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GENERAL DENTISTS AND BOTOX IN UTAH

Recently DOPL has determined, after review by the Attorney General's office, that the Practice Act and Rules governing Utah dentists having nothing that should or would preclude general dentist in Utah from being able to use Botox or other dermal fillers in the head and neck region for esthetic purposes. Therefore, DOPL has finally given general dentists the green light to perform these procedures once they have received proper training.

Many of you may wonder what impact, if any, this development has on your PIE insurance coverage. We have determined that the use of dermal fillers will be covered like any other dental procedure and there will be no additional premium charged to dentists who start doing this procedure. However, we will require dentists who wish to implement the use of dermal fillers such as Botox to furnish proof in the form of a course completion certificate to show that they have taken at least a full day course sponsored by an organization such as the American Academy of Facial Esthetics that preferably has a hands-on component to the course.

Soon we plan to develop and furnish an informed consent form for dentists to use before they perform these procedures, but in the meantime we suggest that you use forms that the course sponsors should be providing as part of their curriculum.

DOPL administrators have infomred me that regulation of dental use of dental fillers will basically be complaint driven meaning dentists who perform these procedures should know what they are doing and strive for results that generate happy and satisfied patients. In other words, procedures involving dermal fillers should be considered to be like anything else we do as dentists that is intended to help the patients we treat.

--RCE

DENTAL STUDENT DEBT

Dr. Chris Salierno, editor of Dental Economics, mentioned in the June 2018 issue an article published in the Wall Street Journal (WSJ) about a young orthodontist, Dr. Mike Meru, who had amassed over $1 million in loan obligations. It is unfortunate that the dental student loan situation got national attention in this matter. Dr. Salierno went on to write that if you look through the comments section with the Journal or at links posted on Facebook, you will find patients and, surprisingly, even dentists who have no sympathy for Dr. Meru's plight. So, who is at fault, Dr. Meru or others?

Dr. Salierno wrote that tuition for graduate schools is getting out of control. As the WSJ article correctly points out, universities are free to charge what they choose and the government allows students to borrow with few restrictions. Even rent and other expenses can now be considered as part of these loans. Are you aware that dental school is the most expensive health-care degree one can get, especially when you factor in private schools? Dr. Drew Jones has covered this topic in his editorial in the July/August UDA Action. Dr. Salierno went on to quote Avishai Sadan, Dean of USC's School of Dentistry: "These are choices. We're not coercing. You know exactly what you're getting into." Dr. Salierno disagrees and opines that "incoming dental students have no idea what they're getting into and loan officers write them blank checks. I think the prevailing belief is that dentists will make a lot of money when they graduate and will be able to pay off their debts without too much trouble."

Second, Dr. Salierno notes that while it's important for students incurring debt to be mindful of their expenses, they should not have to live like paupers for several years after graduation. If you have over $200K in outstanding student debt then you probably should not buy a 40-foot boat. But you should not be relegated to a diet of microwave ramen noodles either. Somewhere between those extremes is a healthy, enjoyable lifestyle that is neither incapacitated by student debt nor irresponsible with additional debt obligations. Do our young PIE insured dentist readers agree or would they rather be frugal until they can chip away at the debt?

Third, Dr. Salierno notes that as the WSJ article explains, Dr. Meru entered a government-sponsored repayment program that will forgive his remaining balance after 25 years. Dentists and

non-dentists commented that it's unfair for taxpayers to essentially be responsible for paying his debt. Dr. Salierno opines that this is not exactly a fair assessment. He claimed that Dr. Meru has to pay 10% of his adjusted gross income minus 150% of the poverty level on a monthly basis for that 25 years, so he's paying a very fair share. Also, Dr. Salierno considers "having well-educated health-care professionals in the United States to be a public good, and I am glad that he and other bright individuals are able to contribute to a thriving orthodontic community in this country."

Dr. Salierno concludes by stating that Dr. Meru's story is a cautionary tale of how our current system can go awry when a young man with a family wants to become an orthodontist. He saluted Dr. Meru for sharing his personal financial challenges with the world. Dr. Salierno went on to state that "dentistry should want to attract the best and brightest to our profession. We want graduates to have the freedom to explore practice opportunities. We should find creative ways to make dental school more affordable and grow facilities that offer loan forgiveness in exchange for treating underserved populations. We should do a far better job of educating prospective dental students about debt. It's a complex problem and we have different ideas about how to fix it. But we should at least come together and support each other when this issue finally gets the attention it deserves."

