Health Focus

INSURANCE

Laura Mutsko
Agent and CSA

Q: Can I buy a hearing aid without a prescription?

A: Beginning in October, a new rule will go into effect that will impact more than thirty million Americans with mild to moderate hearing loss. The FDA recently announced their long-awaited Over the Counter Hearing Aid Guidance. The new rule permits hearing aids to be sold directly to consumers in stores or online without a medical exam or a fitting by an audiologist. The goal is to make hearing devices more affordable for those with low to medium hearing loss.

Under the current rules, prescriptions for hearing aids are required and only provided after the patient meets with a hearing professional for an exam and fitting. The cost of these visits and the hearing devices can total thousands of dollars and can put hearing aids out of reach for many people. The cost of over-the-counter hearing aids is expected to be under $2,000.

There are several key differences between prescription hearing aids and over the counter products. Unlike prescription hearing aids, the over-the-counter devices will be a one-size-fits-most type of device that will be self-fitted by the consumer. Instead of testing using advanced equipment by an audiologist, the consumer will approximate their loss of hearing. Some of the new devices are likely to pair up with smartphones for control and adjustments.

Over-the-counter hearing devices are not recommended for those who are under age 18 or people with severe hearing loss. Professionals recommend hearing exams if someone experiences sudden or severe hearing loss, dizziness, pain, tinnitus, roaring or ringing, or fluid in their ears.

Original Medicare does not offer coverage for hearing care. Some, but not all, Medicare Advantage plans provide limited coverage. However, hearing loss is extremely common affecting around 33% of people in the U.S. between the ages of 65 and 75. This percentage increases to nearly 50% of those over the age of seventy-five. If left untreated, hearing loss is often associated with depression, cognitive decline, and general feelings of isolation and frustration.

This information should not be construed as an endorsement of over-the-counter hearing devices. It is provided as information only. Before you purchase any hearing aid, ask about the company's return policy, loss, damage, repair and replacement policy, and satisfaction guarantees. Take time when you shop for one of these lower-cost devices as they may not be suitable for everyone. The guidance of a professional may be what you need to get the most benefit from a hearing aid.

If you have questions on insurance, including Medicare Advantage plans, Medicare Supplements, and other Health Insurance products, please call me at 440-255-5700 or email me at Lmutsko@mutskoinsurance.com.

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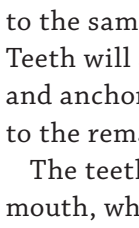

DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: I Can't Chew With My Partial

A: I met this patient and listened carefully to her problem and concern. She told me that she has two new partial dentures and struggles with both of them. Her difficulties were not the same for each of these new devices. Before we get to her problem, let's take a moment to review and explain the subject of today's discussion. Whenever someone loses teeth in their mouth, dentistry recommends replacing the missing tooth or teeth for whatever reason. When concerned about a single tooth replacement, we discuss implants and bridges as quick and easy solutions. If the patient is missing many teeth, permanent options due to complexity may be out of the question. Dentists look at removable options for replacing teeth, and we call these tooth replacements removable bridges or partial dentures. Both terms refer to the same type of apparatus. Teeth will sit on the gum tissue and anchor into place by attaching to the remaining teeth.

The teeth take up room in the mouth, which can sometimes be difficult to find. As we age, the space between the top and bottom teeth decreases. The natural wearing of the teeth through normal or abnormal use is common. The loss of space accelerates if we lose back teeth early in our lives. Since we don't have back teeth with which to chew, the brunt of the chewing occurs on the front teeth. I have written extensively on why this phenomenon is not good or healthy. I want to add to the problems when we rely on our front teeth as the primary means of chewing. The extensive pressure on the front teeth causes those teeth to flare forward. As they angle and flare outward, the loss of space between the top and bottom teeth in the back of the mouth decreases considerably.

With this loss of up and down space for teeth, replacement of teeth can become impossible. A partial denture is made up of a base composed of either metal or another material and then the artificial teeth themselves. All of this occupies space, and if there is a loss of vertical space, the partial denture will not work. What I have just described happened to my patient. She had so little space that the partials would not let her chew as her natural teeth would not touch each other.

