SINGAPORE/LEIPZIG, Germany: With final participation numbers having been announced, the International Dental Exhibition and Meeting (IDEM) confirmed its position as a major dental meeting for the Asia Pacific region. An improved scientific programme and a higher number of exhibitors again drew more than 6,000 dental professionals to Singapore. Exhibitors and the organiser said that they were satisfied with the number and type of visitors this year.

IDEM, which is organised by Koelnmesse Singapore Ltd, is held biannually in cooperation with the Singapore Dental Association and the FDI World Dental Federation.

This year’s scientific programme focused on implantology and aesthetics—two of the most successful sectors in the Asia Pacific dental market. Although sales figures were significantly affected by the global financial crisis in 2008/09, growth rates are expected to pick up once the economic downturn, IDEM 2010 was in line with IDEM 2008. He said that this company will aim to improve the meeting further in order to make it available to further professional groups like dental assistants.

A Yokohama-based college has launched a free dental service for refugee applicants in Japan in collaboration with the UN High Commissioner for Refugees’ Japan office and other non-governmental organisations. The service will be available to eight people a day, aiming to see about a total of 500 patients a year.

Brain unable to trigger tooth pain
A new study from Germany has found that the human brain is not able to discriminate between a painful upper and lower tooth. According to the researchers, the results may help devise better treatments for acute tooth pain and more chronic conditions like “phantom pain” after a tooth has been removed.

Free service for Japan refugees
A Yokohama-based college has launched a free dental service for refugee applicants in Japan in collaboration with the UN High Commissioner for Refugees’ Japan office and other non-governmental organisations. The service will be available to eight people a day, aiming to see about a total of 500 patients a year.

SLActive implants show higher stability
Implants with SLActive surface technology (Straumann) have shown higher stability compared with five other commonly used implants in a new study, the results of which were presented at the 25th Anniversary Meeting of the Academy of Osseointegration, held in Orlando (USA) in March.

Forensic dentistry falls short in India
At a national conference in India, members of the Indian Association of Forensic Odontology (IAFO) have called for new legislation to make the preservation of dental patient records mandatory for dentists in the country. They said that there is currently no legislation requiring dentists to retain those records that could help identify the victims of mass disasters like airplane crashes, bombings or tsunamis.

In addition, they could be used to confirm evidence of child abuse or homicides.

The organisation, which is based in Chennai in Southern India, also demanded the introduction of compulsory credits as well as the inclusion of Forensic Dentistry in curricula at dental schools nationwide in order to attract more students to this career option in the field of dentistry.

According to the IAFO’s own figures, there are currently less than 100 forensic odontologists in India.
Asia News

Be involved in your business

An interview with Teresa Duncan, USA, about fraud and embezzlement in dentistry

Teresa Duncan is President of Odyssey Management, a medical consulting company based in Alexandria in the US. As part of the Let’s Talk Business webinar, she held a lecture at this year’s IDEM in Singapore on embezzlement and fraud in dentistry. Dental Tribune Asia Pacific spoke with Ms Duncan about this, as well as preventative strategies for dentists.

Dental Tribune Asia Pacific: Ms Duncan, fraud and embezzlement appear to be a common issue in dental practices.

Teresa Duncan: Yes, I think instances of embezzlement are definitely on the rise. Even before the recession hit our economy, approximately one third of dentists in the US had experienced some form of embezzlement. There is a new report coming out soon and I am curious to see the results. I expect the numbers to be even higher because I am constantly contacted by new clients.

In your lecture, you have also presented case studies from Asia. Have you observed any major differences in comparison with the US?

Even in Asia, the number is high although not as high as in the United States. This shows me that there are far more checks and balances in Asia or at least higher awareness of the problem. The main difference is the form of embezzlement, for example, when cash is stolen. Embezzlers in the US are more careful in that respect.

What are the most common methods of embezzlement?

In most Asian countries, reporting is also not as common as in the US. Many of these cases are rather handled in-house. In addition, embezzlers are also able to move between jobs very easily.

I hope that with Singapore’s economy recovering so quickly, the number of embezzlement cases will go down.

In your lecture, you have also presented case studies from Asia. Have you observed any major differences in comparison with the US?

Embezzlers in the US are more productive, yet there is not even money left to cover the payroll. In Asia, they are frequently stealing cheques and the embezzlers depositing them in his/her own account. In many cases, cash is also taken from the patient but not recorded in the practice management system.

The common thread is that dentists are unaware of the reports that they may be running or are not paying sufficient attention to the business side of their practices. So they do not realise what’s happening under their nose. I often hear from clients that they are extremely productive, yet there is not even money left to cover the payrolls.

What are your recommendations for fraud prevention?

Doctors should be aware of the reports that they can run using their practice management systems. At least, they should ask for a daily deposit book or charge summaries. The most important thing is to pay attention and be involved in the daily business.

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Thank you very much for the interview.
Dental agreement commits to US export efforts in Singapore

Daniel Zimmerman

The Singapore subsidiary of Ortho Technology has entered into a new distribution agreement with Lien Nah, a Vietnamese dealer based in Ho Chi Minh City. The three-year contract, which was signed at a US exhibitor meeting at IDEM Singapore, applies to the company’s entire range of orthodontic products, Managing Director Alvin Chia stated.

Ortho Technology offers a comprehensive line of orthodontic supplies, including brackets, bands, buccal tubes, arch wires, adhesives, laboratory supplies and patient accessories.

Chargé d’affaires of the US Embassy in Singapore, Daniel L. Shields III, said that the contract is another example of the embassy’s successful efforts to encourage US manufacturers to invest in the region. He said that despite its relatively high-cost operating environment, Singapore has become the 11th largest export market for US companies, leaving even countries like India behind.

SGD Dental Association President Dr Lewis Lee said that the decision to hold pre-congress courses and master classes this year was well received by most congress attendees. He announced plans to broaden the scientific programme in 2012, incorporating more topics like dental materials, orthodontics or oral medicine. A larger number of hands-on workshops will be offered as well, he added.

Delegates that joined the first pre-congress sessions on Thursday morning confirmed that the programme was a large improvement to the offerings in 2008. Most of the people interviewed said that because of these changes they were able to attend most of the sessions held during the course of the meeting.

“I think the congress was pretty well organised and there was less overlapping which made it easier to get into more sessions,” said one dentist from Singapore.

According to Mr Dreyer, preparations for the next edition of IDEM in 2012 have already begun and the first speakers have been announced. Amongst others, there will be sessions on the management of endodontic disasters, the biological effects of current restorative materials on the pulp-dentine complex and current concepts on posts and cores.

The next meeting is scheduled to be held 20–22 April 2012.

Trade between the US and Singapore skyrocketed after the two countries signed a bilateral free trade agreement in 2005. The US currently leads in foreign investment, accounting for 65 per cent of new business commitments to the manufacturing sector (including dentistry) in Singapore, according to figures from the US Commercial Service.