The main challenge is for the young dentists to manage the challenges of making a good living and paying off the debt! Any local commentary on this subject is welcomed!
--RCE

WARREN BUFFET'S BET
OR, SOME HINTS ON INVESTING

No one can argue against Warren Buffet's success and overall judgement in building a financial empire. PIE owns Berkshire Hathaway stock as an investment and receives their annual report every year. In the 2017 report, Mr. Buffet described a bet he made nine years ago that involves an interesting story with lessons that dentists as investors can learn.

Mr. Buffet used an establishment called Long Bets, a non-profit organization established by another successful businessman, Amazon's Jeff Bezos, that accepts a proposition by one person to be proven right or wrong at a future date. Then they accept a contrary minded party to take the other side of the bet and each side names a charity that will be the beneficiary if their side wins.

So, Mr. Buffet argued that active investment management by "professionals in aggregate" would, over a period of years, underperform the returns achieved by "rank amateurs" such as dentists, who simply let their investments sit still and compound. Mr. Buffet thought that the massive fees levied by these "professional managers" would leave their clients worse off than if the amateurs simply invested in an unmanaged low cost index fund. According to one definition I read, an index fund is a type of mutual *fund* with a portfolio constructed to match or track the components of a market *index*, such as the Standard & Poor's (S & P) 500 *Index*. An *index* mutual *fund* is said to provide broad market exposure, low operating expenses and low portfolio turnover.

Mr. Buffet offered to wager a chunk of change, $500,000, betting that no investment pro could select a set of at least five hedge funds that would over an extended period match the performance of an unmanaged S & P 500 index fund charging only token fees. He defined hedge funds as investments involving a limited partnership of investors that use high risk methods, such as investing with borrowed money, in hopes of realizing large capital gains. Mr. Buffet considered these hedge funds to be very popular high fee investment vehicles.

He suggested a 10-year bet and picked a low cost Vanguard S & P fund as his contender. He waited for what he termed a "parade of fund managers who would include their own fund as one of the five" to challenge him and "defend their occupation. After all," he mused, "these managers urged others to bet billions on their abilities. Why not put a little of their own money on the line?"

He was surprised to see no one rise to the challenge immediately. Finally, a manager stepped up whose company raised money from limited partners to form a fund that invests in multiple hedge funds. Mr. Buffet admired this manager's willingness to put his money where his mouth was. So it was a basic Vanguard mutual fund sitting there compounding only vs. a managed hedge fund. The manager did pick five funds-of-funds whose results would be averaged and compared against the Vanguard fund and protected from distortion by the good or poor results of a single manager of just one of the funds.
An interesting caveat of the fund-of-funds was that each of these operated with a layer of fees that sat above the fees already charged by the hedge funds in which it had initially invested. In other words, in this doubling-up arrangement, the larger fees were levied by the underlying hedge funds such that each of the fund-of-funds imposed an additional fee for its presumed skills in selecting hedge fund managers.

What were the results? Controls were mutually agreed upon to create what was termed a neutral environment over the 10 years to mitigate lean years such as 2008. Therefore, the five funds-of-funds delivered a compounded increase of only 2.2% which means that $100,000 invested in those funds would have made all of $2,200. The Vanguard fund over the same time period gained 85% which means it would have resulted in $85,400 gained for its investor, the amateur dentist!

Mr. Buffet conceded that every one of the 100 plus managers of the underlying hedge funds would have had a huge financial incentive to do his or her best and the five funds-of-funds managers would have been similarly motivated to select the best hedge fund managers possible because these five were entitled to performance fees based on the results of the underlying funds.

Mr. Buffet considered the results for the managers of these hedge funds to be dismal, <u>really dismal</u>, and the huge fees that were charged by all fund and funds-of-funds involved were totally unwarranted by performance, yet the managers still received plenty of compensation during the years that passed. Fees, like rust, never sleep.

