Health Focus

OPHTHALMOLOGY

Gregory Eippert, MD

Q: I am considering cataract surgery but very nervous about two things. One, will I feel any pain during the surgery? And two, will my vision truly be better after the surgery?

A: Cataract surgery is one of the most common procedures done in the United States with over two million surgeries performed each year. It is generally a safe, simple, outpatient procedure. Many patients are concerned that cataract surgery will be painful or that it will not significantly improve their vision.

Today's cataract surgery is a painless procedure done one eye at a time so that each eye can heal and adjust individually. The surgery usually takes only 10-15 minutes and is performed under monitored anesthesia care which means you are not put to sleep but in a light level of sedation. Sedation can be titrated to meet the anxiety level of each patient; some requiring more, some less. During surgery, the cloudy lens is removed and replaced by an intraocular lens or IOL chosen to correct your vision.

Cataract surgery generally proceeds without complications and often results in immediate improvement in vision. You may however need an eyeglass prescription to obtain your clearest vision following surgery depending on the intraocular lens implanted and your particular vision needs. Today's cataract surgery has many options to meet your needs and preferences and cataract surgery can provide significant improvement to your vision. There may be situations, though, where other eye problems such as glaucoma or macular degeneration can detract from good vision even after a successful cataract surgery.

The best way to prepare for your cataract surgery is to talk with your eye doctor or surgeon who will help you understand the procedure and answer all your questions and concerns. The more you know about what to expect, the more comfortable and confident you will feel having cataract surgery.

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INSURANCE

Laura Mutsko
Agent and CSA

Q: Does Medicare cover the shingles vaccine?

A: Yes. As of January 1, 2023, Medicare provides 100% coverage for Shingrix, the vaccine for shingles, for people with a Medicare Part D prescription plan or a Medicare Advantage plan with prescription coverage.

The CDC recommends adults 50 years and older receive two doses of the vaccine to prevent shingles and related complications. Shingrix is also recommended for adults 19 years and older who have weakened immune systems because of disease or therapy.

According to the CDC, Shingrix is recommended even if in the past you:

- Had shingles
- Received Zostavax
- Received varicella (chickenpox) vaccine

Prior to the introduction of the chickenpox vaccine in the U.S. in 1995, chickenpox was a common childhood illness contracted by most children before age 10. It caused an itchy blistery rash and according to the CDC, "more than 99% of Americans born on or before 1980 have had chickenpox, even if they don't remember having the disease." Once infected, the virus lies dormant in the nerve cells and may reactivate later in life as a painful skin rash called shingles. The Shingrix vaccine is more than 90% effective in preventing shingles.

Shingrix replaced Zostavax in November 2020. But even if you received Zostavax before it was retired, the CDC recommends getting inoculated with Shingrix: two doses for adults 50 and older spaced two to six months apart.

According to the CDC, you can get Shingrix even if you do not remember having had chickenpox in the past, however you should always discuss all your concerns and questions about Shingrix with your healthcare provider and follow their advice.

If you have questions or concerns about health insurance including Medicare Advantage plans and Medicare Supplements, please contact me at 440-255-5700 or email your questions to me at Lmutsko@mutskoinsurance.com.

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DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: Valentine's Day and Your Smile

A: Valentine's Day is right around the corner. St. Valentine's Day started as a religious feast and transformed into a day when people express love for each other with candy, flowers, and valentine's cards. That tradition came from England in the 1700s and remains the focus of our Valentine's Day celebrations today. Love, romance, and lots of chocolate and candy! You can look forward to a nice meal from your spouse or significant other, maybe even a proposal. The day is about love, but one important factor you must take care of when indulging in goodies is your teeth.

When eating that box of chocolate or candy, don't forget that acid is produced each time bacteria come in contact with the sugars in your saliva. The acid attacks your teeth for at least 20 minutes and destroys enamel. Current recommendations say that you should not brush your teeth for at least 30 minutes after eating; you will push the acid around your mouth.

Most people don't realize that your tongue needs regular cleansing, just as much as your teeth – so show it some TLC. The tongue is the place where bacteria like to hang out, and those bacteria are the ones that cause bad breath. Brush from the back to the front. You can use your toothbrush or get an actual tongue brush, which will work.