As of 2008, the stock of investment by US companies in the manufacturing and services sectors in Singapore reached about US$106.5 billion.
“HC reform legislation ... does not include provisions to meaningfully improve access to dental care”

An interview with Dr Ronald L. Tankersley, President of the ADA

The health-care reform bill recently approved by the US Congress aims to improve access to health care for over 50 million Americans. However, dental groups say that the legislation significantly neglects oral health. Dental Tribune Group Editor Daniel Zimmermann spoke with Dr Ronald L. Tankersley, President of the American Dental Association, about the historic decision and its effect on dentistry in the US.

Daniel Zimmermann: The American Dental Association did not support the health-care reform bill recently approved by Congress. Could you explain the rationale for your decision?

Dr Ronald L. Tankersley: As America’s leading advocate for oral health, our decision was primarily based on the oral-health provisions of the bill. We could not support the health-care reform legislation because it does not include provisions to meaningfully improve access to dental care for millions of American children, adults and elderly by properly funding Medicaid dental services.

You say that the reform does not do enough to assure that low-income families receive adequate oral health care. On the other hand, millions of people will finally be able to buy health insurance regardless of their social status or pre-existing medical conditions.

While countless other groups can weigh in on the health-care reform’s overall merits and flaws, people look to the ADA for a determination of its effect on oral health care. And when the government is willing to spend close to a trillion dollars over the next ten years, but not spend a dime on improving access to Medicaid dental services for those most in need, somebody has to raise an objection. If we didn’t do that now, how could we expect lawmakers to take our concerns seriously in the future? That was the basis of our decision.

You have also rejected the idea of workforce pilot programmes. Could you tell us the reason for this?

The ADA’s opposition to the alternative dental models pilot programme was limited and based upon our long-held belief that certain surgical procedures must be performed only by licensed dentists.

The big losers of this reform are going to be the insurance companies. What effect do you think the reform will have on the dental profession itself?

Although the ADA could not support the final legislation, we did recognize that it contained many worthwhile provisions pertaining to oral health. These general, paediatric or public-health dentists and funding for the National Health Services Corps loan repayment programs. These provisions, which the ADA supported and lobbied for, will have a meaningful effect on dentistry and dental patients.

In your opinion, what should be changed in the reform bill to make it feasible for dentists and advance patient care?

When it comes to improving access to oral health care, our message remains: fund Medicaid, the Children’s Health Insurance Program and other dental public health programs sufficiently. These programmes are only capable of fulfilling their roles if they receive adequate funding. Many states spend less than 0.5 per cent of their Medicaid dollars on dental care—an astonishingly low rate, considering the importance of oral health to overall health. Further, poor dental reimbursement rates paid to dentists mean that many of them can’t participate in Medicaid, which is one of the reasons that many states fail to provide oral health care for even half of their eligible children.

The federal government can and must do more to ensure states are able to come up with their share of these benefits.

Republicans and other interest groups have announced that they will oppose the reform bill. Where will you position yourself once the law has come into effect?

The ADA will continue to lobby for improvements to Medicaid dental benefits and will be watching closely as federal agencies implement provisions of the law. We want to ensure that the provisions we support are carried out correctly, and will work to change the provisions we oppose.

Thank you very much for the interview.
US health care reform sets back dentists

Daniel Zimmermann

NEW YORK, USA/LEIPZIG, Germany: After almost a year of political negotiation, the US Congress has approved legislation to overhaul the country’s deficient health-care system. The reform bill, which won the ballot in the House of Representatives by only six votes, has been a priority of President Obama’s political agenda and the centre of political debate since it entered Congress in 2009. It will extend health-care benefits to over 50 million Americans who are currently without insurance because of pre-existing medical conditions or the lack of financial funds.

Through this historic step, the US has become the last of the developed countries to introduce a universal health-care model. In its current health-care system, which was shaped in the early 1970s, coverage is provided mainly by the private sector.

“It was the right vote,” President Obama said during a White House press conference. “The reform plan won’t fix everything wrong with the nation’s health-care system, but it moves us decisively in the right direction.”

Dentist organisations like the American Dental Association (ADA) have heavily opposed the legislation that will first become effective in 2012. In a statement released days before the ballot, the organisation rejected the House proposal because it does not include provisions to improve access to dental services provided by Medicaid, a state and federal-funded health programme for low-income families.

The ADA is also opposing workforce pilot programmes, which they fear could lead to non-dentists performing surgical dental procedures.

Insect glue to seal wounds in surgery

Daniel Zimmermann

NEW YORK, USA/LEIPZIG, Germany: Silk spun by caddis-fly larvae underwater could one day suture surgical wounds, new research from the University of Utah suggests. The study found that the sticky fibres used by the insects to build protective shells remain intact in aquatic environments. These chemical and structural properties could make the material valuable as an adhesive tape in medical and dental surgery.

Caddis-flies, commonly known as rock rollers, usually live in bodies of water such as rivers, lakes and marshes. They are related to Lepidoptera, an insect order that includes moths and butterflies that spin dry silk. Caddis-fly larvae also spin silk but they do so underwater in order to build an inch-long, tube-shaped case around themselves.

In the study, the researchers examined the silk made by a caddis-fly species living in the lower Provo River near Salt Lake City, under laboratory conditions. They found that the fibre is made of large proteins that contain an amino acid named serine that becomes phosphorylated as the protein is synthesised. These phosphates are negatively charged and line up parallel to positively charged amino acids, thereby attracting each other and making the protein water-insoluble. Comparison with amino acids from three other species uncovered great similarities, which suggests that other caddis-fly species also use phosphorylation to spin silk underwater.

Besides these insects, such adhesives were also identified in sandcastle worms, mussels and sea cucumbers.

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LEIPZIG, Germany: Clinical tests at the Department of Molecular Biology at the University of Salzburg in Austria have confirmed that dental treatment with Prozone, a next-generation ozone generator by Austrian manufacturer W&H, is highly effective against bacterial strains that are responsible for oro-dental infections and the development of dental caries. In the control study conducted in 2009, samples of Staphylococcus aureus and Escherichia coli were gassed immediately and after 1.5 hours with ozone several times for 24 seconds. The results demonstrated that 24-second treatments with ozone had visible effects on the treated area. In all tests, immediate treatment was more effective than treatment after 1.5 hours. When the duration of the treatment was increased, the areas with no bacteria or a low bacterial count also increased.

Treatments with ozone, a reactive three-oxygen molecule also found in the Earth’s atmosphere, is a comparatively new concept in dentistry. Earlier studies indicate that it only takes a few seconds of therapy to kill 99 per cent of bacteria, making it a thousand times more powerful than other bacteria-killing agents.