The way to fix this problem and regain space is to make existing teeth, her natural teeth, taller. When teeth are big and not worn away, they create more space in the areas of missing teeth. Making teeth larger is not a difficult job. Through the use of bonding and sometimes crowns, I can make teeth taller, resulting in the ability to replace missing teeth with a well-made partial denture.

Let's get back to our patient. She complained that her lower partial was hurting her teeth because it was too tight. I was able to fix that easily with some minor adjustments. Her other complaint of not being able to chew was a result of our lack of space, as I just described. Her lack of space was so bad that, in addition to complaining about not being able to chew, she showed me a broken front tooth. The tooth fracture occurred because of the tremendous amount of chewing force that was put on that tooth due to the loss of her back teeth.

I proposed that we remove the fractured tooth, build up her remaining five teeth and then make a new partial. The treatment plan was simple once we determined the source of her problem. If you find that chewing has become a chore or causes you discomfort, please call me at 440.951.7856 and set up a visit. Nicole will be happy to do this for you and I look forward to hearing from you.

Jeffrey Gross, DDS, FAGD, is an Ohio licensed general dentist and is a staff member at Case School of Dental Medicine in the Department of Comprehensive Care.

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OPHTHALMOLOGY

Gregory Eippert, MD

Q: Glaucoma is a general term used to describe a group of eye disorders that damage the optic nerve. One of the major risk factors is eye pressure.

A: Your eye constantly produces a clear fluid called aqueous humor. As new aqueous flows into your eye, the same amount should drain out. The fluid drains out through an area called the drainage angle. This process keeps pressure in the eye (called intraocular pressure or IOP) stable. An abnormality in the eye's drainage system can cause fluid to build up, leading to excessive pressure that causes damage to the optic nerve. The optic nerve is a bundle of nerve fibers that connects the retina with the brain and plays a crucial role in vision as it sends signals from the retina (neural tissue in the back of your eye, like the film of an old-fashioned camera) to the brain. Your brain relies on these signals to create images.

At first, glaucoma doesn't usually have any symptoms. That's why half of people with glaucoma don't even know they have it. The vision loss starts out in the edges of the visual field and slowly impacts the central vision. It takes months to years after the nerve damage has occurred before you may notice the symptoms. Once vision is lost, it cannot be recovered.

Many factors lead to glaucoma. While increased eye pressure is the only known modifiable risk factor known at this time, Glaucoma can also develop with normal eye pressure.

Frequent eye screenings are critical for early detection and intervention. If you are a glaucoma suspect or have a diagnosis of glaucoma, see your eye doctor for regular, dilated exams and/or testing as frequently as recommended by your doctor.

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Did you know?

Despite its reputation as the most formidable type of mold individuals can find in their homes, black mold is similar to other indoor molds in regard to its effects on human health. According to the Centers for Disease Control and Prevention, black mold, or stachybotrys chartarum, isn't any more harmful than other types of mold, including cladosporium, penicillium, aspergillus, and alternaria. The reputation of black mold, which can look black or greenish-black, likely has something to do with its appearance. But homeowners still have reason to be fearful of mold in their homes, regardless of what color the mold may be. That's because mold can lead to a host of unwelcome health problems, including stuffy nose, sore throat, coughing or wheezing, burning eyes, or skin rash. Symptoms may be even worse for people with asthma and mold allergies.

Health Focus

DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: The Pain is Somewhere Over There

A: I heard this complaint a couple of weeks ago, and the week before, I heard the following: "I have a toothache on both the bottom and top, and I can't pick which tooth is hurting me." And last and not least, "whenever I chew, I get a pain up to my ear." Believe it or not, these statements are related and rooted in the same source. When I examined all of these patients, there was nothing glaringly wrong, either visibly or on an x-ray. Yet, all of these problems and issues stem from a biting problem or a misalignment of the teeth. Those who follow me regularly know my mantra regarding teeth and biting. It would be best to keep your teeth apart and your lips together when you are not eating. Teeth only are meant to come together when we eat, not at any other time. This is one reason why gum chewing is so bad for you. Your teeth clash in meaningless action. Chewing food is meaningful, and gum chewing is meaningless. In addition to gum chewing, grinding or clenching does not have any purpose. Your teeth meet and press on each other. These actions of clenching or grinding have far-reaching consequences.