So, Mr. Buffet had the following opinions in his summary:

1. Over a 10 year period a S & P 500 mutual fund will outperform a portfolio of funds of hedge funds when performance is measured on a basis net with fees, costs and expenses deducted from profits.
2. Active investors who try to do better than average in securities markets will incur far greater costs than passive investors who buy and let their investments sit.
3. Costs skyrocket when large annual fees, performance fees and active trading costs are all added to the active investor's equation.
4. A number of smart people are involved running hedge funds, but their efforts are self-neutralizing and their IQ will not overcome the costs they impose in investors.
5. Investors will do better over time with a low cost index fund than with a group of funds-of-funds.
6. His bottom line: When trillions of dollars are managed by Wall Streeters charging high fees, it will usually be the managers who reap outsized profits, not the clients. Both large and small investors should stick with low cost index funds.

How can this information help PIE insured? You will be better off to buy good index funds and let them sit rather than having some big talking broker either churn your investments, meaning there is buying and selling going on all the time, or push you into buying hedge funds. You do need to discipline yourselves to set money aside for your retirement and if you do use a broker or money manager, make sure that someone is looking over their shoulder rather than your having to trust some smooth talker in your neighborhood or church that may be the next felon reported in the newspaper or web that has ripped off friends for several hundred thousand dollars with Ponzi schemes or worse!

--RCE

CAN YOU REUSE HEALING COLLARS?

A recent issue arose in Nevada which may be of interest to our insured. I am quoting from an article I received through the University of Utah School of Dentistry website which described the problem as follows: UNLV is notifying 184 patients that they may have had dental implant work done with an instrument that had been used on other patients.

A recent review of the dental implant process at the university's Faculty Dental Practice Clinic found that healing abutments, which are manufactured to be a single-use item, were reused. The reuse of a healing abutment might increase the failure of a dental implant because of healing complications.

"I am deeply disturbed by the allegations against the dentist in our dental school," Regent Trevor Hayes said. "However, I am proud of the swift response of Chancellor (Thom) Reilly and the system (Nevada System of Higher Education) staff in addressing these allegations and getting to the bottom of it. I have many concerns and questions regarding UNLV's timeliness of response and depth of response, and I want to know why the system had to take over this matter."

Symptoms of dental implant failure include swelling, severe pain, discomfort, gum inflammation or loosening or movement of the implant.

The dentist who reused the abutments, Dr. Phillip Devore, resigned as UNLV's director of the faculty group practice in December and now works in private practice at Image Dental. He said there was never a public health risk because he sterilized the abutments. He said he would sometimes use a healing abutment up to five times.

So, if you are routinely using these abutments more than once you might want to reconsider after knowing about the problems going on in Nevada!

--RCE

ASSOCIATE HORROR STORIES AND COMMENTARY

Unfortunately not all associateships or even partnerships work out well. A few become downright horror stories! The following account describes some horror stories I have read in dental publications and I have a few to report that have happened in Utah. Hopefully these extreme situations do not occur very often, but my hope in publishing these is to allow both owner and associate dentists to assess their own situations and make midcourse corrections as necessary and prevent some of these incidents from coming across my desk and requiring intervention to either prevent or try to defend a malpractice case.

#1. I moved back to a large city post-residency for an associate position. On day three the office manager handed me a panoramic x-ray and asked: "Can you perio chart this patient?" "Sure," I said. "What treatment room are they in?" She replied, "They're not. Dr. Y does it all the time." I quit that day.

Commentary: Many dentists may not realize what is involved in proper periodontal charting and analysis. First of all, a panoramic x-ray is not the best way or even the standard of care for use in diagnosing the scope of periodontal problems. A full mouth series of periapical images, including bitewings, is what should be taken. Some dentists wonder about using CBCT images to help diagnose periodontal conditions but that means a lot of unnecessary radiation to the patient and a deviation from ADA guidelines. A standard full mouth series is the better choice. Probings must be done in the mouth and not guessed at using radiographs. They must also be documented in the chart.

#2. Nearly 15 years ago I was in discussions with a colleague to become an associate in a pricey ($10-15k/mo) downtown practice. It was technically OK. But upon further investigation I discovered the owner's mountain of debt, ugly divorce, that his wife took him to the cleaners, and that he had anger management issues, which included breaking a patent's jaw. This necessitated an army of bloodsucking lawyers to protect him. My stock investment in an impending IPO seemed his only way out. The stock turned out to be one of the biggest bogus frauds in state history!