The new study demonstrates that treatment has to be performed immediately and in order to ensure the best results. Delayed treatment also results in reduced bacteria count but visible effects are less significant. Devices such as Prozone that utilise ozone technology expose filtered air to a high electrical voltage, which directly applies the treatment area where it destroys bacteria and viruses through oxidation.

Needles relieve patients of anxiety

Claudia Salwiczek
DTI

LEIPZIG, Germany: Using acupuncture might help dentists to treat highly anxious patients, new research from Denmark and the UK suggests. In a study published by the British Medical Journal Group in March scientists from the universities of Copenhagen and Sheffield found that targeting two specific acupuncture points at the top of the head decreases the average Beck Anxiety Inventory (BAI) score in adult patients by more than half.

The study’s findings were based on 45 women and men from dental practice lists in the UK. All participants were in their 40s and had been attempting to manage their anxiety regarding dentists for between 2 and 50 years, the study states. The acupuncture was carried out by the dentists, all of whom are members of the British Dental Acupuncture Society.

According to recent studies, up to a third of all dental patients in developed countries suffer from some form of dental anxiety. One in ten patients are so afraid of dentists that they defer dental treatment altogether.

The authors of the study said that sedatives, relaxation techniques and hypnosis, amongst other methods, have been found to be helpful in overcoming the problem, but they are often time-consuming and require considerable psychotherapeutic skill. They caution that further larger studies are required in order to confirm the value of acupuncture in controlling dental anxiety, but suggest that it may offer a simple and inexpensive method of treatment.
“Global thinking and local business—our core strategies”
An interview with Dr Luo Chuan Hao, VOCO

VOCO is a Germany-based manufacturer that specialises in the production of modern aesthetic dental materials. The company has been conducting business in Singapore and the South-East Asian region since 1995. Dental Tribune Asia Pacific spoke with Export Area Manager Dr Luo Chuan Hao about the market in Singapore and the company’s offering at this year’s IDEM.

Dental Tribune Asia Pacific: Dr Lou, your company has been conducting business in South-East Asia since 1995. What is your current reach and are there plans to extend distribution to more countries in the region?

Currently, we sell our products in almost all countries in South-East Asia, including Malaysia, the Philippines and South Korea. Our next goal is to increase our market share.

More dentists in Singapore and South-East Asia are becoming aware of the aesthetic aspects of dentistry, mainly driven by patient demand and new developments in the industry. Will these trends determine where the market is heading?

Yes, we also see this as an important trend. We introduced the Amaris composite in 2007 and Amaris Gingiva last year in order to fulfil this demand. We are also increasing our sales for the Grandio and Structur ranges.

You say that you launched Amaris Gingiva, another innovative restorative, in Singapore last year. What response has the material received from the dentists?

The response has been very positive. Dentists in South-East Asia like this product very much. Amaris Gingiva is currently the only highly aesthetic light-curing restorative in gingival shades that can be used chairside.

When it comes to new products and innovation, companies usually focus on big trade shows like IDS or the Midwinter Meeting in Chicago. But do you have anything for IDEM?

You are correct. Generally, we present new products here in Singapore after we have launched them at other meetings. However, this time we will also showcase our new product GrandTec alongside several established products like Grandio, Grandio Flow, Amaris, Amaris Gingiva, Structur, Ionoseal, Futurabond and GIC.

GrandTec is a glass-fibre strand impregnated with light-curing, methacrylate resin in an uncured condition. It was developed for application in traumatology, periodontology, orthodontics, conservative dentistry and prosthodontics. The glass strands can be equally applied to natural teeth, models and impressions, and adhere after light-curing.

GrandTec is intended to ensure the stability of the teeth after orthodontic and periodontic treatment. It can also be used as a base for replacing missing teeth, as well as locking and splitting avulsed or loosened teeth.

The glass strands can also be used for the temporary or semi-permanent treatment of a tooth space using an extracted, natural tooth, as well as temporary treatment during osseointegration of an implant.

Thank you very much for the interview.

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FDI teams up with OSAP to improve global patient safety standards

FDI World Dental Federation is participating in an official review of the WHO Patient Safety Curriculum Guide, together with the Organization for Safety and Quality Improvement (OSAP), and other leading global medical profession associations.

Patient safety is an emerging discipline, aiming to reduce harm to patients caused by healthcare and to identify opportunities for improving patient outcomes. According to the WHO Research Priority Setting Working Group on Patient Safety, tens of millions of patients worldwide suffer disabling injuries or death due to unsafe medical care every year.

The multi-professional WHO Patient Safety Curriculum Guide was first published in 2009 to provide medical schools with guidelines for teaching patient safety, and has since been downloaded by more than 1000 institutions in 100 countries. In growing recognition of the harms caused by health care, the WHO initiated a review of the Guide and invited FDI World Dental Federation to participate as a primary partner in the project, together with the International Council of Midwives and other members of the World Health Professions Alliance (WHPA). International Council of Nurses, International Pharmaceutical Federation and World Medical Association. Professors Takashi Inoue and Nermin Yamalik, of the FDI Education Committee, will be contributing to the review. Details are expected to be finalised during a consensus meeting at the 2010 OSAP Annual Symposium in June, iii

FDI explores preventive dentistry at 2010 AEEDC Dubai

FDI World Dental Federation introduces the Global Caries Initiative to the Gulf Region as part of a global consultation process

Representatives from FDI World Dental Federation, including Dr Roberto Vianna, FDI President, were recently in Dubai for the 2010 UAE International Dental Conference & Arab Dental Exhibition (AEEDC Dubai), where they participated in the AEEDC Conference Program, the Gulf Cooperation Council Preventive Dentistry Conference and the 7th Annual Arab Scientific Dental Alliance, introducing the FDI Global Caries Initiative to key opinion leaders of the Gulf Region.

The Global Caries Initiative (GCI) was first conceived during the FDI Caries Conference in July 2009, where conference attendees—including leading experts in epidemiology, cariology, dental education, prevention and change management—concluded there is a need to establish a broad alliance of key influencers and decision-makers to effect fundamental change across health systems and in individual behaviour in order to eradicate caries worldwide by 2020.

Departing from this objective, FDI World Dental Federation embarked upon a global consultation process to assess the potential challenges and impact of introducing a preventive model to existing systems for caries management. The most recent seminar took place at the 2010 AEEDC Conference Program: Dr Julian Fisher, FDI Associate Director of Education and Scientific Affairs, described the context of GCI in a presentation entitled, “The Global Caries Initiative: A Profession-Led Call-to-Action” and Dr Nigel Pitts, of the University of Dundee (Scotland), presented his research related to “A New Approach to Caries Classification, Detection and Assessment: The Experiences of ECIDAS”, which addressed an underlying theme identified early in the GCI consultation process, that is, the need for the profession to establish a common language for caries. Dr Pitts has been working with FDI World Dental Federation to explore an international caries classification system within the context of GCI.

