Global trends in focus of World Dental Forum

Dental laboratory giant invited to Mainland China and Macao

HONG KONG/LEIPZIG, Germany: Affiliates of Modern Dental Laboratory (MDL) have recently met during the World Dental Forum in Shenzhen and Macao in China. The event also saw more than 200 dentists from Europe, North America and Asia gathering for three days of learning and discussing new trends in the global dental industry. Chinese dental industry representatives and other professionals including the dean of Hong Kong’s Faculty of Dentistry Prof. Professor Lakshman Samaranayake attended the meeting.

MDL is one of the largest providers of dental restorations in China and pioneers for the outsourcing of manufacturing which has become an increasing trend in Europe and even more in the United States.

According to Chinese lab consultant Ma Yun Xiu, there are now more than 8,000 dental labs of different sizes in China alone of which 100 are able to provide qualified services for clients in overseas. MDL has been producing ISO 13485:2003 certified dental work for dentists and patients in the US from its main lab in Shenzhen since 1976. The company also says to maintain the largest dental technology school worldwide with a staff of 3,000.

“It was thrilling to bring a group of dentists from the US to Modern Dental Laboratory during the World Dental Forum, allowing us to see firsthand how worldwide dentistry is positively reaching US dentists and patients today,” said Patrick Tessier, CEO of Modern Dental Laboratory USA. “Many of the doctors told me that what stood out for them during the tour is that there is a quality check after every process, not just at the final restoration.”

MDL said that the company will held its next Forum in conjunction with the centennial celebrations of the University of Hong Kong in 2012.

First Afro-American takes presidency

The American Dental Association has elected Dr Raymond F. Gist, a dentist from Flint, Michigan, as their new president. Gist is the first African-American to hold the organization’s highest elective office. He announced to focus on membership outreach and advocacy efforts that will have special appeal to young dentists.

India, Malaysia agree to free trade

India and Malaysia have agreed on a new free trade deal that will take effect in mid-2011. The Comprehensive Economic Cooperation Agreement covers trade in goods and services, investment and economic cooperation. It is expected to be signed by end of January next year, according to a joint statement.

Displaced dental workers given help

The Filipino Department of Labor and Employment has announced that it will provide financial and livelihood assistance to the 50 dental technicians left unemployed by the closure of a Manila lab in August. It also said to have teamed up with the National Association of Dental Prosthetic Laboratories, Inc. to seek training opportunities and possible future employment for the 400 workers in other dental laboratories in the country.

The facility concerned was one of Laotian Prime Minister Bouasone Bouphavanh. European and Asian leaders, including the president of Hong Kong’s European and Asian leaders, met in October in Brussels to discuss new measures against counterfeit products.

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Samaranayake speaks

An interview with the dean of HK’s only dental school

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Extra

The latest news from the FDI head office

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No. 10 Vol. 8

Daniel Zimmermann

DTI

Indian edu standards under scrutiny

HONG KONG/LEIPZIG, Germany: Dental education in India faces a major overhaul, as the Dental Council of India (DCI) is considering the revision of current regulations. In a public note released in September, the organization, which regulates dentistry and dental education, urged dental professionals nationwide to review a number of suggestions regarding the manner in which to raise educational standards, including the reduction of seats in dental colleges and reviewing the clinical acumen of dentists every ten years.

The number of private dental colleges in India has skyrocketed lately, which has raised concerns about falling standards and the employability of future dental graduates. The DCI previously rejected applications for over 40 new colleges and requested state health ministers halt registration or reduce the number of seats at these colleges according to vacant positions available.

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“A well-recognised health profession”

Prof. Lakshman Samaranayake talks about the University of Hong Kong Faculty of Dentistry

Established in 1980, the University of Hong Kong’s Faculty of Dentistry is not only one of the youngest but also fastest growing dental schools in Asia. Recently, the school opened a new Centre for Advanced Dental Care that aims to provide higher clinical training to students and visiting dentists. At the Open Day in November, Dental Tribune Asia Pacific spoke with the Dean, Prof. Lakshman Samaranayake, about the Faculty and what makes studying Dentistry at the University of Hong Kong unique.