First of all, those actions or habits put continual pressure on your teeth. According to Dental Health Directory Library, the human jaw can apply approximately 68 lbs/sq inch of pressure on the back teeth. If you intentionally clench your teeth, you may increase that force to about 150 lbs/sq inch. However, individuals who clench and grind their teeth subconsciously at night can place up to 1200 lbs/sq inch of force. Teeth were never meant to have continual pressure. The act of chewing applies forces, then lets up, and then re-applies pressure. The pressure is never constant for an extended time. These forces far exceed what a tooth is capable of withstanding. The result can be a fractured tooth, a loose tooth, or a tooth that requires a root canal, as the nerves and blood vessels inside the tooth are irreversibly damaged. Many of the crowns that I make for teeth are done on fractured teeth. These teeth fracture due to excessive forces. Often these harmful habits are the culprit.

In addition to the tremendous forces exerted on the teeth, the jaw bone also is a recipient of these forces. The lower jaw transmits its trauma from excessive forces to the muscles and ligaments that attach the lower jaw to the head. These delicate structures all come together right in front of the ear. This intersection of jaws and soft tissue is called the temporomandibular joint. We call it TMJ for short. Those three letters are mentioned a lot when people have non-descript jaw pain. It is not sinus; it is not tooth related; it is joint inflammation caused by inappropriate biting forces.

So what is the cause of these forces that wreak havoc in our mouths? Sometimes it is stress in our lives that stems from family or jobs. Some people get ulcers, others pull their nails, and others clench or grind. Let me take a moment to say that it doesn't matter if you are a clencher, grinder, or both. These actions are all bad for you. So one solution is to eliminate the stress in one's life, and the clenching, etc., get better. Many times that is easier said than done. Some of these oral actions become ingrained habits that are difficult to break. When such a situation exists, the dentist steps in and makes a custom-fitted mouth appliance to either help you break the habit or protect your teeth from damage. There are many styles and shapes of these devices. A professional needs to assess you, make recommendations and fit you properly. A patient told me last week, "I was skeptical of your grinding hypothesis. Now that I am wearing a device, I feel great, and everything is comfortable. You have made a true believer out of me." So if you find that you have teeth breaking, fillings are always falling out, crowns are popping loose too frequently, or a toothache that you can't pinpoint, call me at 440.951.7856. Together we can play detective and work on figuring out the problem. You only have one set of teeth; let's do all we can to care for them.

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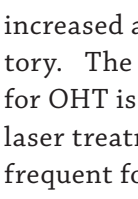

OPHTHALMOLOGY

Gregory Eippert, MD

Q: What is ocular hypertension?

A: Ocular hypertension is when the pressure inside the eye (intraocular pressure or IOP) is higher than normal. IOPs greater than 21 mm Hg are typically considered indicative of ocular hypertension or OHT. OHT is not the same as glaucoma, which is a disease of the eye often caused by high IOP. In people with OHT, the optic nerve appears normal and no signs of glaucoma are found with visual field testing which tests side or peripheral vision. However, people with OHT are considered 'glaucoma suspects' and should be monitored closely by an eye care professional to help prevent or delay the possible onset of glaucoma.

The decision to treat OHT involves the evaluation of several risk factors for progression including central corneal thicknesses, IOPs consistently above normal range, cup-to-disc optic nerve measurements that are suspicious, increased age, and family history. The first line of treatment for OHT is generally eye drops or laser treatments combined with frequent follow-up visits as determined by your eye doctor.