Flossing may seem to be a drag, but it is extremely important. You are preventing gingivitis and periodontal disease by reaching the bacteria in your gums. As I have written in past articles, these bacteria are also connected to heart disease, diabetes, and different cancers.

And, for the most important part of the day – The Kiss. You need to make sure that your breath smells great! Make sure to stay hydrated by drinking plenty of water. Water keeps your mouth moist and washes away all the odor-causing microbes. In the past, we have said to drink at least eight glasses a day. There is no hard data on the origin of that number. It may come from the same place as 10,000 daily steps. The point is drinking, and complete hydration is good for us, and each one will know his optimal number of glasses of water. Certain fruits also contain essential vitamins that promote healthy teeth and gums. Vitamin C is a natural neutralizer for odor-causing bacteria. In addition, apples help generate saliva and assist in plaque removal from around your teeth. Less plaque means fewer bacteria. Bad breath can also start in the stomach, where bacteria are in your gut. If there are too many "bad bacteria," the smell can go back to your mouth. Eating yogurt with probiotics will help kill the bad stuff.

In keeping with the theme, February is also American Heart Month. As such, we also would like to focus on those matters that affect our hearts. Heart disease is a broad term referring to those problems that affect arteries, valves, heart rhythms, and more. Those who follow my column read about the relationship between oral health to heart issues. I believe in a plant-based diet emphasizing proper nutrition and plenty of activity, sometimes called exercise. To eat nutritiously, you need teeth functioning the way they were designed.

Last week was Ground Hog's Day, and February is a short month. We are in for a warmer week, so let's get out of the winter blues and focus on taking charge of our health. Diet, professional checkups, and teeth cleaning will pave the way to an exciting energy renewal in Spring. Nothing exudes energy better than a great smile! Now is a perfect time to call for a wellness visit with us. Please call Nikki, and we can look at you and ensure that all is good or, if not, guide you in that direction. Call me at 440.951.7856, and let's meet.

Jeffrey Gross, DDS, FAGD, is an Ohio-licensed general dentist and is on the staff of Case Western Reserve School of Dental Medicine.

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Did You Know?

The Centers for Disease Control and Prevention has estimated that millions of Americans experience traumatic brain injuries each year. In addition, each year around 1.5 million registered hospital admissions are related to traumatic brain injury in European countries. Studies indicate 69 million cases of traumatic brain injury are reported worldwide each year. Recovery from a traumatic brain injury can be lengthy. However, each incident is different and recovery rates and levels of disability after injury vary.

A person with traumatic brain injury may need specialized medical attention and therapy. Recovery rates are higher in cases of mild to moderate traumatic injury. TBI further reports recovery statistics in moderate cases are approximately 60 percent, and about 25 percent are left with some disability. Mild injury cases often have good prognoses, but persistent neuropsychological deficits. Severe cases have the worst prognosis, with only around 25 to 30 percent resulting in positive outcomes.

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Health Focus

INSURANCE

Laura Mutsko
Agent and CSA

Q: Does Medicare cover the treatment of age-related macular degeneration?

A: Age-related macular degeneration (AMD) is an eye disease that can result in severe loss of central vision and the ability to see fine details, making it difficult to read, drive or perform other daily activities. While vision can become severely impaired, people rarely go blind because of it.

The risk factors for AMD include being over 50 years old, history of smoking, high blood pressure and eating a diet high in saturated fats. Although there is no cure, there are treatments that may slow AMD's progress.

Original Medicare Part B may cover certain diagnostic tests and treatment (including treatment with certain injected drugs) of eye diseases and conditions. After you meet your Part B deductible, you will pay 20% of the Medicare-approved amount for the drug and your doctor's services. In a hospital outpatient setting, you may also be responsible for a separate facility copayment. Your doctor must determine that your vision test is medically necessary to diagnose or treat AMD in order for Medicare to cover your exam.

To find out how much your tests or service will cost, talk to your doctor or health care provider. Your cost may vary depending on whether you have other insurance, whether your doctor accepts assignment, and the recommended course of treatment.

It is recommended you contact your health care provider if you experience any of the following symptoms:

• Reduced central vision in one or both eyes.

• Visual distortions, such as straight lines seeming bent.