Dental Tribune Asia Pacific: Since 1997, Hong Kong has been administered by the People’s Republic of China. Did this have an influence on the Faculty and Hong Kong dentistry in general?

Prof. Lakshman Samaranayake: The handover had a major impact on our relations with the key academic institutes in Mainland China. In collaboration with the Beijing University School of Stomatology, for example, the Faculty initiated the Mainland’s first ever joint international clinical programme in 2007. We have also initiated joint Annual Fellowships in Advanced Dentistry together with the Chinese Stomatological Association and established the Wah-Ching China Dental Sciences Development Project.

Where do the majority of your students come from and do you cooperate with other universities abroad?

The vast majority of our undergraduate students are local, and only a minority come from Mainland China or the region. However, we are proud to say that we have over 200 postgraduate students from over 50 nations registered in the Faculty right now and at least the same number of agreements with major universities overseas to promote academic research and cultural exchange. In the last two years, the Faculty has been also regular host to dental school representatives from around the world, and signed academic and research collaboration agreements with dental schools in Thailand, Finland and the US, amongst others.

How many Dentistry students graduate from the Faculty each year and what are their overall job prospects?

Each year, around 50 dentists graduate from our school. They are able to pursue a career in private general or specialist practice, hospital dentistry, government dental services, or teaching or research.

Dentistry is a well-recognised health profession in Hong Kong and dental graduates have the benefits of a high professional status, as well as an above-average income. Dental graduates from the Faculty normally secure gainful employment in the field of dentistry shortly after graduation. In 2009, all Bachelor of Dental Surgery (BDS) graduates found jobs or pursued further studies within the first six months of graduation. Let me add that more than 50 per cent of dentists in Hong Kong are alumni of our Faculty.

You rival with other dental schools in Asia. In your opinion, what makes dental training in Hong Kong unique?

Our training is unique for a number of reasons but think one of the main things that makes us different is that we use English as main instructional language. Our teaching staff also comes from more than ten different countries and they enrich the courses with international knowledge. The Faculty is also one of the best equipped in Asia, with students having the latest digital technology at their disposal.

Last, we are the only dental education facility in Asia that offers Problem-Based Learning (PBL) programmes for undergraduates.
Asian experts discuss implants at German meeting

Daniel Zimmermann
DTI
LEIPZIG, Germany: Over 180 dentists from Asia, Germany and the UK recently discussed new concepts in restorative implant dentistry at a joint symposium held at the University of Tübingen in Germany. Japanese scientists led by Prof. Takashi Miyazaki from Showa University presented new research on utilising spark erosion for the improvement of implant surfaces. The technology is currently being used in other industrial fields for cutting metal using high voltage electronic discharges.

Dental implantology has seen an upswing in countries like Korea and China, where more than 80 of all dentists are now able to place implants. According to Prof. Yen Lin of the School of Stomatology at the Beijing University in China, who also attended the meeting, between 2,000 and 5,000 implants are placed in the clinic’s Department of Implantology each year.

Industry reports predict that the market will grow to over US$125 million by 2013, reflecting a compound annual growth rate of more than 30 over the next four years.

The symposium, chaired by Clinical Director Prof. Heiner Weber, was organised by the Department of Prosthodontics at the University of Tübingen. Since the 1980s, the university has been educating dentists, technicians and dental students from different parts of Asia in dental surgery.

Asia, Europe take on fake drugs

Daniel Zimmermann
DTI
LEIPZIG, Germany: Politicians and business leaders participating in the Asia–Europe Summit ASEM 8 in Brussels in Belgium have decided to strengthen trans-regional cooperation in health care services between Asia and the European Union. They have also called for improved intervention policies on counterfeiting, including the recognition of Good Manufacturing Practice certification by Asian countries.