Commentary: If something sounds too good to be true, trust your instincts! Discuss any investments with an experts in this field that you can trust (see investment article in this Newsletter). Also, it does not hurt to vet the associate if you are the owner and the owner if you are a prospective associate! We have also recommended that you retain your own legal counsel to review contracts and terms, particularly if purchasing stock in the practice.

#3. During my first associate position, on December 15 I asked the owner dentist, "May I have my check before I leave?" The doctor replied, "No. You want my family to have a Christmas, don't you?"

Commentary: The contract you sign and have reviewed should spell out when you are to be paid, etc. Unfortunately some dentists that bring on associates have not done their homework to see if the practice can sustain an additional dentist, and run into problems with cash flow, etc. Study the numbers before you sign on the dotted line!

#4. My GP boss did his own ortho with no school or proper training. He finished a case CR/CO 5 mm discrepancy and told the patient's mother, "Mom, she has to learn to bite farther forward." In another situation he did a short pyramid prep. The zirconia crown came off a third time. He then told her, "Well, there's nothing more I can do. You're just going to have to keep getting it recemented."

Commentary: Obviously the owner dentist had no business doing orthodontics but unfortunately there are dentists that attempt it that have no idea what they are doing. We have dealt with these situations in Utah and in nearly all situations the case has to be started over and the parents and adult patients are really frustrated over the wasted time and in some cases the irreversible damage. There is no excuse for trying to do specialty procedures with inadequate training, especially when you know that there are excellent specialists in this state that can handle even the most difficult cases.

In terms of bad crown preparations, it is easy to over-cut preps and have little or no retention, particularly on back teeth where there is not a lot of room coronally to have a good, retentive preparation. As we mentioned in the mandatory course, you can cut retentive boxes in the prep that can be reproduced in ceramic restorations to enhance retention. I deal with a number of situations every month where patients are upset about open margins or repeated re-cementation issues. These problems can and should be prevented with more judicious case planning and execution. As written above, there is no excuse for trying to do advanced restorative procedures when you know that there are excellent prosthodontic specialists in the state that can handle these difficult cases!

#5. The owner has informed me that we are to take a CBCT on every patient and that we are to do and charge for bone grafting every time we do an extraction. I wonder about the ethics of doing this to all patients.

Commentary: There are clear guidelines on the use of CBCT images furnished by the ADA and the specialty organizations. The main purpose of the CBCT is to assess problems in 3 dimensions and the dental organizations that are most involved in the use of CBCT technology are the endodontists and oral surgeons. Oral radiologists also have a say in how these x-rays should be used. Accordingly, the AAE and AAOMR have issued a joint position statement wherein they outline their position on CBCT use. The position statement notes that "CBCT should be use only when the patient's history and a clinical examination demonstrate that the benefits to the patient outweigh the potential risks. CBCT should not be used routinely for endodontic diagnosis or for screening purposes in the absence of clinical signs and symptoms. Clinicians should use CBCT only when the need for imaging cannot be met by lower dose two-dimensional radiography.'

PIE's position is that this statement applies to other aspects of dentistry as well. In other words, unless you are planning on placing implants or have a third molar extraction that requires a 3-D image to assess anatomy of the surgical site, or need a 3-D image of a tooth contemplated for root canal therapy to determine the presence of fractures or extra canals, etc. the CBCT machine should not be used.

As far as bone grafts for extractions, this is overtreatment unless an implant is planned to replace the extracted tooth. How many years have passed where we did no grafting after an extraction and the patient got along just fine? Obviously, if the extraction is in the anterior and bridgework is planned in lieu of implants, there may be indications to graft bone to help create a better esthetic result. In the posterior there will certainly be thinning of the ridge and loss of bone but what difference will it make, especially in the posterior area where esthetics are not a concern and there is no implant, etc. planned?

In conclusion, there are no guarantees that all associateships and other situations where the seller becomes an associate, etc. will work out but steps must be taken to ensure that quality of care and ethics toward patients and other dentists are not compromised. A rule of thumb might be: Would you make the same recommendations or handle the case in the same manner financially if your mother was the patient?

--RCE

DENTISTS AND TEXTING

We are finding that more and more dentists and offices are using texting as a source of communication. This is often easy and convenient but occasionally we are asked about and have seen pitfalls pertaining to this method. What do you need to know about texting and malpractice claims?