For low-risk patients, your eye doctor may suggest observation and monitoring as the best course of action. In this case, patients are typically seen every 6 months for follow-up visits that include IOP measurement, dilated exams, and alternating visual field and optical coherence tomography imaging (OCT) for early detection.

The bottom line is that ocular hypertension requires continuous monitoring whether you are being treated or being observed and monitored. Regular and complete eye exams with your eye care professional are the best preventative measures for OHT and general eye health.

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Does breast cancer run in families?

No woman is immune to breast cancer. However, some women with extensive family histories of the disease may wonder if they're more vulnerable to breast cancer than those without such a link. According to the Centers for Disease Control and Prevention, roughly 3 percent of breast cancers result from inherited mutations in the BRCA1 and BRCA2 genes that are passed on in families. Inherited mutations in other genes also can cause breast cancer (as well as ovarian cancer), but BRCA1 and BRCA2 are the most commonly affected genes. And it's not just women who can inherit these mutations. Though men account for only a small percentage of breast cancer patients, they can get the disease, and those who inherit mutations in BRCA1 and BRCA2 are more likely to develop breast cancer than other men. The CDC notes that not everyone who inherits a BRCA1, BRCA2 or other mutation will develop breast cancer, and women with such mutations can take steps to help lower their risk for the disease. Doctors can discuss those steps with women, but they may include genetic counseling and testing. The CDC also notes that, even in instances when counseling and testing is not ultimately recommended by a physician, women should consider talking to their doctors about starting mammography screening in their 40s. That's earlier than some organizations recommend, though physicians may feel it's worth it depending on the individual.

INSURANCE

Laura Mutsko Agent and CSA

Q: What should I do if my health insurance refuses to pay a bill?

A: Just because a medical bill is denied by your health insurer does not mean you should immediately pay it. Billing mistakes may be unintentional but an alarmingly high percentage – up to 80% by some estimates - contain at least minor errors.

Your initial bill is a summary of your services prior to your insurance company processing their share of the costs. You should wait until you receive an Explanation of Benefits (E.O.B.) from your insurer before you pay any bills.

When you receive the E.O.B., verify that their information matches your records, and the amounts on your bill and the E.O.B is the same. This task will be easier if you have kept a record of your doctors' visits, procedures, tests, and other medical visits including the dates of service and the care you received. Some common errors to look for are duplicate charges, charges for cancelled tests or procedures, incorrect patient information and incorrect quantities of items provided. If you find any errors, report these to your provider's billing service and ask them to resubmit the claim.

If your insurance is not covering something you thought would be covered, call their customer service line, and ask why. The insurer may be missing a key medical record indicating a service was medically necessary or the physician did not get prior authorization for a service. If your claim is still denied, ask how you can file an appeal. The appeal process takes time, however it is estimated that almost 40% of initial appeals result in the health insurer reversing their decision.

I suggest you enlist a spouse or a trusted person to help you with this process. Notify your insurance company and medical provider that this person is authorized to speak on your behalf. Don't give up until you get answers that you understand.

One of the services I provide my customers is assistance with billing problems like these. There is never a charge for my services. It is one of the benefits of having me as your insurance agent.

I welcome your questions concerning life, health, or Medicare insurance. Please contact me at 440-255-5700 or Lmutsko@mutskoinsurance.com to set up an appointment to discuss your needs.

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Health Focus

OPHTHALMOLOGY

Gregory Eippert, MD

Q: Which types of herpes viruses can affect the eyes? What are the symptoms and how is it treated?

A: There are two main types of herpes viruses that can affect the eyes: herpes simplex (HSV) which is the same virus that causes cold sores, and herpes zoster (HZV) which is the same virus that causes chickenpox and shingles.

Herpes viruses of the eyes are often painful and can affect all parts of the eye including the skin around the eye. Since the effects can range from mild to severe and could possibly affect your sight in severe cases, a thorough eye exam by your eye doctor is recommended for each occurrence to assess the extent of eye involvement.