• The need for brighter light when reading or doing close-up work.

• Increased difficulty adapting to low light levels, such as when entering a dimly lit restaurant or theater.

• Increased blurriness of printed words.

For all your questions concerning life and health insurance including Medicare Advantage Plans, Medicare Supplements and more, please contact me at 440-255-5700 or Lmutsko@mutskoinsurance.com. I look forward to assisting you.

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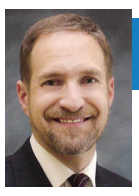

DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: Hey Doc, Can We Save Some Teeth?

A: Normally, it occurs during our initial consultation when a patient asks me that question. We discuss trying to keep teeth and, if necessary, strategically remove some teeth and plan their replacement. Together, my patient and I develop a plan to fit their needs and desires. We discuss details, timing, cosmetics, and a host of other considerations. When I first met her, we had all of those discussions. She showed me her mouth, which had rampant gum disease and multiple loose teeth. How loose is loose? Some of her teeth fell out without any help as they had no gum or bone support due to gum, or periodontal disease, which is the proper term for that condition. In this case, the question about retaining teeth did not appear until our second appointment.

At that visit, we planned to remove all of her lower teeth and give her a denture. When I deliver a full denture on the day of extractions, we use the term "immediate denture." One of the biggest reasons for using an immediate denture is cosmetics. This approach ensures that there will not be any time without teeth. Since her gums were in such bad condition, I felt that if I removed some plaque and build-up before the surgical date, her healing would be more predictable as gum disease affects how well and quickly tissues heal. Last week, she saw Sarah, one of my hygienists, who cleaned her up in anticipation of the upcoming teeth removal.

This week, she told me that she felt so good she was committed to more gum work in hopes that we could keep more teeth. Her statement threw me for a loop as her full denture was sitting on the counter in front of me. I gathered my thoughts and looked at the improvement in her gums after one short session. Frankly, I did not expect that type of result in such a short time. Her body responded above and beyond what we typically see.

Last week, I mentioned that February is American Heart Month. I spoke with a friend and colleague, Dr. Ian Neeland, a cardiologist in town, about this subject. Dr. Neeland is the Director of the UH Center for Cardiovascular Prevention and an Associate Professor of Medicine at Case Western Reserve University School of Medicine, among many other titles. He told me, "The risk for heart disease may be as high as 2-fold in men with periodontal disease and bone loss." He also said, "intensive (periodontal) therapy was associated with a significant improvement in blood vessel function at six months. However, it is not known if intensive therapy would have this effect in the long term or whether such interventions prevent the progression of cardiovascular disease or improve cardiovascular outcomes."

Can modern medicine promise that developing or current heart problems will disappear with oral health? I believe that a statement such as that would be a stretch. However, many, if not all, diseases in the body result from more than one factor. Improving gum and bone health appears to impact general body inflammation, which has been suggested in recent years as a component in heart and other disease processes.

My patient and I decided not to remove all of her teeth and follow our first plan of making a full denture. Her excitement and motivation to improve her home care, coupled with more visits from my hygiene department, became our new direction. I will replace the teeth she already lost due to advanced disease to restore esthetics and function in her mouth. If you think or have been told that your oral condition is hopeless, let's take a second look. Please call Nikki at 440.951.7856, and we can talk about it. As always, I look forward to meeting you.

Jeffrey Gross, DDS, FAGD, is an Ohio-licensed general dentist and is on the staff of Case Western Reserve School of Dental Medicine.

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OPHTHALMOLOGY

Gregory Eippert, MD

Q: I am a 67-year-old male with 20/20 vision and no family history of any eye disease. I went to the eye doctor a couple years ago and my eye pressure was slightly high. Should I be worried about glaucoma? What are the primary risk factors for glaucoma?

A: Your question is a good one and provides an opportunity to discuss some of the myths about glaucoma. First, a definition: Glaucoma is a chronic eye disease that damages the optic nerve. A healthy optic nerve is necessary for good vision since it transmits information from our eyes to the brain. Glaucoma results in loss of peripheral (side) vision and, if left untreated, can result in blindness.