1. Patients can and will use texts against you in claims. For example, you will be out and about and a patient will catch you off guard with a text asking a question and you will fire off an answer without thinking. Rather than a quick answer you should text back something like: "Let me check this out and I will get back to you."

2. You have received an insurance payment and your office manager wants to text the patient to let them know that they still have a balance. This should not be done! With all the hype about privacy issues, and HIPAA, etc. you do not know who might have access to such a message. You are better off to use the old fashioned telephone to contact the patient and ask them to call the office rather than leaving a detailed message about the balance, etc.

3. Texting is acceptable to remind a patient of an appointment but you should not go into any detail as far as the nature of the appointment. For example, a text that goes: "Reminder of your appointment Wednesday October 17 at 3:00" is acceptable. But "Reminder of your appointment Wednesday, October 17 at 3:00 to adjust your denture is not." Keep in mind that some people do not erase texts and that anything stored in a phone can be used as evidence or can be accessed/reviewed at times data is transferred. And sometimes the wrong number is used such that the text goes to who knows where?
--RCE

FAN MAIL FROM AN INSURED

In this day and age of fierce competition and negative reviews on social media, etc., occasionally it is nice to get positive feedback. Following is a letter from a PIE insured we received some time ago after the first round of mandatory courses that we thought we would publish here so you can see that we try our best to do a decent job for our insured.

Dear PIE,
For some time I have had the desire to write and express my feelings about PIE and its policies and conveniences. I have long appreciated the information that PIE includes in its newsletters. There has never been an issue of those newsletters that was devoid of very useful information that I have been able to use almost every day of my life, both at home and in the office.

I have experienced other companies for many years (having practiced in another state previously). I do not recall that I received newsletters that were as useful as those of PIE. I would say that, as far as I am concerned, "our competitors" should go elsewhere to peddle their wares. I shall be one who will vehemently protect our reputation (that of PIE) and I shall refute attempts to discredit our company!

Hurray!!!! I am proud of the fact that our "corporate stockholders and over-paid executives" do not take advantage of the very successful policies that we are all enjoying as "insured" under the PIE banner! I, for one, will continue with PIE Mutual, Inc.

We appreciate the thoughts of this dentist and other insured who vouch for PIE and also do what they can to follow the advice from the Newsletter and courses to keep claims and claim related expenses low!

CBCT ACCESS IN NORTHERN UTAH

As we have noted in prior PIE Newsletters, Cone beam (CBCT) technology and 3D reconstruction is today's technology and will assist in the diagnosis and treatment planning of case specific solutions in a wide variety of dentistry and general medicine cases. Although the 3D images will never replace periapical or bite wing x-rays and may not be as useful in some cases as a standard panoramic x-ray film, the CBCT x-ray can provide vital information related to structural integrity, bone density, soft tissue pathology and relationship of dental structures.

The appropriate use of cone beam imaging where indicated, and utilizing a consistent case selection technique, will provide all dental professionals with an additional diagnostic imaging technique. One problem many dentists face is the expense of purchasing a machine for a solo practice and dealing with pressures of recouping the investment once the unit is part of your office armamentarium. One solution is to have access to other CBCT machines in various facilities.

For dentists in northern Utah, Weber State University, Department of Dental Hygiene has completely remodeled its 18 chair dental clinic three years ago and can now provide CBCT images for your patients. As a cost saving to you and your patients, your office can now schedule CBCT in their clinic by calling 801-626-6131. The fee for the 3D x-ray is $125.00 due at the time of services. They will provide a CD with all images and the viewing software. Their faculty dentists will not read the x-ray, however, that is up to you although it is recommended that you have a dental radiologist review the images if possible to ensure that nothing is missed.
--RCE

GUEST COMMENTARY

- **RICHARD T. BAUMAN, DMD**
- **MEMBER, PIE BOARD**

Have you ever had a bad day in the office? Maybe you can relate to a recent experience I had. A distant relative was in town for a family reunion and need an endodontic retreatment on tooth #18. This was a very difficult procedure. I struggled to get patent and the patient couldn't open very wide. In then end we did it and the radiograph looked good. Mission accomplished. Then on the follow up call they were in pain with some swelling. Some antibiotics were prescribed. A couple of days later they were still in pain. Switched the antibiotic and the pain seemed to be resolving. Mission accomplished! Distant relative went home. Next time we talked was a couple months after treatment. First thing they said when next we spoke……you know, I've had a tingling in my lip since you worked on my tooth. Um…that is not what I was expecting. That dreaded paresthesia feeling washed over me. I asked how big the tingling area was and it was very small. Then they said, it seems like the sensation is returning