Counterfeit goods, including medical products, account for US$200 billion or 2 per cent of the world’s trade, according to figures from the Organization for Security and Co-operation in Europe. Many of them originate in countries like India and China, where restrictions against counterfeiting are ineffective. Amongst others, the US Food and Drug Administration had to recall tons of counterfeited Colgate toothpaste in 2007, which were produced in China and contaminated with a chemical compound commonly used in antifreeze.

“Counterfeit medical products are not only of concern to dentists and the dental industry. They represent a threat for all medical professions,” Friedrich A. Herbst, Executive Director of the Association of International Dental Manufacturers told Dental Tribune Asia Pacific. “The spread of counterfeit products can only be reduced when each and every individual along the distribution chain is committed to ensuring that the product or good he is offering, distributing or selling comes from a reliable source which is known for its personal integrity and ethical standards.”

Herbst added that the World Health Professions Alliance, a non-governmental body representing over 600 health organisations around the world, recently announced a public health alert on the prevalence of falsified medical products. The organisation also provides resources on their website (www.who.org) for physicians and dentists seeking more information on the matter, he said.

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Dear reader,

Daniel Zimmermann
Group Editor
Dental Tribune International

There is no doubt that counterfeiting has become a serious problem not only for the industry but consumers alike. Fake medicine, originating mainly from countries like India, China or South Africa, even poses a increasing threat to public health, according to the World Health Organisation.

Despite a few tons of fake toothpaste and mouth wash, dentistry has long been spared by the problem of counterfeiting but the trend in the globalised dental industry for outsourcing production to low-wage countries has made it more difficult for dental professionals to determine exactly where their products come from.

To make things more complicated, patients usually put a lot of trust in their dentist and leave critical thinking outside practice doors.

The dental community has to be aware of this relationship and that what they sell or put in patients’ or consumer’s mouth can significantly impact their overall well-being. Therefore, the fight against fake products has to be fought not only on a political level but, up and foremost, in every single dental practice.

Yours sincerely,
Daniel Zimmermann
Group Editor
Dental Tribune International

Clinical controversies in implant dentistry

Lisa Townsend
Dental Tribune UK

More than 5,000 dentists, dental clinicians and implant specialists from around the world met in Glasgow to discuss some of the very latest techniques in implant therapy at the 19th annual scientific congress of the European Association for Osseointegration (EAO).

With a truly international flavour, the four-day congress focused on the science related to dental implants. The range of topics covered was extremely varied and included: imaging, periodontal therapy, prosthodontics etc. Saturday morning’s session was even focused on ‘controversial issues’ including implant placement adjacent to and within endodontically infected sites or when and how to connect implants to teeth.

In addition to the main sessions, there was a comprehensive parallel session programme, short oral communication sessions and more than 350 poster presentations covering six topics such as implant therapy outcomes, surgical aspects, tissue augmentation and material research.

The Association itself had much to celebrate as it unveiled its new identity to better reflect its new role in the implant industry for ensuring product quality and safety, as well as promoting a partnership approach to the advancement of the profession. The EAO showcased a bright new logo and distinctive colour scheme, designed to project a more dynamic feel to the association. The conference seemed to be bouncing from the start, with many delegates commenting on the new branding and the high quality of the speakers.

The EAO is now looking forward to its 20th annual conference next year, to be held in Athens, Greece 15-15 October 2011.

Contact Info
Lisa Townsend is the Group Editor of Dental Tribune UK. She can be contacted at lisa.townsend@dentaltribuneuk.com.
Athens hosted World Congress in endodontics

Daniel Zimmermann
DTI

ATHENS, Greece/LEIPZIG, Germany: New findings in evidence-based endodontics were recently discussed at the World Endodontic Congress in Athens in Greece. The event, which took place in early October and was organised by the International Federation of Endodontic Associations (IFEA), also saw new products launched, including a number of newly improved reciprocating files that are said to be more tolerant to circular fatigue.