Myth #1: Having 20/20 vision and no symptoms means you will not develop glaucoma. Glaucoma, the second leading cause of blindness in the world, is often called the 'silent thief of sight' because in most cases there are few or no symptoms until noticeable vision loss occurs. Early glaucoma can be determined by your eye doctor's observation of the appearance of your optic nerve and diagnostic testing. So even if there are no outward symptoms, early glaucoma may be present, and, left untreated, your vision could slowly deteriorate.

Myth #2: Glaucoma affects only the elderly. While it is true that the risk for having glaucoma increases as we age, and that most open-angle glaucoma is age-related, there are other types of glaucoma that can affect people of all ages. Examples include congenital glaucoma (from birth), secondary glaucoma as a result of another eye condition, and pigmentary glaucoma.

Myth #3: Glaucoma only occurs if you have elevated eye pressure. While elevated eye pressure is a major risk factor, glaucoma can also occur with normal pressures and is actually called 'normal pressure' or 'low tension' glaucoma. Also, not everyone with elevated eye pressure will develop glaucoma. The determining factor is whether or not the optic nerve is damaged from the pressure. Those with higher eye pressures should be monitored on a regular basis as recommended by their eye doctor.

Myth #4: Since there is not a cure for glaucoma, there is no reason to start or continue any treatment. While there is currently no cure for glaucoma, there are effective medications, laser treatments, and surgeries to help control the disease. While glaucoma cannot be cured, it can often be managed and treated particularly when detected in the early stages.

Myth #5: Since no one in my family has glaucoma, I will not get this eye disease. While certain forms of glaucoma are inherited, and having a family history of glaucoma is a risk factor, there are many patients who are the only ones in their family diagnosed with glaucoma. Sometimes there does not appear to be any family history because the history is unknown or not all family members have been examined for glaucoma. It is recommended that all patients diagnosed with glaucoma share this information with their family members and ask them to have a dilated eye exam. Risk factors for developing glaucoma include racial ancestry, age, high eye pressure, severe nearsightedness, and family history.

The most important thing to do for your eye health, particularly if you have any concerns or risk factors for glaucoma, is to have regular, dilated eye exams.

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Health Focus

DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: How Will I Look While Waiting For My Implant Crown?

A: I hear this question from my patients, which is most often asked when there is a cosmetic concern. But before we get to the question, let's define some terms. The phrase implant crown is a source of confusion for many patients. After all, isn't an implant an artificial tooth? Isn't a crown an artificial tooth? Why are they used together if both terms mean an artificial tooth? Isn't that redundant?

The answer is simply no to the redundancy question. A natural tooth is comprised of two main parts. The part that we can see is above the gums, and the part that we cannot see is in the gums. The part we see is called the "natural crown" of the tooth. The part that we don't see is the root of the tooth. When we lose a tooth and decide to replace it with a dental implant, both portions of it are replaced. The missing root section of a natural tooth is replaced with a small metal support called a dental implant. That part is in the gum, and we can't see it. The replacement for the part of the tooth we see is called a crown, which replaces the "natural crown" of the tooth. Just like a crown that rests on the head of a king, the dental crown rests on top of the implant.

In the process of placing a dental implant, there is a lag time between the implant, the hidden part, placement, and the top crown, which we see in our mouth. During this lag time, the bone and tissue of the jaw grow around the submerged implant and lock it into place. This secure and strong attachment between the body and implant allows it to withstand the forces of chewing.

With this background, we can begin to answer our question. As I alluded to earlier, most people only express concern for a missing front tooth or maybe a side tooth whose absence is noticeable during speech or smiling. In the absence of cosmetic concerns, most patients are fine leaving a space devoid of a tooth in the back of their mouth.

The transitional cosmetic replacement for a front tooth is a removable device. The replacements are small and don't lock in very well. Often patients take the device out when they eat and only wear it for show. When they go out to eat, the simple function of chewing becomes a challenge.

Not much has changed over the years since we encounter this problem until recently. I realized I have a technique with which I can replace one tooth cosmetically and securely while we wait for the implant to become secure. I use this technique for patients who need to wait an extended period for their permanent tooth and want a solid replacement. I had an epiphany and understood that I could also help my patients waiting for their implant crown with this approach, which is now part of my treatment recommendations.