Dr Roberto Vianna reinforced the FDI World Dental Federation commitment to oral health in an address to attendees of the Gulf Region:

The annual FDI Corporate Partners meeting took place at the end of February during the 445th Chicago Dental Society Midwinter Meeting. FDI President Dr Roberto Vianna opened the meeting, welcoming delegates to the FDI Corporate Partners for their unwavering support, particularly in view of the economic challenges still affecting business worldwide. Joining the FDI President at the meeting were FDI President-Elect, Dr Orlando Inoue from the Goldman School of Dental Medicine, Dr Katharina Eli, Executive Director, Dr David Alexander, and other full-time FDI professional staff from the Finance, Communications and Congress departments.

Dr David Alexander presented a detailed report of ongoing FDI activities and achievements in 2009, including the introduction of a new FDI website, preparations for the 2010 Annual World Dental Congress in Salvador da Bahia, Brazil, future congress venues, progress on the Global Caries Initiative and a summary of internal process improvements across the organisation. Dr Alexander reminded participants of the critical importance of partnership between FDI World Dental Federation and the dental industry, encouraging an “open dialogue, which strengthens our relationship and brings mutual benefits to both partners.” The presentations portion of the meeting included a financial review by Jerome King- man, FDI Director of Finance and Operations, who summarised the 2009 year-end results and budget forecasts for 2010 and beyond.

The annual FDI Corporate Partners meeting is held in the first quarter of each year, alternating venues between the Chicago Dental Society Midwinter Meeting and the International Dental Show in Cologne, Germany.

Inside the FDI: Spotlight on congress

By Ndolo Moka Lisette

The lie, lie...the minute hand of the clock ticks away, representing the passing of time—and for the Congress team at the FDI World Dental Federation headquarters in Geneva—serving as a poignant reminder that the 2010 Annual World Dental Congress is drawing closer. From the various work stations around the office, one hears the sound of keyboards clattering, papers shuffling, phones ringing and voices buzzing: Congress planning in motion. As preparation for this year’s Congress intensifies, the full-time staff team—under the leadership of Neil Kirkman, FDI’s Manager of Activities and Exhibitions—is busy finalising the details of the 2010 Congress to ensure a seamless experience for this year’s attendees in Brazil.

An event of such magnitude relies on a solid foundation and, as Kirkman explains, “success is a high level of collaboration across the organization, with close attention to “the many stakeholders involved; understanding their needs and expectations, developing the right formula to satisfy the largest possible audience, and working to create a win-win for everybody involved.” Mr Kirkman joined FDI World Dental Federation in February 2010 and is responsible for strategic development and execution of the FDI Annual World Dental Congress, working closely with elected and staff leadership, as well as member associations, to deliver world-class international dental conferences.

For almost 20 years, Mr Kirkman has developed and coordinated international conferences, seminars, exhibitions, and festivals for organisations including the European Society of Cardiology, the International Union Against Cancer and the Young Presidents Organization. “In managing events of this scale, both immediate and long-term planning is critical”, he says. Plans for future FDI Congresses in Mexico City 2011 and Geneva 2012 are already in the works, as well as research into venues as far ahead as 2016.
Members’ Corner:  
Dr Michael Glick — Outstanding scientist and clinician

Dr Michael Glick:  
In this interview with WDC, Dr Michael Glick discusses his work with the World Dental Federation and his views on the role of the dental profession in oral and general health.

WDC: In October 2009 you were appointed Dean of the University at Buffalo School of Dental Medicine. What motivated you to this role and what do you hope to achieve?  
Dr Michael Glick: This position is a chance to have an impact with respect to dental education and consequently, the future of dentistry; to build on the best of what we’re doing and take it to the next level. I am proud to be a dentist. But first and foremost I see myself as a healthcare professional. There is a small but growing trend to enhance overall health by providing medically based point-of-care screening in dental offices. In fact, last year I co-ordinated a seminar at the ADA’s Annual Session that was a hands-on course for dentists in office-based screening. There is a small, critical mass developing that is eager to improve overall health care delivery, and education is where it all begins.

You dedicate a lot of time to FDI World Dental Federation as Chairman of the Science Committee. What motivates you to participate in organised dentistry at the international level?  
Working with FDI World Dental Federation is an opportunity to make a difference and I gladly give my time to help bring about positive change in the way the dental profession is perceived; for instance, in re-evaluating how we provide care or providing care to people who do not have access. The structural complexity of our profession can be complicated, which further emphasises a need for unity at the international level in order to make any progress.

What does FDI World Dental Federation bring to the world of dentistry?  
FDI is the largest dental organisation in the world, bringing together representatives from many different disciplines to form a unified, global voice of dentistry. This gives us the privilege and opportunity to make a huge impact through the profession to act as the facilitator for change. For example, in caries prevention, FDI is leading. The Global Caries Initiative, a profession-led project with the goal of significantly diminishing the prevalence of caries worldwide by 2020. Other recent projects, such as the Oral Health Atlas and Dental Ethics Manual, are further examples of practical tools produced by FDI that dentists can use in their countries to support advocacy and awareness around oral health.

You recently attended the FDI mid-year committee meetings in Geneva. What are some of the agendas for the Science Committee in 2010?  
This year, the Science Committee wants to focus on setting a research agenda to respond to major global oral health care issues. We also want to proactively generate collaboration between researchers in different parts of the world and partner with organisations working towards the same goals, such as the International Association for Dental Research (IADR). As Chairman, I see my role as a facilitator: that is, does the Committee work reflect the mission and vision of FDI? This is a question I ask myself when embarking on a new initiative. Another area of focus for the Committee is science and evidence behind policy. To this effect, we are working to design FDI scientific statements that will help underpin policy and provide FDI members with valuable scientific resources.

How do your many responsibilities relate to your personal vision in oral health?  
All of my work, whether as the dean of a dental school, editor of JADA or the chairman of the Science Committee, reflects my philosophy about health. I am lucky to have the opportunity to have a voice in sharing these beliefs with a larger group. But I see many examples of how dentists make a difference in their community at so many levels—such as extending free care. Every little bit makes a difference.

Dr Michael Glick is Dean of the University at Buffalo School of Dental Medicine in the United States. He currently serves as Chairman of the Science Committee for FDI World Dental Federation.
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*Graphical representation based on SEM photography; for illustration only*
Hypersensitivity is characterized by short, sharp pain arising from exposed dentin in response to stimuli such as cold, hot, sour or sweet food and drinks, air (cold weather) or pressure and cannot be ascribed to any other dental disease. The cause of hypersensitivity is loss of enamel on the tooth crown and gum recession exposing the tooth root (Figure 3). Dentine is generally covered by enamel in a tooth crown and by a protective layer called cementum in the tooth root surrounded by gum. Dentine contains thousands of microscopic tubular structures that radiate outwards from the pulp (Figure 3). Loss of enamel can occur as a result of aggressive and incorrect tooth brushing, over consumption of acidic food and excessive tooth grinding. Gum recession may occur due to aggressive and incorrect tooth brushing, aging, gum diseases and certain dental procedures. The cementum on the exposed tooth root will then easily be removed and dentine is exposed resulting in dentine hypersensitivity.