Speakers included experts from Europe and the Middle East, as well as North and South America, who lectured on current issues in the field such as effective root-canal debridement and disinfection techniques that improve the success of root-canal treatment. Other presentations explored the use of 5-D imaging and microscopes during endodontic procedures. Dr Gabriela Martin, a clinician from Argentina, and many others presented new evidence for regeneration of the pulp. Until now, pulp revascularisation has been largely considered impossible owing to the presence of bacteria in the root canal.

IFEA is an umbrella organisation comprising 26 national endodontic associations worldwide. According to its statutes, the organisation aims to promote endodontic education on a global scale through congresses and lectures. The organisation’s World Congress is held every three years.

UK dental students face higher fees

Lisa Townshend
DT UK

LONDON, UK: Members of the House of Lords have recommended an increase in university tuition fees in the UK. Reports in the media also suggest that the new coalition government aims to cut university budgets by £82 million (US$130 million) next year and that the number of student places available is to be halved.

The proposed changes hold far greater implications for dental and medical students, as their courses are significantly longer than the usual three years. Recently, figures of £7,000 (US$11,050) per year have been mentioned; however, there is also talk of an unrestricted annual fee to be determined by individual universities. Should these changes be effected, then students would potentially leave university with a staggering amount of debt.

As it stands, many students struggle to find a job after graduation owing to the economic climate, resulting in their being burdened by ever-increasing debts on their student loans. Thus, increased loans as a result of increased fees and no certain way off paying such debt off will undoubtedly put off prospective students. A decrease in the number of future dental and medical university students however could result in a sudden shortage of trained professionals in the future and ultimately affect economic growth. Figures suggest that, in the UK between 2000 and 2007, the increase in employed university graduates accounted for six per cent of growth in the private sector.

It is believed that were the proposed changes to be implemented, elite universities, where students compete for places, would end up charging higher fees for the privilege. However, in the case of dental and medical students, it appears to be common opinion that they are guaranteed a job that is well paid and because of this they leave university in a better position to pay back their fees.

(Edited by Daniel Zimmermann, DTI)
LONDON, UK: The 10th Biannual Meeting, held in London, was a truly collaborative effort. Organised by the European Association of Oral Medicine and the three London dental schools (King's College London; Queen Mary, University of London; and University College London's Eastman Dental Institute) and supported by GSK, the conference highlighted the importance of oral medicine in diagnosing and treating conditions such as xerostomia and hyposalivation. The opening plenary session of the main part of the conference was dedicated to this topic.

After opening remarks by Baroness Gardner of Parkes and Chief Dental Officer for England Dr Barry Cockcroft, it was time to turn over the session to the two Chairs, Prof. Isaac van der Waal (Head of the Department of Oral and Maxillofacial Surgery and Oral Pathology of the VU University Medical Center/ACTA Dental School, Amsterdam) and Prof. Crispian Scully CBE (Director of Special Projects at the UCL Eastman Dental Institute, and Professor of Special Care Dentistry, University College London). After setting the scene for the session, they introduced the first speaker, Prof. Stephen Porter.

Prof. Porter is Director and Professor of Oral Medicine at the UCL Eastman Dental Institute. In his presentation, Hyposalivation: Prevalence, assessment, differential diagnosis and quality of life impact, he gave a general overview of the condition of xerostomia in terms of prevalence. He discussed the age factor in the condition, as well as issues such as immunosuppressant disease and drug/radiotherapy treatments. He also looked at the issue from the point of view of the patient, whose quality of life may be affected because of reduced sleep and impaired eating function.

Next to speak was Dr Jackie Brown, specialist in Oral and Maxillofacial Radiology. She is Consultant in Dental and Maxillofacial Radiology at Guy's and St Thomas' NHS Foundation Trust; and is Senior Lecturer at King's College London Dental Institute, of Guy's, King's College and St Thomas' Hospitals, and at the UCL Eastman Dental Institute. In her presentation, Contemporary imaging in salivary gland disease diagnosis, she considered the role of imaging in the distinguishing and identifying diseases affecting the salivary glands. She discussed the various imaging equipment available, including ultrasound and CBCT, as well as their advantages and disadvantages.