If you are concerned about how you will look during the transition time of implant placement to finish, please call me. Let's discuss your situation and what opportunities arise to keep you smiling. Please call Nikki at 440.951.7856, and schedule a free appointment. As always, I look forward to meeting you.

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OPHTHALMOLOGY

Gregory Eippert, MD

Q: What can you tell me about diabetic retinopathy and how it affects my eyes? How often should I have my eyes checked if I have diabetes?

A: Diabetes is the number one cause of blindness in the United States. With diabetes, your body does not use or store sugar (glucose), properly. High blood sugar levels or, severely fluctuating levels, can cause damage to the blood vessels in the retina, the nerve layer at the back of the eye that senses light and helps send images to the brain. Damage to the retinal blood vessels is called diabetic retinopathy and can be a serious sight-threatening complication of diabetes.

Non-proliferative retinopathy or NPDR is an early form of the disease where the retinal blood vessels leak fluid or bleed. This bleeding and leakage can cause a macular edema, swelling of the macula, and can damage central vision. Proliferative retinopathy or PDR is an advanced form of the disease that occurs when blood vessels in the retina are replaced by new abnormal fragile vessels that bleed easily and may result in a sudden loss of vision. The signs and symptoms of diabetic retinopathy can appear in one eye only but usually both eyes are affected though not necessarily equally.

Treatment of diabetic retinopathy varies depending on the extent of the disease. In the early stages of NPDR, regular monitoring may be the only treatment. Following your doctor's advice for diet and exercise and controlling blood sugar levels can help control the progression of diabetic retinopathy. When treating PDR, laser surgery may be required to seal leaking blood vessels, or injections and/or medications to decrease inflammation or stop formation of new abnormal blood vessels. In advanced cases, vitreous surgery or surgical repair may be required.

Anyone who has diabetes is at risk of developing diabetic retinopathy. Since diabetic retinopathy is a disease that remains asymptomatic until a very advanced stage, it is extremely important that you see your eye doctor at least once a year for a complete dilated retinal exam, or more often as recommended. Your eye doctor will send a report of the eye exam to your primary care provider or diabetes specialist. Early detection and treatment can limit the potential for significant vision loss from diabetic retinopathy.

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INSURANCE

Laura Mutsko Agent and CSA

Q: My mother was recently diagnosed with glaucoma. Will Medicare cover any costs?

A: February is Low Vision Awareness Month, so it is a good time to address your question. If you are not familiar with the term, "low vision" it is when even with regular glasses, contact lenses, medicine, or surgery, people have difficulty seeing making everyday tasks difficult to do.

One of the leading causes of low vision is glaucoma. Glaucoma is a group of eye conditions that damage the optic nerve, resulting in low vision or blindness. It is more common in older adults, but it can occur at any age. (Both Bono and Christy Brinkley have been diagnosed with glaucoma.) However, recent studies indicate that getting regular eye exams can diagnose glaucoma early and reduce the risk of vision loss.

Original Medicare Part B provides coverage for testing once every 12 months if you're at high risk for glaucoma. You will be responsible for your deductible and 20% of the cost.

You are at high risk if:

- You have diabetes.
- You have a family history of glaucoma.
- You are African American and age 50 or older.
- You are Hispanic and age 65 or older.

Unlike Original Medicare, many Medicare Advantage plans provide coverage for routine vision care as an added benefit. Check your plan for details. Your final share of the cost will depend on several factors, including any other insurance you have, how much your doctor charges, and where you receive care. Check with your insurance plan and your physician to determine your share of the cost for treatment.

To see what it's like to live with glaucoma or other eye conditions go to the National Eye Institute's virtual reality app. Search "NEI VR See What I See" in your phone's app store. You will be able to get a better idea of how glaucoma affects a person's vision.

For more information about vision insurance and other health insurance including Medicare Advantage plans, Medicare Supplements and more, please contact me. I can be reached at 440-255-5700 or Lmutsko@mutskoinsurance.com.

I look forward to assisting you.

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Did you know?

A 2017 study from the National MS Society indicated that the prevalence of multiple sclerosis in the United States was much more significant than previous estimates suggested. The study found that nearly one million people in the U.S. had MS. The NMSS notes that study marked the first scientifically sound study of MS prevalence in the U.S. since 1975, which is perhaps one reason why the estimate of individuals living with MS more than doubled upon the release of the 2017 report. The updated prevalence is an important tool in the fight against MS, as the NMSS notes it can serve as a starting point for researchers who want to determine if MS instances are rising and if there are any geographic clusters of MS that could provide clues as to potential risk factors and triggers for the disease.