Various signs and symptoms are associated with an ocular herpes outbreak including excessive eye irritation, sudden and severe ocular pain, swelling around the eyes, recurrent eye infections, redness, rash, or sores on the eyelids and around the eyes especially on the forehead, swelling and cloudiness of the cornea, tearing, foreign body sensation, watery discharge, sensitivity to light, and blurring of vision, among others.

Treatment varies depending on which part of the eye is affected. If the top layer of the cornea is affected, epithelial keratitis, treatment is with antiviral eye drops or ointments, or antiviral pills. These do not kill the virus, but stop it from spreading until the infection clears. If the deeper layer of the cornea is affected, stromal keratitis, steroid drops may be used together with antiviral drops. If just the eyelids of conjunctiva are affected, no treatment may be advised as these infections usually settle on their own.

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INSURANCE

Laura Mutsko
Agent and CSA

Q: What is the difference between a Medicare HMO and Medicare PPO?

A: The two most common types of Medicare Advantage Plans are HMOs and PPOs. The biggest differences between these two are out-of-network coverage, size of network, costs, and the need for a primary care physician.

Regardless of whether you have a PPO or an HMO, you should always go to the nearest hospital or urgent care center for treatment in a medical emergency. All plans help pay for medically necessary emergency and urgent care services. When it is not an emergency, PPO and HMO plans work differently.

HMO stands for health maintenance organization. A Medicare Advantage HMO plan provides all the benefits covered by Original Medicare. However, your benefits are provided through the plan's network of health care providers. For the most cost-effective health care you will use the physicians, hospitals, labs, and other health care facilities specified within the network. With most HMO plans, you will select a primary care physician who will function as your health care 'gate-keeper,' providing you with referrals before you consult any specialists.

HMO plans can also be more restrictive for travelers. The HMO's network may be limited to a specific geographic area except in emergency situations.

PPO stands for preferred provider organization. PPO plans give you more flexibility in choosing which health care providers you see. You do not need a primary care physician so you can go to any health care professional you want without a referral inside or outside of your network. If you choose to go outside your network, you will have higher out-of-pocket costs, and not all services may be covered.

Plan Networks. A defining feature of HMO and PPO plans is their networks of doctors, hospitals, and other health care providers. Different plans offer different providers in their networks, so it is important to confirm that your doctors, specialists, health care providers and hospitals are in your plan's network.

If your current coverage is not meeting your needs, it may be time to switch to a different type of coverage. I work with many respected insurance companies and will help you find a plan that fits your health care needs. Give me a call at 440-255-5700 or email me at Lmutsko@mutskoinsurance.com.

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DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: "There is Nothing New Under the Sun." Ecclesiastes1:9

A: If you are wondering, I did not give up my dental practice to become a religious leader. Although the title of this week's column could lead you to believe I did move in that direction. That being said, I want to share some thoughts with you on how important it is to keep an open mind regarding dental care. An open mind is important for the doctor and the patient. Openness starts with the professional but needs to trickle down to the patient. This can only happen when there is communication and trust between those two individuals.

I saw a patient his week who lost her upper right molar. Although many patients did not give enough importance to this tooth, she understood that it is one of the keys to effective and efficient chewing. In practice, the first molars, the first big teeth we encounter as we move from the front to the back of the mouth, account for 80% of our chewing strength. These teeth take the stress off the rest of the teeth, resulting in all the teeth lasting longer with less wear and tear.

My regular readers know that implant dentistry is a normal part of my practice and has been for almost 30 years. For a long time, I was the only general dentist placing implants back in the day. With that as a background, my patient's choice for replacing her upper right molar should be an implant with a crown. As with any medical procedure, there are certain requirements and prerequisites for that technique to create the desired result.

When it comes to implant dentistry, there is a unique set of needs to allow the procedure to take place. First and foremost is adequate bone. What does that term mean? Adequate bone is defined as enough width and height around the proposed implant to anchor the implant. If the bone is lacking in either of those dimensions, the implant procedure will not work, and we need to look for alternative treatment.

