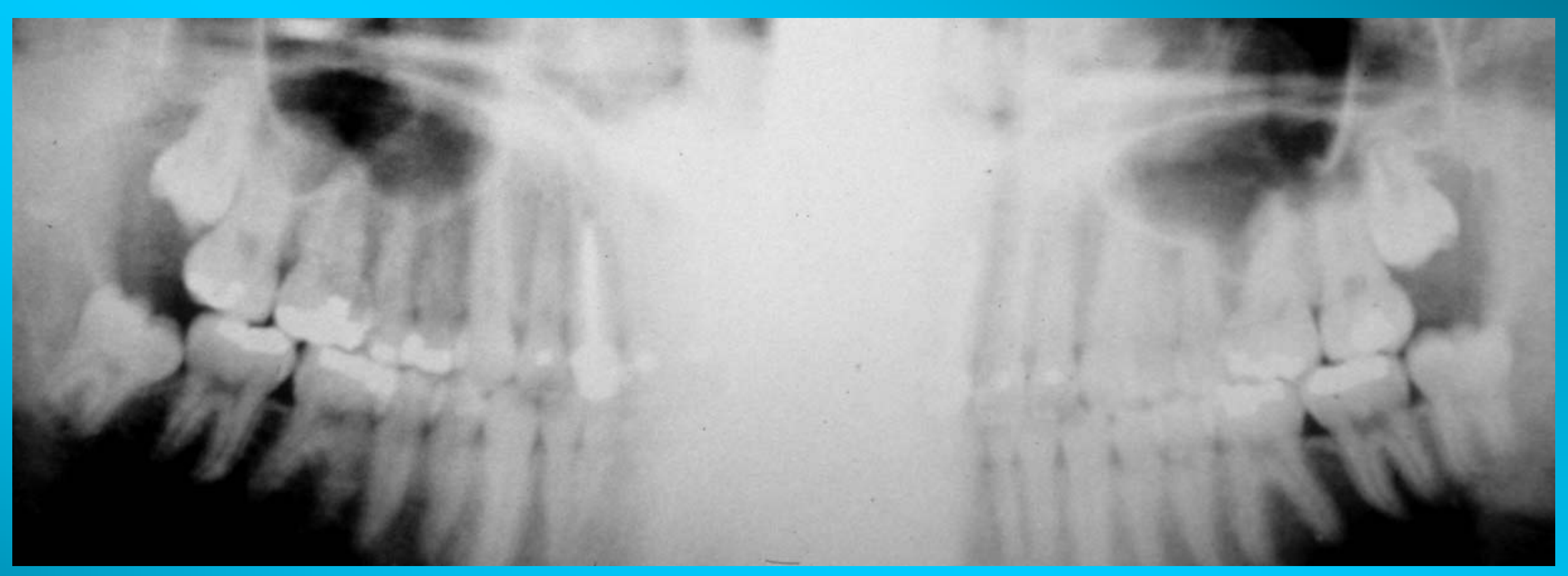
Typical Overclassification/Overcharge



Classification of Extraction by Procedure

By O.S.		By JWF
#1 7240	→	7220 (soft issue)
#16 7240 (FBI)	→	7220
#17 7230 (PBI)	→	7220
#32 7240	→	7220/7230