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Health Focus

INSURANCE

Laura Mutsko
Agent and CSA

Q: Is it mandatory to sign up for Medicare at age 65?

A: You become eligible for Medicare at age 65. However, it is not mandatory for you to enroll at 65 if you or your spouse have creditable health insurance coverage from an employer or union-based plan.

If you do not enroll for Part B during your initial enrollment period, you may qualify for a Special Enrollment Period (SEP) to sign up for Part B (and/or Part A) anytime if you or a spouse is working, and you're covered by a group health plan through that employment.

When you sign up for Part B, you automatically begin your Medigap Open Enrollment Period. Once your Medigap Open Enrollment Period begins, it cannot be changed or restarted. You do not want to make this decision until you know all your options.

If you decide not to enroll at 65 and do not have creditable coverage you will be subject to late enrollment penalties. The penalty for late enrollment is a10% surcharge on Medicare Part B premiums for each year you delay enrolling in Part B, starting the month you become eligible for coverage as long as you have Medicare Part B.

The best way to avoid any Medicare pitfalls is to be well informed. You can get clear-cut, straight forward information about Medicare at an upcoming Getting Started with Medicare Seminar. Registration is going on now for the following class:

Wednesday, March 29
6:00 – 7:30pm
Mentor Library
Registration: 440-255-8811

Monday, April 3, 2023
6:00pm – 7:30pm
Willoughby Hills Library
Registration: 440-942-3362

For additional dates and times visit www.mutskoinsurance.com/seminars. You can also call Mutsko Insurance Services at 440-255-5700 or email Laura Mutsko at Lmutsko@mutskoinsurance.com for help with your insurance needs.

These events are only for educational purposes and no plan specific benefits or details will be shared. Pre-registration is required. Some venues may charge a nominal fee.

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OPHTHALMOLOGY

Gregory Eippert, MD

Q: What causes glaucoma?

A: Glaucoma is a type of optic neuropathy that damages the optic nerve. The optic nerve, located in the back of the eye, is the main visual nerve that transmits the images we see to the brain for interpretation. It is made up of more than a million nerve fibers. When these nerve fibers are damaged, blind spots and vision loss can occur in your field of vision.

Glaucoma is usually, but not always, the result of high pressure inside the eye. Over time, increased pressure can damage the optic nerve fibers. The cause of glaucoma differs depending on the type, and a few of the most common types are discussed here.

With primary open angle glaucoma or closed angle glaucoma, the main cause is elevated pressure inside the eye, referred to as IOP or intraocular pressure. This increase in pressure is due to a buildup of fluid that flows in and out of your eye. This fluid normally exits your eye through a drainage system at the angle where the iris and cornea meet. When that drainage system doesn't work properly (open angle glaucoma) or it is blocked (closed angle glaucoma), the fluid cannot filter out at its normal rate, and the IOP increases.

With normal tension glaucoma, damage occurs to the optic nerve but the IOP remains within normal ranges. The cause for this type of glaucoma is thought to be a highly sensitive optic nerve or decreased blood flow to the optic nerve due to constricted or narrowing blood vessels.

Glaucoma, left untreated, progressively damages the optic nerve and can result in vision loss or blindness. Since glaucoma causes no pain until irreversible damage occurs, see your eye doctor yearly for complete, dilated exams especially if there is a family history of eye disease or other risk factors.

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What to know about cancers of the mouth

Cancers of the mouth can affect anyone. The National Institute of Dental and Craniofacial Research says oral cancer makes up an estimated 3 percent of all cancer diagnoses made in the United States each year, which equates to roughly 54,000 new cases.

Because the mouth is comprised of many different types of cells, there are various forms of oral cancer. Each type depends on which cells are affected. Here's a closer look at the different types of oral cancer.

Squamous cell carcinoma

Memorial Sloan Kettering Cancer Center says squamous cell carcinomas account for 90 percent of all oral cancers. Squamous cells are thin and flat and make up the tissues that form the surface of the skin. They're also found in the lining of hollow body organs and the respiratory and digestive tracts.