Diagnosis is Important
Dentine hypersensitivity may share similar symptoms with dental decay and gum disease, hence, it is essential to consult a dentist when you suffer from pain of similar nature. In addition, the cause of dentine hypersensitivity should be identified and a diagnosis by exclusion must be made for dental hypersensitivity, ruling out other conditions requiring different treatment. Once the diagnosis of dentine hypersensitivity is confirmed, the dentist may discuss with you regarding decreasing the intake of acid-containing foods, and show you correct brushing techniques.

Home Management with Desensitizing Toothpaste
Traditional beliefs of gargling warm water with salt and biting ampalaya (bitter fruit) and medications for pain relief often cannot eliminate dentine hypersensitivity. Use of desensitizing toothpaste is considered by many as the "first option" recommendation. Some desensitizing toothpastes contain potassium salts to interrupt the neural response to pain stimuli. It is effective but often takes 4 to 8 weeks for pain relief. Other desensitizing toothpastes contain strontium salts to occlude open dentinal tubules from external stimuli associated with dentine hypersensitivity. Certain patients, however, do not find it effective. New desensitizing toothpastes with arginine and calcium carbonate (Arginine-CaCO₃) that occludes and blocks open dentinal tubules, are now available in the market. Our study on 390 adult patients with dentine hypersensitivity demonstrated significant pain relief after using professional desensitizing paste with Arginine-CaCO₃.1 The new Colgate® Sensitive Pro-Relief™ desensitizing toothpaste containing Arginine-CaCO₃ and fluoride is developed for routine daily use.
Home Remedies for Dentine Hypersensitivity

Hypersensitivity is characterized by short, sharp pain arising from exposed dentin in response to stimuli such as cold, hot, sour or sweet food and drinks, air (cold weather) or pressure and cannot be ascribed to any other dental disease. The cause of hypersensitivity is loss of enamel on the tooth crown and gum recession exposing the tooth root. Dentine is generally covered by enamel in a tooth crown and by a protective layer called cementum in the tooth root surrounded by gum. Dentine contains thousands of microscopic tubular structures that radiate outwards from the pulp and are covered by a layer of fluid containing dentinal fluid. Loss of enamel can occur as a result of aggressive and incorrect tooth brushing, over consumption of acidic food and excessive tooth grinding. Gum recession may occur due to aggressive and incorrect tooth brushing, aging, gum diseases and certain dental procedures. The cementum on the exposed tooth root will then easily be removed and dentine is exposed resulting in dentine hypersensitivity.

Diagnosis is Important
Dentine hypersensitivity may share similar symptoms with dental decay and gum disease, hence, it is essential to consult a dentist when you suffer from pain of similar nature. In addition, the cause of dentine hypersensitivity should be identified and a diagnosis by exclusion must be made for dental hypersensitivity, ruling out other conditions requiring different treatment. Once the diagnosis of dentine hypersensitivity is confirmed, the dentist may discuss with you regarding decreasing the intake of acid-containing foods, and show you correct brushing techniques.

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References:

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CAD/CAM in dentistry—Does it pay off?

An interview with Prof. Dr Dr Albert Mehl, University of Zürich, Switzerland

The International Dental Exhibition & Meeting in Singapore showcased some impressive advancements in CAD/CAM dentistry. For private dentists, however, there is much uncertainty regarding response to these developments. DT Switzerland Editor-in-Chief Johannes Eschmann spoke with Prof. Dr Dr Albert Mehl, currently Guest Professor at the Centre for Dentistry and Oral Medicine at the University of Zürich, about whether investing in CAD/CAM pays off and for whom.

Johannes Eschmann: Most failures of conventional technology occur during impression preparation (insufficient illustration of the preparation margins, insufficient drainage). Owing to auto-mixing technology (cartridge systems, Pent-X, etc.), mistakes caused by the material are rare and failures often result in a perfect-fit restoration, even when using conventional technology. What do CAD/CAM systems offer for dental practices?

Prof. Albert Mehl: Most importantly, treatment times were reduced because the dental restoration can be manufactured in the same session as the preparation (chairside method). Temporaries become obsolete, thus making uncomfortable transition times a thing of the past. More acceptable is the adhesive technology, sufficient retention for a temporary filling, since it is not available because of the minimally invasive preparation. Furthermore, the latest studies demonstrate improved bonding to teeth with freshly cut dentine and enamel.

Computer-aided milling and polishing allows the use of high-quality materials, which are manufactured industrially under optimal conditions, resulting in longer-lasting restorations compared to conventionally manufactured restorations. This has already been documented in numerous scientific studies. Through the combination of time saving, cost reduction and increased quality, the chairside method offers an interesting perspective for modern dentistry. This pertains mainly to single-tooth restorations but we can expect new possibilities in the production of fixed partial dentures with small span widths in the near future.

The time needed to manufacture a digital impression is the same for both techniques. The preparation is equally complex and partly requires more working steps such as powdering or opaque coating. How does the significant investment in digital impression technology pay off?

When considering concepts that entail the sending of data of a digital impression to a decentralised production site via the Internet, one can say that the time-frame equals that of conventional impression techniques. The extent to which the to the tooth and surrounding soft tissue. According to the industry, amortisation could be achieved through the cost savings of computer-aided production in production centres, software updates and systems for the chairside production of single-tooth restoration, and extension to diagnosis and treatment planning software (in combination with digital imaging, implant treatment planning and online exchange of information between specialist groups).

The enormous potential of digital scanning has been recognised by the industry and this is currently in heavy development. As soon as quality and practicability has been demonstrated within clinical environments, amortisation will no longer be an issue.

How can the aesthetic disadvantages of single-session treatment (CEREC/EAD) be solved in the future? Staining is only a remedy here, because the colour wears off rather quickly.

Sophisticated, aesthetic single-session concepts in the anterior region are difficult and achievable only with much experience. Hence, most dentists will probably choose to apply the different veneer layers manually. However, aesthetically pleasing results can be obtained using multi-coloured blocks. It is expected that these blocks will be improved by optimising the form and position of the layers and that the software will in position the restoration within the block for optimum colour effects. In order to standardise this process, the use of tooth colour measurement systems may also be relevant.

Are you referring to integrating digital colour measurement systems with CAD/CAM?

This is an interesting factor. The virtual 3-D model is important not only for the computer-aided fabrication of dental restorations, but also for every other kind of diagnostic, such as the exact 3-D determination of tooth movements, archiving of virtual models and the documentation of 3-D changes.