and the tingling area keeps getting smaller. Ahh blessed hope! I am one lucky guy! Have you ever had that pit in your stomach when a patient of yours tells you they are still numb following an endodontic procedure, or any procedure? It is really an unpleasant feeling. Knowles et al. found that the incidence of paresthesia in endodontically treated mandibular premolars was about 0.96%. So only about one in every one hundred you do. That doesn't sound too bad until you are the hundredth patient or it happens to be a relative. So how can we avoid and treat paresthesia of endodontic origin?

This article is not the place to go into extensive details on all aspects of endodontic paresthesia's but maybe I can give a little information to help you avoid or manage these cases better. Benjamin Franklin said an ounce of prevention is worth a pound of cure. With paresthesia's that is absolutely true. To avoid them we need to know of the most common causes. For endodontics we are most concerned with direct trauma from endodontic instruments and chemical trauma from endodontic materials.

Key #1 - **Evaluate the periapical radiograph or CBCT before treatment**. Look at the proximity of the root apex to the mandibular canal or the mental foramen. Look to see if there is an open apex or a periapical radiolucency. Most cases I have seen involved a periapical radiolucency as the bone between the apex and the nerve has already been removed making it much easier for our treatment to affect the nerve.

Key #2 – **Get consent that includes the risk of paresthesia**. Or better yet, use the PIE form. Although lingual and inferior alveolar nerves are the most commonly affected, there are case reports of maxillary nerves being affected. I was consulted by a neurologist on a case of dysethesia (pain) of the infraorbital nerve following infiltration with Septocaine and a routine restoration. The only thing that could have caused the issue was the anesthetic. All areas have risk of paresthesia even though the mandible is more common.

Key #3- **Nerves are more sensitive to chemical damage that other tissues**. We understand that trauma to a nerve can cause paresthesia. However, in endodontics, we have more paresthesias from chemical damage. Every chemical we put into a tooth from bleach to calcium hydroxide or EDTA to sealer has some capacity to damage the nerve. The worst cases I have seen typically involve calcium hydroxide or sealer. Brassler teaches a single cone hydraulic obturation technique where you fill the canal with Brassler endosequence sealer and then slowly put a cone into the area. The cone creates pressure forcing the sealer into lateral and accessory canals. However, if you are patent or you have a periapical lesion, it will also force the sealer out the apex. I have seen cases with excessive sealer around nerves with this technique. This leads to the next key!

Key #4- **Short fill is better than long in danger areas.** If you are close to the nerve radiographically or a lower pre-molar in the area of the mental foramen or you have a periapical radiolucency – alter your obturation or calcium hydroxide placement technique to ensure you do not get any out the end. Both are very basic and cause chemical damage to nerves.

Key #5- **Take a post-operative radiograph**!!! This is very important. Most people take a post-operative radiograph for the final fill but may not with calcium hydroxide. You need to know what it looks like to manage the case if the patient is still numb after the anesthetic should have worn off. If you have no film and the patient calls the next day saying they are still numb you have no idea if it may be from infection, anesthetic, calcium hydroxide or trauma. You need to know if there was a potential for chemical damage as it changes the recommended treatment.

Key #6- **Follow up with patient if you have an over-fill.** If your post-operative radiograph shows sealer or calcium hydroxide out the apex make sure you inform the patient that you need to know if the anesthetic does not wear off. Treatment is very time sensitive. Or better, call your patient that night or the next morning to ensure they are no longer numb.

Key #7- **Treatment is time sensitive-Refer immediately** - If you have radiographic evidence of calcium hydroxide or sealer out the apex and your patient is still numb the next day then you need to refer to an endodontist or oral surgeon that same day. They must be seen and potentially treated immediately. They need to assess to see if surgical intervention is warranted. Pogrel has shown that surgical intervention in the case of chemical damage it very time sensitive and should be performed within 48 hours to have the best outcome. Steroids, B complex vitamins and other treatment options can also be helpful.

Luckily the risk of paresthesia in endodontics is low, but we can do a few things to decrease our risk even further. I'd rather have a short fill in high risk teeth than a paresthesia case.