Then it was the turn of Prof. Gordon Proctor (Professor of Salivary Biology and Head of Salivary Research Unit, Department of Clinical Diagnostic Sciences, King's College London Dental Institute), who discussed Drug-related hyposalivation: A review of physiology and sites of drug action. Prof. Proctor highlighted the relationship between drug therapy and salivary flow rates. He discussed the findings from various studies looking at this relationship, including one specific paper by Wolff et al.,

Xerostomia, not such a dry subject
Dry mouth and hyposalivation discussed at EAOM Meeting in London
Major salivary gland output differs between users and non-users of specific medication categories (published in Gerodontology 25/04, 2008).

Speaking just before the coffee break was Prof. Jennifer Webster-Cyriaque (Associate Professor, Departments of Dental Ecology and Microbiology and Immunology, Schools of Dentistry and Medicine, University of North Carolina at Chapel Hill). In her presentation, Viral infections of salivary glands resulting in hyposalivation, she examined various viral infections that can affect saliva production, including HIV, herpes and polyomaviruses (such as BKV). One of the main challenges, according to Prof. Webster-Cyriaque, is determining the manner in which viruses access and infect the salivary cells.

Following the coffee break, during which delegates had the opportunity to network and discuss the morning’s presentations, Prof. Roland Jonsson, Vice-chairperson of the Gade Institute at the University of Bergen, gave a presentation on Immunopathology resulting in hyposalivation. He focused mainly on Sjögren’s syndrome, stating that it is a condition that is not easy to diagnose in its early stages. He stressed that biopsies are very important for the diagnosis and understanding the pathogenesis of the condition. Detailing various studies, Prof. Jonsson hypothesised that a virus might trigger the inflammation.

Also focusing on Sjögren’s syndrome, Dr Elizabeth Price followed Prof. Jonsson’s presentation with Systemic disease associations of hyposalivation. Dr Price has a specialist interest in Sjögren’s syndrome and runs a specialist Sjögren’s clinic at the Great Western Hospital in Swindon. She discussed the condition in more detail, and highlighted that along with dry eyes and mouth, tiredness and fatigue are common symptoms. She also discussed the condition’s association with thyroid disease and osteoarthritis.

Next, Prof. Sue Lightman (Medical Research Council Senior Clinical Fellow, Senior Lecturer at the Institute of Ophthalmology and Consultant Ophthalmologist at Moorfields Eye Hospital in London), considered Ocular associations of hyposalivation. She detailed the manner in which dry eyes can rapidly arise and the way in which conditions such as Sjögren’s syndrome originate.

The final speaker of the session was Dr Philip Fox, Visiting Scientist at the Department of Oral Medicine, Carolinas Medical Center in Charlotte, USA, and an independent biomedical consultant primarily in the area of clinical trial design and analysis. This was the practical part of the session, as it focused on the treatment of patients suffering from xerostomia. According to Dr Fox, clinicians must remember that their primary aim is to treat patients. To this end, clinicians can encourage patients to chew and stimulate the masticatory function.

Dr Fox also considered different ways of managing xerostomia, including different formulations, such as Biotene, produced as gels, gums and mouth rinses. He concluded by reminding the audience that their patients and what makes the mouth feel moist and comfortable for them are the most important issues for clinicians.

This session offered a very detailed examination of some of the causes of xerostomia and hyposalivation and allowed delegates to gain a better understanding of the manner in which these conditions affect salivary flow. It also offered delegates an update regarding the rationale for many of the products clinicians could recommend to patients for relief.

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Foreign markets are very important to us

An interview with Olaf Sauerbier, CEO of VOCO GmbH, Cuxhaven, Germany

VOCO, based in Cuxhaven on the northern coast of Germany, is an established international provider of high-quality dental materials. In addition to products for restorative dentistry, it offers a wide range of materials and preparations for the fields of prosthodontics and prophyaxis.