Does the extended workflow—from practice to centre to laboratory and back to the practice—offset the time-saving factor?

This is the case and certainly a disadvantage of a centralised production process. The advantage, however, is that such centres can invest in high-quality and highly precise production technologies. These machines are maintained by specialists and require high capacity. The storage of many different materials including a variety of shades and implant systems is easier and more economical as well. Overall, production costs are very low and theoretically offer superior quality at the same time, which is something that needs to be considered when we speak of the time disadvantage. I anticipate that decentralised production will play a vital role in dentistry for larger restorations such as fixed partial crowns and implants.

The first IT systems that were available to dentists at the end of the 1990s/beginning of the 2000s were expensive mini-computers (VAX) that were never actually amortised. Will it be the same with CAD/CAM? What do you foresee price development to be?

An amortisation of CAD/CAM systems depends not only on the possibilities and range of indications, but also on clinical concepts and the patient base (for example, the number of ceramic restorations produced and the extent of the potential for this kind of treatment). This needs to be analysed case by case. Generally speaking, we have already undergone the introduction phase and many CAD/CAM practices now demonstrate impressively that the system can actually be amortised quite well.

Many companies have found CAD/CAM technology to be one of the key technologies in dentistry today, and large sums are invested in research and development, which will boost development processes. Many of these improvements can be incorporated into the systems later, as a large part of the expertise is incorporated into software. There are likely to be changes in the software as well, but those will take much longer. Dentists thinking about investing in a CAD/CAM system should make their decision regardless of such considerations. After all, factors—range of indication, user friendliness, testimonials of fellow colleagues, economic efficiency, and scientific approval—have been analysed, entry into the CAD/CAM world clearly does make sense.

In the short and intermediate term, we do not expect a significant decrease in price. But as a scientist, I always look far into the future and am convinced that after the high development costs have been compensated, prices will have the potential to decrease in the long term.

The vision is that someday every dental practice will own such a system. IT technology is a good example and CAD/CAM technology, which is based on this IT technology, will follow suit.

iTero, 3M ESPE Lava COS, CEREC/EAD—how many points of laserlight are technically required?

For dental restorations, an accuracy of 0.5 mm is required. Surprisingly, little is known

“Decentralised production will play a vital role in dentistry for larger restorations such as fixed partial crowns and implants.”

Prof Dr Dr Albert Mehl

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However, first experiences suggest that this is indeed possible. Digitalisation would then enable the same advantages in other areas. The virtual 3-D model is important not only for the computer-aided fabrication of dental restorations, but also for every other kind of diagnostic, such as the exact 3-D determination of tooth movements, archiving of virtual models and the documentation of 3-D changes.
about how critical this level really is, but we apply this standard, and surfaces should be scanned with a grid of at least comparable size. Double resolution (25 µm) would be even better. An average molar surface of 2 cm², for example, would yield 320,000 measuring points.

The ideal number then depends on the data processing. By combining several scans, these numbers can be increased significantly. The software can then calculate the optimum distribution of measuring points, thereby improving the results even more.

These technical details principally influence accuracy and clinical adaptability. However, we cannot fully evaluate the quality of intra-oral scanners based on these details because they only constitute a small percentage of the overall complex measurement systems. In addition, there is the decisive factor of software interplay. Clinical and scientific experiences of each measuring system are far more important.

What are the advantages and disadvantages of digital bite registration versus traditional bite registration with subsequent manual adjustment? With iTero, for example, the required material thickness can immediately be calculated and a post-preparation can be done, in case it has been reduced insufficiently.

The software allows a more precise positioning of the jaw and a superior analysis of the occlusion compared to the conventional, manual procedure on the plaster model, on condition that the digital impression ensures a high degree of measurement accuracy for the jaw impression. In addition to the controlling of the restoration material thickness, contact patterns can be analysed. 2-D slices can be adjusted for visualisation in different areas, and articulation movements can be measured. Using software, the resilience of teeth can be simulated, enabling new possibilities for diagnosis of the contact situation.

Do you believe that prostheses manufactured via rapid prototyping, for example laser sintering or Fused Deposition Modelling, can be done in practice with better aesthetic quality and without the assistance of a dental technician?

There is debate about whether this is possible. While this procedure has become common in some milling centres with regard to metal and acrylic resins, restorations with aesthetic materials such as dental ceramics and composites have shown some principal and unresolved issues. Basic research is needed in this field. As a second step, production devices should be made compact so they become more cost-efficient for dental practices. In conclusion, this technology is unlikely to experience a major breakthrough in the medium term.

Thank you very much for this interview.

(Translation provided by Annemarie Fischer, Germany)
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Root recession coverage made predictable using resorbable barriers

By Dr. David L. Hoexter, Nikisha Jodhan & Jon B. Suzuki

Gingival recession is defined as the location or displacement of the marginal gingiva apical to the cemento-enamel junction (CEJ).1 Recession is the exposure of root surface, resulting in a tooth that appears to be of longer length. From a patient’s perspective, recession means an anaesthetic appearance and is associated with ageing.

The gingiva consists of free and attached gingival tissue, as seen macroscopically. The free marginal gingiva, located coronal to the attached gingiva (AG), surrounds the tooth and is not attached to the tooth surface. The AG is the keratinised portion of gingival tissue (KG) that is dense, stippled and firmly bound to the underlying periodontium, tooth and bone. In ideal health, the most coronal portion of the AG is located at the CEJ, where the most apical portion is adjacent to the mucogingival junction (MGJ). The MGJ represents the junction between the AG (keratinised) and alveolar mucosa (non-keratinised).2

There are numerous aetiological factors that may result in recession. Generally, the aetiology can be categorised as either mechanical or as a function of periodontal disease progression. Recession usually occurs due to tooth malposition,3,4 alveolar bone recession,5 high muscle attachments and frenal palls,6 and iatrogenic factors related to restorative and periodontal treatment procedures.7,8

The detrimental effects of recession include compromised aesthetics, an increase in root sensitivity to temperature and tactile stimuli, and an increase in root caries susceptibility due to cementum exposure. Thus, the main therapeutic goal of recession elimination is to control root coverage in order to fulfil aesthetic demands and prevent root sensitivity.9

Miller classifies recession defects into four categories:

- Class I: marginal tissue recession does not extend into the MGJ;
- Class II: marginal tissue recession extends to the MGJ with no loss of interdental bone;
- Class III: marginal tissue recession extends to or beyond the MGJ, loss of interdental bone is apical to the CEJ but coronal to the apical extent of the marginal tissue recession;
- Class IV: marginal tissue recession extends beyond the MGJ, interdental bone extends apical to the marginal tissue recession.10

A possible treatment modality for recession includes restorative/mechanical coverage, such as cervical composite restorations. This kind of treatment may effectively manage root sensitivity and caries. However, such treatment entails a long-term compromise from an aesthetic perspective. Composite restorations stain over time, and any marginal leakage may lead to secondary caries, recurrence of sensitivity and/or local inflammatory changes. Additionally, colour matching can be difficult and such restorations may involve the undesirable removal of vital tooth structure in order to create adequate retention form. Thus, clinicians must determine whether the restorative benefits outweigh the aesthetic shortcomings and whether it is possible to employ a treatment modality with few, if any, functional and aesthetic disadvantages.