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Screening Benefits

Medical & Dental Insurance Can

- **Contain the Cost**
- **Protect the Patient**

by applying

Evidence-Based Benefits

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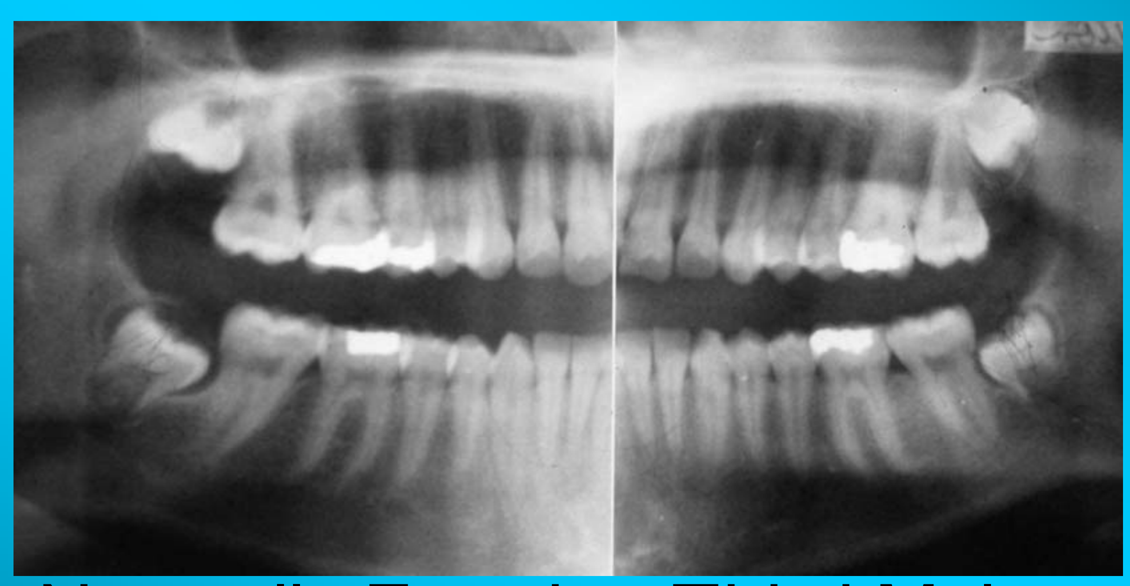
Fraudulent Overclassification/Overcharge

as 4 Full Bony Impactions



Normally Erupting Third Molars

Extraction Should Not be a Covered Benefit

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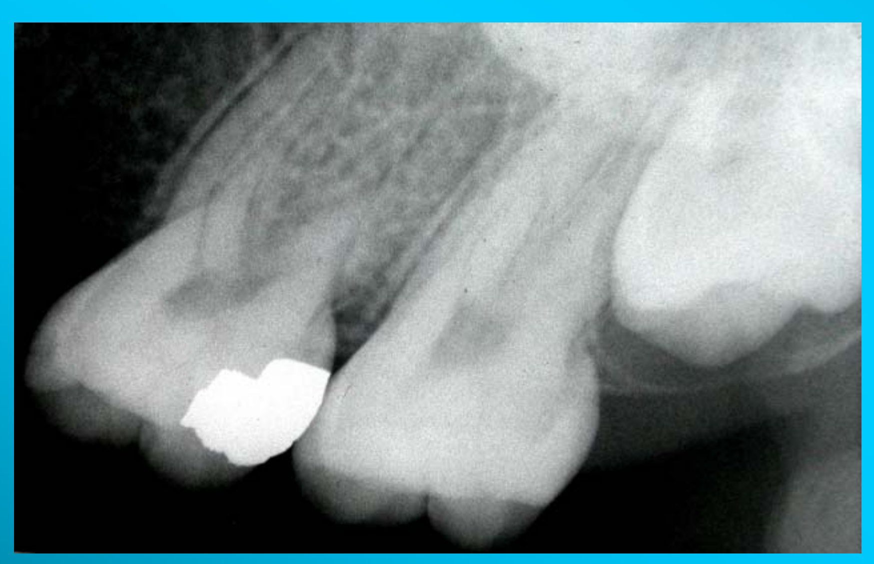
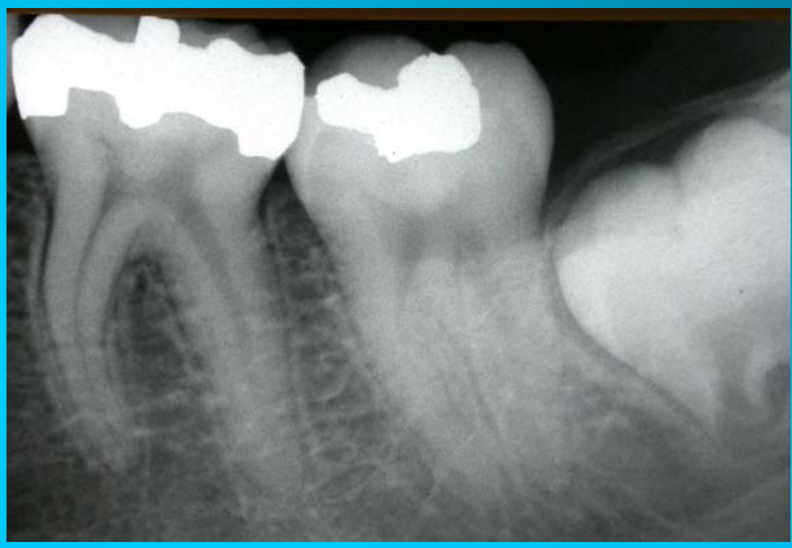
Typical Overclassification/Overcharge
as 2 Full Bony Impactions