Dental Tribune Group Editor Daniel Zimmermann spoke with Olaf Sauerbier, CEO and Chief of Marketing and Sales, about new products and aesthetic trends in restorative dentistry.

Daniel Zimmermann: What is the situation in your company?

Olaf Sauerbier: To be honest, the recession never really caught us. We usually tend to perform slightly better than the overall market and expect to do no different for this business year. The year 2010 started off better than last year ended, and we saw some significant growth in most of our business segments in the first and second quarters. Although we have invested significantly in our German businesses by extending our sales team by 15 new employees, foreign markets are very important to us. At the moment, we are expanding our existing businesses worldwide, especially in North America. It will be a while before we are able to take full advantage of the enormous potential this market has to offer.

Did the products you introduced two years ago at IDS Cologne meet your expectations?

The most important product we introduced at IDS in terms of sales was definitely the non-run, non-drip NDT syringe. This new delivery form helped us to increase sales of most of our highly flowable materials like Grandio Flow, Grandio Seal and Jconoseal. Our gingiva-shaded restoration system Amaris Gingiva has also shown good performance. We have to admit that the market for such a product is still small, but, on the other hand, we see the demand for aesthetic restorations of exposed necks of teeth increasing owing to demographical changes and people ageing.

Those who have highly aesthetic restorations very well owning it hard to pass this product by, almost ideal properties for a filling material and exhibits the same physical properties as natural tooth substance. All our competitors are moving towards this ideal but see us far ahead. We have been working with nanotechnology since the early 2000s and based on the results of this launched our first nano-hybrid composite GrandioSO in 2005. This product is still in high demand in Germany and many other markets.

But we did not stop there. With GrandioSO, we are now able to present another nanohybrid composite to the dental community that has outperformed our original expectations. In terms of its physical properties, it is probably the most tooth-like material on the market.

When and where will it be available?

It is already available in Germany and other selected European markets. Like its predecessor, GrandioSO is universally applicable but a little more translucent, so it can be used for restorations in the maxillary anterior region.

Will GrandioSO be the main focus of your presentation at IDS next year and are you planning to introduce more products there?

GrandioSO will not be the main focus of our IDS presentation, but there are other products that we plan to launch this month and at IDS 2011.

Thank you very much for the interview.
A word from Jérôme Estignard, FDI Interim Executive Director

Mr Jérôme Estignard has been appointed Interim Executive Director by the FDI Council during the 2010 FDI Annual World Dental Congress held in Salvador da Bahia, Brazil. He will manage the FDI head office during the search for a permanent Executive Director.

Mr Estignard has been with the FDI since November 2009 as Finance & Operations Director. His prior experience includes five years as Senior Auditor at PriceWaterhouseCoopers in France and twelve years at SITA in France, Germany and Switzerland, including Head of Financial Reporting at SITA, Switzerland, from 2004 to 2008.

Mr Estignard holds an MBA from International University in Geneva (Switzerland), a degree in Accounting and Finance from the ICS Business School in Paris (France) and a degree in Business Economics from the University de Sceaux (France).

“Last month FDI hosted another Annual World Dental Congress in Salvador da Bahia, bringing together close to 10,000 participants worldwide. Striving towards better oral health never stops and we are now focusing on building a solid foundation for the work ahead of us.

FDI is a membership organisation and as such, we are seeking to enhance services for our members, taking into account advices and opinions from all members, National Dental Associations and stakeholders.

I am privileged with a trust that the FDI Elected have placed in me and am very enthusiastic about our future. With the support of the FDI Council, numerous volunteers, head-office staff and our partners, FDI is continuing its journey towards the vision of optimal oral health for all.

The FDI head office stays at your disposal and service. We welcome your questions and feedback, especially on the FDI’s new projects, launched at the recent FDI Congress in Salvador, such as Data Mirror and VOX. Both tools are developed with one goal—to better serve our members.”