Another treatment modality for recession is mucogingival surgery. Mucogingival surgery refers to periodontal surgical procedures designed to correct defects in the morphology, position and/or amount and type of gingiva surrounding the teeth.11

In the early development of mucogingival surgery, clinicians believed that there was a specific minimum apical-corneal dimension of AG that was necessary to maintain periodontal health. However, subsequent clinical12 and experimental13 studies have demonstrated that there is no minimum numerical value necessary. However, for aesthetics, a uniform colour and value of AG is desirable amongst adjacent teeth.14

Some of the earliest techniques for correcting recession involved extension of the vestibule.15 The subsequent healing usually resulted in an increase of AG. However, within six months, as much as a 50 per cent relapse of the soft-tissue position was reported.16 Thus, these techniques did not adequately address recession.

In order to improve aesthetics and increase AG for root coverage procedures, current periodontal surgery largely involves the use of gingival grafts. There are a multitude of surgical techniques, which can be distinguished based on the relationship between the donor and recipient sites. Gingival graft procedures involve either (a) pedicle soft-tissue grafts, which maintain the pedicle blood supply, or (b) free autogenous soft-tissue grafts. Techniques involving the latter type require the clinician to prepare two surgical sites: one to harvest the tissue (1) and another one to prepare the recipient site (2). In this case, the autogenous soft-tissue graft has a separate blood supply to the recipient site. Combinations of (a) and (b) have also been reported.17,18

The pedicle soft-tissue graft was first described by Grupe and Warren in 1956.19 This involved raising a full-thickness flap and laterally positioning and suturing donor tissue into place from an adjacent area, while maintaining a pedicle blood supply. This technique and others that followed were designed to increase the zone of AG. Later modifications of this technique included the double pedicled flap20 introduced by Cohen and Ross in 1956—the oblique rotational flap21 and the rotational flap.22 Another type of gingival movement flap was described later as the coronally repositioned flap.23 This technique involves mobilising a full thickness flap and repositioning the tissue to the CEJ, thereby covering the exposed recession.

The use of free gingival grafts was described in the 1960s by Naulas and Aitkins.24 The free autogenous graft can be made up of either epithelialised gingiva or connective tissue. Initially, the therapeutic goal was to increase the zone of KG.
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The clinical objective has now evolved to covering the recessed root with a zone of attached KG. This can be achieved in one or two stages. Initially, Sullivan and Atkins described a one-stage procedure in 1986. Its purpose was to increase the zone of KG without concentrating on coverage of a recessed root. In the 1980s, a two-stage modification was suggested for an increase in root coverage, which proved to be more successful with increased predictability. This involves first placing the free gingival graft or the free connective tissue graft apical to the area of recession, and using the coronally repositioned technique after healing.

Free autogenous grafts are predominantly harvested from the palate. Recently, materials other than gingival grafts have been explored. Using a guided tissue regeneration (GTR) technique, an acellular dermal matrix has been reported to yield favourable outcomes in root coverage. This material may provide the patient with a less invasive alternative than a palatal donor site, in order to achieve root coverage.

Procedures combining both free grafts and pedicle techniques have also been detailed. For instance, when a connective tissue graft is employed, the graft is placed subepithelially with a coronal advancement of the overlying keratinised tissue. GTR techniques have also been developed more recently. In 1992, Pino Prato et al. described a combination technique of sub-epithelial placement of a membrane with coronal advancement of the flap, such as e-PITEC. The function of the membrane is to maintain space during the healing period for tissue regeneration to occur. From a patient's perspective, biodegradable membranes with GTR might be preferable in order to avoid a second-stage surgery for membrane removal.

The goal is to restore gingival health, colour and aesthetics by covering the exposed root predictably with healthy gingival tissue and in doing so decrease sensitivity. Using GTR and coronal repositioning techniques, we achieve predictably covered roots.

Variations in mucogingival procedures have been developed to include root surface bio-modifications by treating the root surfaces with a variety of materials. These measures enhance the regeneration process of a new connective tissue attachment. In order to increase root coverage, a new clinical attachment is necessary. Root surface bio-modification involves the root surfaces with citric acid, tetracycline or EDTA in order to remove the smear layer and expose dentinal tubules and thus facilitate a new fibrous attachment. An enamel matrix derivative claimed to support the action of enamel matrix proteins by inducing an acellular cementum, periodontal ligament and alveolar bone formation is also available in the range of root surface bio-modification materials.

The following case report considers predictable aesthetic root coverage by comparing a GTR technique to a non-GTR technique in a split-mouth procedure involving the same patient.

Case report

A young, adult male patient presented with recession bilaterally in his maxilla. The upper right maxilla had extensive recession on teeth #6 and 7 (Fig. 1). The upper left maxilla had similar recession on teeth #11 and 12. Additionally, tooth #11 had a cervical groove, which was stained and hard but not decalcified.

After local anaesthesia using lidocaine, the desired flap design was completed. There was an adequate zone of KG present before treatment, which was preserved and repositioned coronally. Upon resection of the tissue, the full extent of the underlying recession was evident (Fig. 2). The area and recession were uncovered following removal of debris and granulomatous tissue. The resorbable membrane material was shaped and placed on the exposed roots. The membrane was first placed on tooth #6 and thus the tooth appeared darker as it absorbed blood. The membrane was placed on tooth #5 second and thus the tooth had not absorbed the blood at the time of the photographs, which accounts for the colour difference at this time.

The coronally repositioned flap was sutured in place with the flap covering the root submerged membranes and previous recession.

Fig. 9: Gingival tissue coronally repositioned to cover the GTR membrane on tooth #11 and tooth #12.

Fig. 10: Gingival tissue coronally repositioned to cover the GTR membrane on tooth #11 and tooth #12.

(Figs. 5 & 4). Periodontal dressing (Gee-Fak, GC) was utilised as a bandage and placed over the surgical area. It was removed a week later at the same time as the sutures. The patient then lasaged and returned to the usual oral hygiene routine, initially lightly and gradually more vigorously. Once healed and oral health was maintained, the recession was covered and root regeneration continued. Upon periodontal probing, no pockets were present (Fig. 5). The final view presents a visual symmetry of health and colour that is maintainable.