That is the case with my patient, and she did not want to try creating more bone. She wanted to replace her tooth as soon as possible, and bone creation procedures took time. The next treatment option is a permanent bridge. When I do this procedure, the teeth on either side of the missing tooth will receive crowns to anchor the bridge. Those teeth are in great condition in her case, and she did not want me to shape those teeth for the bridge.

At this point, many people would run out of options, but I reached into years of practice and recommended a very popular technique before implants became commonplace. I suggested that we utilize a bonded bridge for replacing the missing tooth. With this procedure, lack of sufficient bone is not a factor. The concept of no or minimal preparation of the adjacent teeth solved her problem. I could even do the procedure without any numbing solution because it is so gentle and not invasive.

The bonded bridge technique is not new, but neither is her problem. As the title of the column says, there is nothing new under the sun. At the same time, there may be exceptions to that statement but in life, that message is true quite often. My patient was very pleased with the approach as it solved all her problems and saved her money. I would call that a win-win for all concerned. If you are missing teeth and want to explore various techniques to replace the tooth, please call me at 440.951.7856. Nicole will be happy to do this for you so we can meet.

Jeffrey Gross, DDS, FAGD, is an Ohio licensed general dentist and is a staff member at Case School of Dental Medicine in the Department of Comprehensive Care.

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Have your problems addressed by medical professionals in "***Health Focus***"! Send your question to: advertising@news-herald.com

Health Focus

INSURANCE

Laura Mutsko
Agent and CSA

Q: What benefits will seniors see from the recently passed Inflation Reduction Act of 2022? When will these changes go into effect?

A: The Inflation Reduction Act of 2022 was recently signed into law by President Biden. Among the goals of the IRA legislation is to make prescription drugs more affordable for millions of Medicare beneficiaries.

The first changes will go into effect in 2023 with additional reforms being rolled out over the next few years. The changes will apply whether you have a standalone Medicare Prescription Part D drug plan or a Medicare Advantage Plan with Prescription coverage. Here is a brief overview of what you can expect:

2023

Insulin will be more affordable. All insulin drugs, not just specific types, will be capped at $35 per month for all Medicare Part D and Advantage plan beneficiaries. All Medicare plans with drug coverage must comply with the $35 cap beginning in January 2023.

People with Medicare will be able to receive critical vaccines free of charge. Medicare Part B coverage for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including the shingles vaccine, will be expanded to cover costs at 100%.

The Act will establish an "inflation rebate" that requires drug companies to pay a rebate to Medicare if they increase a drug price beyond the pace of inflation. This will help keep in check unjustified price increases for drugs that have been on the market for years.

2024

The IRA will eliminate the 5% coinsurance for Part D catastrophic coverage and expand eligibility for Part D Low-Income Subsidy full benefits up to 150% FPL.

2025

Medicare will put in place a $2000 cap on out-of-pocket drug costs for seniors by 2025 and will allow these costs to be paid monthly rather than all at the beginning of the year.

Between 2024-2030 the Act will establish a limit on Medicare Part D premium growth to no more than 6% per year.

The Act will allow Medicare to directly negotiate to lower the cost of prescription drugs to ensure older Americans get the best-possible deal on high-cost drugs. The Department of Health and Human Services will start price negotiations next year for 10 expensive and popular drugs, which would increase over time. The new negotiated prices are expected to begin taking effect in 2026.

If you have questions on Life or Health Insurance including Medicare Advantage plans, Medicare Prescription plans or Medicare Supplements, please call 440-255-5700 or email me at Lmutsko@mutskoinsurance.com. We will set up an appointment to discuss your insurance needs and find the best coverage for you.

We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options.

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DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: Why Can't You Just Do A Filling?

A: I met this lovely lady yesterday who came to me for a second opinion. Her dentist told her that the upper left cuspid, also known as the eye tooth, needed a root canal followed by a crown. Her dentist does not do root canal therapy and referred her to someone else. She told me that she reads my column frequently and wanted my opinion. She shared her age with me and as a ninety-year-old, was agitated that she needed this procedure and had to spend money on it. I took an x-ray, and a conversation ensued. I want to share some of the topics that we discussed and elaborate on some of those topics.