FUN Surgery

Should Not Be a Covered Benefit

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Victimizing the Victim

Administrative Saving on Insurance Fraud
Does Not Protect the Patient

Oral Surgeons Force the Patient to Pay
Up Front or By Collection.

Employers, Unions and Insurance Companies
Are Not Strong Supporters of
Cost Containment

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Evidence-Based

Vs

Economic-Based

Third Molar Surgery

Dollars Tell the Story

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"There is no other major medical or dental specialty, except perhaps plastic surgery, that makes so much money out of so little pathology."

Friedman JW. The intelligent consumer's complete guide to dental health: how to maintain your dental health and avoid being overcharged and overtreated. 2002. (www.authorhouse.com)

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The Cost to the Public & The Pain

9.9 Million 3rd molar Extractions[1] = $3,210,339,250[2]
Panoramic films (3.8 M cases) = 304,000,000[3]
3 M cases (80%) I-V or GA = 900,000,000[4]

$4.4 Billion Gross Cost

Producing

8 Million Days of Standard Discomfort and/or Disability

[1] Extrapolations from the Moore & Tulloch, et al, and ADA studies.
[2] Avg. fee D7220-$200, D7230-$300, D7240/7241-$375 multiplied by annual number of impactions estimated by 2005-06 ADA Survey of Dental Services Rendered.
[3] Estimated avg. fee of $80/case (4.9 million annual estimate for OMS, 2005-06 ADA Survey)
[4] Estimated avg. fee of $300 for I-V Sedation or General Anesthesia

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$900,000,000 (sic)

General Anesthesia, IV Sedation & Iatrogenesis

3 Million GA + IV Sedation **by O.S.***

Most of Which Is FUN!

Mortality Rate - Very Low – **1/835,000****

Or 2 Deaths a Year

Morbidity Unknown

(Fractures, TMJ, Hypoxia)

For Treatment, Most of Which Could Be Done With a Local Anesthetic

*Moore PA, et al. Dental therapeutic practice patterns in the U.S. I. Anesthesia and sedation. General Dentistry 2006;54:92-98.

**D'Eramo, EM, et al. Adverse events with outpatient anesthesia in Massachusetts. J Oral Maxillofac Surg. 2003;61(7):793-800.