Recession was also present at the maxillaries left side (teeth #11 and 12; Fig. 1). After local anaesthesia of the area involved, a full thickness mucoperiosteal flap was completed. This exposed the extent of the recession defects (Fig. 7). Tooth #11 was treated, as was the other side of the mouth, by utilising the GTR technique using an acellular connective tissue membrane to preserve the space for regeneration. Tooth #12 was treated the same way, except that no membrane barrier, resorbable or non-resorbable, was used (Figs. 8 & 9). Thus, there was no use of GTR technique on tooth #12. Both teeth had the flap manipulated with the coronally repositioned graft, covering the recessed root and suturing to the CEJ level. Both sides were covered with periodontal dressing. Antibiotics (tetracycline) and an analgesic (Tylenol-Codine) were prescribed for the first week after the operation.

One week after the surgical phase, the dressing and sutures were removed and the mouth lasaged. Oral hygiene was restored to good, maintainable habits following the healing phase of over two months. Upon observation, tooth #11, for which the GTR membrane had been employed, had res-established healthy gingiva that was not probable. The recessed root and the stained cervical groove were covered. In contrast, tooth #12, for which no GTR membrane had been utilised, displayed recession ap祟 prior to the surgery (Fig. 10).

In summary, this split-mouth technique demonstrated that using an acellular resorbable barrier membrane is more predictable for achieving root recession coverage than coverage of a recessed root without such a membrane.

Contact Info

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Welcome to the 32nd APDC

More than 1,000 dental professionals to gather at Asia Pacific Dental Congress in Sri Lanka

Dental professionals from all over South East Asia are expected to gather in Colombo for the 32nd Asia Pacific Dental Congress (APDC). The event, which is here for the second time, will feature a comprehensive five-day scientific programme and a trade exhibition showcasing the latest offerings from the industry.

According to the organiser, the 32nd APDC will see exhibits representing every segment of the dental market from over 50 companies and local dealers. Amongst others, manufacturers from India, Singapore, Hong Kong and China will showcase their portfolio alongside international participations from Germany, Canada, Japan, Brazil and Sweden.

Including representatives from the industry, the show is expected to gather 1,000 dental professionals in the capital of Sri Lanka.

The congress programme, which is titled Clinical Excellence in Dentistry through Knowledge, Evidence and Technology provides a list of renowned speakers from South East Asia as well as other parts of the world, such as Germany, Switzerland, Australia and the UK. It will start off on 12 May with a number of workshops focusing on implantology, ceramics and bleaching. Other highlights include sessions on orthodontics by specialist Björn Ludwig from Germany and minimal invasive dentistry by Dr Sushil Koirala, Nepal.

Visitors will also be able to participate at a APDC golf tournament, where even though they may not be the eventual winner, they still have a chance to win the “furthest drive” and “closest to the pin” competition. The 129-year old Royal Colombo Golf Club, where the competition will be held, is considered as Sri Lanka’s finest golf club. The fee of US$135 will include green fees, club and shoe hire, refreshments, caddies, transport as well as an APDC golf cap.

The organiser has also announced to provide tours to famous sights and landmarks of Sri Lanka.

The 32nd Asia Pacific Dental Congress will be held at the Sirimavo Bandaranaike Memorial Exhibition Centre in Colombo, 12–16 April 2010.

www.apdc2010.com
The 32nd APDC—A congress of highest calibre

Welcome message by Dr Jeffrey Tsang, President APDF/APRO

The 32nd Asia Pacific Dental Congress in Colombo, Sri Lanka, is the second time for the Sri Lanka Dental Association (SLDA) to host the APDC. I was present at the previous Congress and must admit that I enjoyed it very much. On behalf of APDC (APRO) I would like to extend my congratulations to the SLDA. I am confident that another congress of highest calibre is forthcoming.

The Asia Pacific Dental Federation (APDF) has grown into a federation that comprises 26 countries. The key objective of the organisation is to raise public awareness of oral health care and the prevention and treatment of oral diseases. The APDF will present quality and diverse symposia, lectures, presentations and hands-on workshops for all members of the dental profession. I strongly believe that participants will find the programme stimulating and enlightening.

In addition, the trade exhibition will provide an ideal platform to showcase advanced technology and innovation.

Colombo is a unique mix of land and water and features a scenic countryside. The excellent hospitality by Sri Lankan people is renowned.

I would like to thank the 32nd Local Organizing Committee for all the hard work and dedication for organising this congress. I look forward to seeing you in Colombo.

An excellent academic programme

Welcome message by Prof. Prasad Amaratunga, President Elect of the APDC/APRO

It is indeed an honour and a great privilege to welcome you to the 32nd Asia Pacific Dental Congress (APDC) in Colombo, Sri Lanka, 12–15 May 2010.

Under the theme Clinical Excellence in Dentistry, through knowledge, evidence and new technology, the Chairman of the Scientific Committee has organised an excellent academic programme aiming at the general dental practitioner. Topics include dental implantology, fixed prosthetics, aesthetic dentistry, endodontics, periodontology as well as minimal invasive oral surgery. Moreover, advance sessions have been organised for scientists and researchers to share knowledge and present their latest findings.

Sri Lanka has already been the host of several international dental conferences including the APDC in 1997, the South Asian Dental Congress in 1994 and the Commonwealth Dental Congress in 2006. Therefore, the LOC has gained the knowledge and the skills in organising a rewarding and satisfying conference. In addition to updating their skills in dentistry, participants will also have the opportunity to enjoy or visiting wildlife parks. They can also relax on the many beautiful beaches that the island has to offer.

I am looking forward to meeting you in Colombo.

Exhibitors list and floor plan—APDC Sri Lanka 2010

Welcome message by Dr M. Farhim Jameel, President of the Sri Lanka Dental Association

A unique scientific and cultural experience

On behalf of the Sri Lanka Dental Association (SLDA) and the Local Organising Committee, I am pleased to invite you to the 32nd Asia Pacific Dental Congress (APDC) scheduled to be held in Colombo, Sri Lanka, 12–15 May 2010. More than 1,000 participants are expected and we would like you to join us in this unique scientific and cultural experience.

The 32nd APDC Congress will be a great opportunity for dental professionals from around the world to share the most up-to-date information and scientific advances. More than 20 invited specialists from a wide range of disciplines will participate in the scientific programme, and their presentations will provide delegates with information on the latest developments in dentistry.

In addition to the outstanding scientific programme, visitors will be able to enjoy the rich culture of Sri Lanka which is also called the Pearl of the Indian Ocean.

From the golden beaches to the ancient cities of Anuradhapura and Polonnaruwa, from the rock Fortress of Sigiriya named the 8th Wonder of the World to the cool climate of the hill station Nuwara Eliya surrounded by lush green tea estates, Sri Lanka will indeed take your breath away.

Colombo, which is also known as the “Garden City”, has also a large variety of restaurants and shopping areas. The month of May is a wonderful time to visit, and we encourage you to extend your trip and discover the beauty of the island.

We look forward to seeing you in Sri Lanka for a stimulating and enjoyable conference!
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