When I looked at her x-ray, I immediately agreed with her dentist. The tooth in question showed a serious area of decay on the back side. The decay was deep and extended into the center of the tooth where the nerve resides. Often at the age of 90, the nerve shrinks away which would explain why she did not have any discomfort associated with that tooth. The lack of pain is not an indicator as to which treatment is warranted. Pain is our body's way of telling us something is wrong. However, things can be wrong without pain. Either the pain is around the corner, or it is simply not present and never will be.

Her decay was unique in the fact that it started just a little above the gum but soon moved and submerged below this gum area. Cavities of this type are very difficult to find, and they are mostly hidden. When the decay gets very large, it starts to peak up above the gun and the dentist can catch it. I'm sure that many of you are asking about x-rays. We take dental x-rays to allow us to see hidden areas, such as below the gum area or in between teeth. Could this cavity have been found earlier? I can't answer that question, but one thing to remember is the following.

We take x-rays of the back teeth at the annual or semi-annual checkup and nothing more. My patient's decay appeared in a front tooth and would not appear on a routine exam. This fact of only seeing the back teeth is why we instituted pictures of the front teeth when we do back teeth x-rays.

Let's get to the crux of her question once we have accepted the fact that she has a large cavity on this tooth. Fillings whether they be silver or white all have indications and limitations. When I place a filling, it is moldable and responds to my shaping and contour creation. When I am satisfied with the shape, I can harden it at will or let it set chemically on its own. If a tooth has a very large defect or one that extends below the gum, a filling is not an option. Simply put, the filling, in that case, cannot be placed well. If it is not placed well then it will be a source of future decay and breakdown.

Also, if the area of decay is close to the nerve, placement of a filling so close to that area will result in much pain, inflammation, or even infection. Those cases with a cavity so close to the nerve, require a root canal treatment first followed by a crown for strength and for the creation of the proper shape and surfaces of the tooth.

Not every tooth that has a cavity is a good choice for a filling. Your dentist needs to carefully examine and analyze each situation individually. Where indicated, the most conservative treatment is always our first choice. However, if we sacrifice quality while seeking conservatism, that is not a good direction in which to move. If you need to hear another thought or opinion on your proposed treatment, please feel free to call me at 440.951.7856 and set up a visit. Nicole will answer the phone and arrange for us to meet.

I look forward to hearing from you.

Jeffrey Gross, DDS, FAGD, is an Ohio licensed general dentist and is a staff member at Case School of Dental Medicine in the Department of Comprehensive Care.

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OPHTHALMOLOGY

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Q: Why is an eye exam so important? How often do I really need to see an eye doctor?

A: During a comprehensive, dilated exam, your eye doctor does much more than determine your prescription for eyeglasses or contacts. The doctor will check for common eye diseases and problems such as glaucoma, cataracts, macular degeneration, and floaters, among others; assess how your eyes work together; and evaluate your eyes as an indicator of your overall health.

What makes your eyes such good barometers for both your eye and body health is the fact that not only do brain tissue, muscle, and blood vessels all meet in your eyes, but it all occurs in a place where your eye doctor can actually see them functioning, a 'live' view, without using invasive techniques. This makes your eyes the ideal place to spot evidence for systemic disorders, which run through your entire body, like diabetes and high blood pressure. Further, the doctor can obtain even more detailed information with additional diagnostic testing such as visual fields, OCTs, and fundus photos.

Comprehensive eye exams, unlike vision screenings, are completed by an eye doctor and include careful testing of all aspects of your vision. Based on results of this exam, your eye doctor will recommend a treatment plan for your individual needs or refer you to a specialist for other conditions. No matter who you are, and regardless of your age or physical health, regular eye exams are important to help you take care of and preserve your vision throughout your life. Generally, a comprehensive eye exam is recommended every 1 to 2 years or more frequently if advised by your eye doctor.

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