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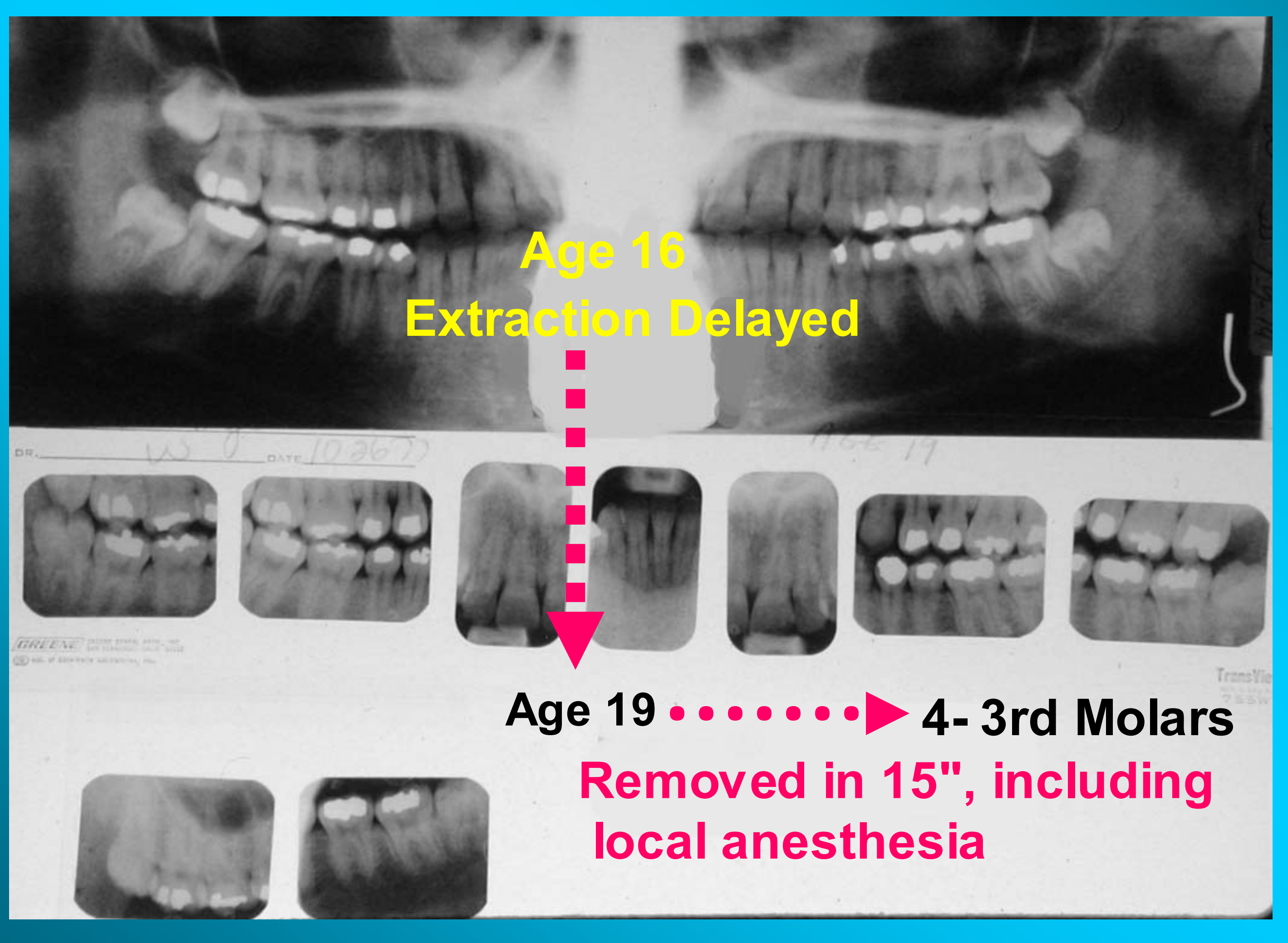
Look, Ma! No General Anesthesia