Verrucous carcinoma

This is a slow-growing cancer that is made up of squamous cells. It is a rare subtype of squamous cell carcinoma that only accounts for about 5 percent of oral cavity tumors, according to the City of Hope® cancer center.

Oral melanoma

Melanomas develop in melanin, which are the pigment-producing cells that color the skin. Melanoma can occur anywhere on the skin, including inside the nose or mouth.

Lymphoma

Oral cancers also can affect lymph tissue. In terms of mouth cancer, lymphoid tissue can be found in the base of the tongue and in the tonsils.

While most mouth cancers are squamous cells, the cancer will be further classified depending on the exact location where it begins.

• Buccal mucosa: The buccal mucosa is the inner cheek tissue. Lumps in this area should be checked out by a doctor.

• Gum cancer: Gum cancer may be mistaken for gingivitis, but the two are not one and the same.

• Mouth floor: Cancer in the floor of the mouth occurs in the horseshoe-shaped area under the tongue.

• Hard palate: The hard palate is the roof of the mouth. This cancer often starts as an ulcer, according to MSKCC.

Oral cancers also can affect the lips, tongue and jaw.

Quite often dentists, who should inspect the mouth twice per year, are the ideal health professionals to detect oral cancers early on. Any abnormality in the mouth should be examined and addressed by a doctor. Risk factors for developing mouth cancers include smoking, drinking alcohol, using other tobacco products like chewing tobacco, and exposure to sunlight.

Individuals should be cognizant of oral cancers. Though oral cancers may not be as prevalent as other forms of the disease, they still pose a threat, especially when they are not detected in their earliest stages.

DENTAL CARE

Jeffrey Gross, DDS, FAGD

Q: I Never Fixed My Lower Teeth, and Now I'm 80

A: I met this gentleman this week as a new patient as he sought a new dentist after his previous dentist was no longer in practice. We spoke about missing teeth and teeth needing work towards the sides and back of his mouth. His smile was pleasing, and he told me how he had orthodontic care as a younger man and made his upper teeth look and feel good. Our conversation focused on the back teeth and the needed work, but his lower front teeth kept getting back into the conversation.

When he spoke, I saw that the lower central teeth were much higher than the adjacent ones. The rest of the front teeth were all jumbled upon each other. It became apparent that this situation bothered him, but it was too late to do anything to help the situation.

He appeared to be bothered by the appearance of those teeth in question, but I had another concern. It was obvious that he had wonderful dental care from his previous dentist, and he wanted to hang onto his teeth for the duration. The presence of crooked teeth, along with age, make that prospect a challenging one. Crooked teeth create nooks, crannies, and dark areas where food and bacteria can lodge. Food will stick in those areas and miss our brushing. Very few patients have the skill level and visualization to keep these areas clean. As some of us age, brushing and flossing can become a real challenge due to limited dexterity influenced by aging joints, vision, and even arthritis.

All the factors I mentioned make me consider aligning teeth whenever possible. During the first go around for this patient some sixty years ago, he used braces to move and align his teeth. Many orthodontists and general dentists still use braces. In the past 20 years, removable therapy using devices called aligners have become popular. For my adult patients, I am a fan of aligner therapy. The term describes what the devices do. Put into simple English, they align and straighten teeth.

When your teeth are straight, two things occur. The first phenomenon is your saliva and tongue keep your teeth cleaner as there are no hidden areas to trap food. The second observation is the cleansing performed by you becomes much easier and attainable.

Fortunately for my patient, he is missing two teeth on either side of the lower crowded, and crooked teeth. I suggested that we unravel and align his teeth using those spaces. Depending on his actual measurements, he may prevent the need to replace those teeth with implants of bridges as we will move teeth into those areas. That is a large saving in time and effort for all concerned.

After presenting this plan to him, he realized he could fix a concern that had been with him for many decades. He wasn't too old to correct the problem and solve a couple of others along the way. If you find cleaning your teeth is a chore due to tooth position or just want to freshen up your smile, please call me. Let's discuss your mouth and your desires for the future. Please call Nikki at 440.951.7856, and schedule a free appointment. As always, I look forward to meeting you.

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