From Complex to Simple Extractions



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On the Other Hand

Next Slide, Please

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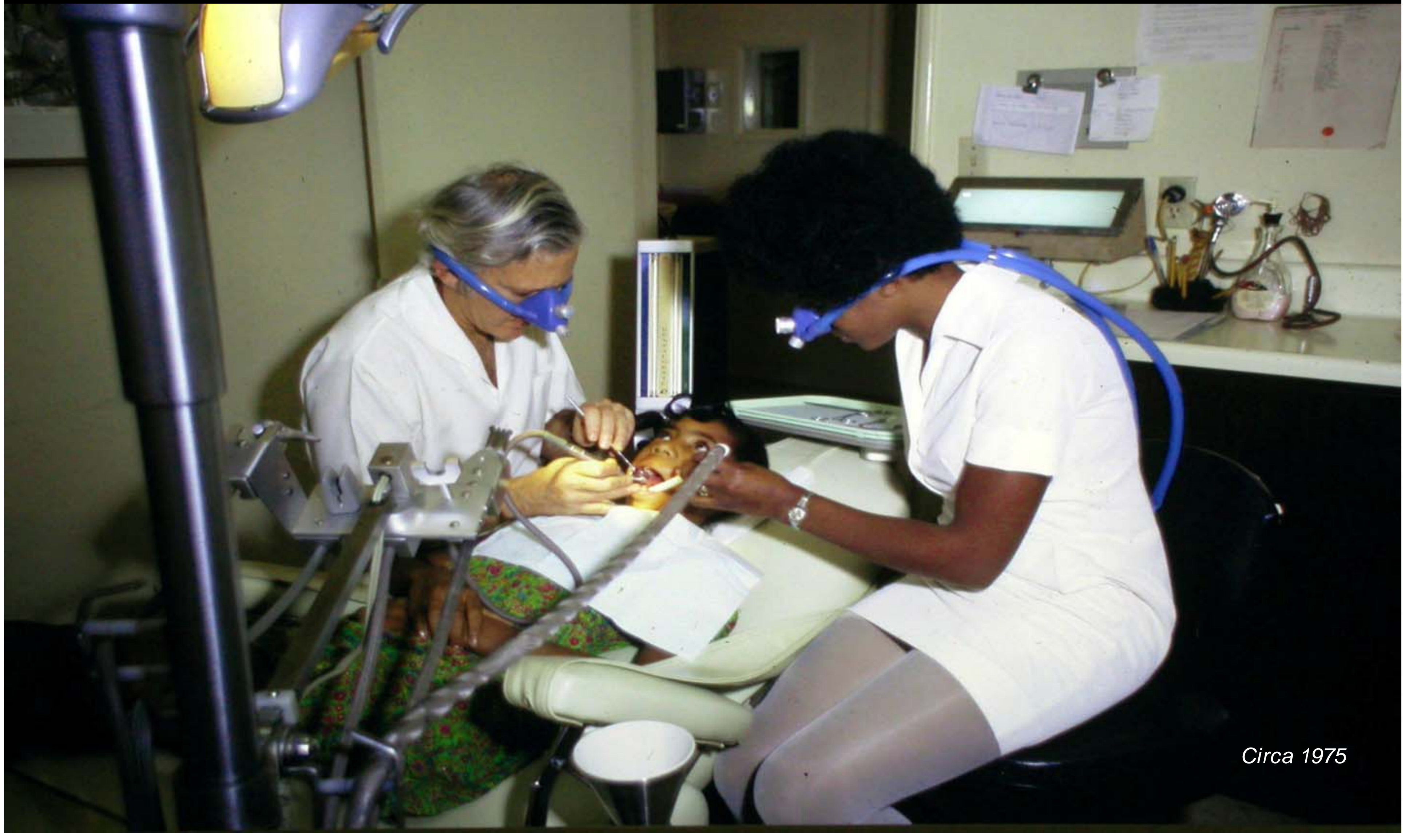
We use Nitrous Oxide in Our Office !



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Other Practitioners' Gullibility & Culpability

Not all, but many

- General Practitioners
- Pediatric Dentists
- Orthodontists

Initiate the Referral Process.

Is This Not Also Malpractice?

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A Cute Remunerative 3rd Molar Surgery

9.9 M “Impactions” = $4.4 Billion ÷ 5969 Active O.S.*

Average 3rd Molar Gross Income = **$733,000**

Eliminating 67% “Impactions” would

Reduce O.S. Gross Income by **$491,000**

as a result of

- **6.6 Million Fewer Extractions**

on

- **2.5 Million Fewer People**

*2005-06 ADA Survey of Dental Services Rendered.

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Summing Up
The Oral Surgeons' Grand Slam Scam

Grand Total: $4.4 Billion + 8 Million DSD

Two-Thirds FUN Surgery =

$2.9 Billion SCAM

Inflicting

5.4 Million Avoidable

Days of Standard Discomfort and/or Disability

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Put an End to Economic-based Practice

If we really believe in evidence-based practice & protecting the public from avoidable injury, then we are morally & ethically bound to

Eliminate

Prophylactic Removal

of

Wisdom Teeth (period).

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Evidently, that's all, folks!

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