Mr Jérôme Estignard

National Dental Associations rally to help rebuild Haiti’s oral health infrastructure

When Chantal Noël, National Liaison Officer of the Association Dentaire Haïtienne, spoke at the General Assembly and at the NLO Forum in Salvador da Bahia—a cohort study in Salvador da Bahia—a cohort study—she expressed enthusiasm to work with VOX, the FDI new communication platform, in the quest to rebuild the oral health capabilities of her country. Eight months after an earthquake devastated Haiti, many of the dental offices are still in ruins.

Chantal Noël plans to enlist the support of NDIAs worldwide in the rebuilding and re-equipping efforts. She will use VOX to communicate with all FDI members about the equipment that is needed by Haitian dentists. Chantal gave insight into the benefit that such a tool can bring to a National Association which has been affected by a natural disaster.

Already engaged, the American Dental Association is raising funds for Haiti through a campaign called “Adopt-a-Practice; Rebuilding Dental Offices in Haiti”. The ADA will use VOX to promote this campaign and is urging other National Dental Associations to participate. Without help, most Haitian dentists will not be able to rebuild their practices. The campaign aims to raise $550,000 by the end of 2010. For more information or to donate go to: www.ada.org/4412.aspx.

FDI successfully launches new communication platform—VOX

The platform was presented to members in both the FDI General Assembly and National Liaison Officers forum, following online access being made available to members.

This new FDI web-based membership communication platform comes in response to requests from FDI members, and it is tailored to meet their diverse needs.

VOX aims to unify FDI members, governance and staff online contact through an intuitive application that provides information about FDI Members, facilitates FDI one goal—to better serve our members.

FDI Members, facilitates FDI one goal—to better serve our members.

The launch of VOX marks the completion of phase 1, development and testing, and now FDI members are invited to use the platform themselves to make it a success. Meanwhile, ongoing development of the tool will continue to provide FDI and its members more advantageous functions, such as personalised web pages for each member and online International Directory.

Announcing the six winners of this year’s FDI/Unilever Poster Award Competition, FDI Interim Executive Director Jérôme Estignard said: “Tooth loss and oral health self-perception of adults covered by health strategy for the family in Salvador, Bahia, Brazil.”

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FDA new communication platform—VOX

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The launch of VOX marks the completion of phase 1, development and testing, and now FDI members are invited to use the platform themselves to make it a success. Meanwhile, ongoing development of the tool will continue to provide FDI and its members more advantageous functions, such as personalised web pages for each member and online International Directory.

Announcing the six winners of this year’s FDI/Unilever Poster Award Competition, FDI Interim Executive Director Jérôme Estignard said: “Tooth loss and oral health self-perception of adults covered by health strategy for the family in Salvador, Bahia, Brazil.”

Chantal Noël is raising benefit that such a tool can bring to a National Association which has been affected by a natural disaster.

FDI new communication platform—VOX

Mr Estignard held an MBA from International University in Geneva (Switzerland), a degree in Business Economics from the University de Sceaux (France), and a degree in Accounting and Finance from the ICS Business School in Paris (France) and a degree in Business Economics from the University de Sceaux (France).

“Last month FDI hosted another Annual World Dental Congress in Salvador da Bahia, bringing together close to 10,000 participants worldwide. Striving towards better oral health never stops and we are now focusing on building a solid foundation for the work ahead of us.

FDI is a membership organisation and as such, we are seeking to enhance services for our members, taking into account advices and opinions from all members, National Dental Associations and stakeholders.

I am privileged with a trust that the FDI Elected have placed in me and am very enthusiastic about our future. With the support of the FDI Council, numerous volunteers, head-office staff and our partners, FDI is continuing its journey towards the vision of optimal oral health for all.

The FDI head office stays at your disposal and service. We welcome your questions and feedback, especially on the FDI’s new projects, launched at the recent FDI Congress in Salvador, such as Data Mirror and VOX. Both tools are developed with one goal—to better serve our members.”

Mr Jérôme Estignard

National Dental Associations rally to help rebuild Haiti’s oral health infrastructure

When Chantal Noël, National Liaison Officer of the Association Dentaire Haïtienne, spoke at the General Assembly and at the NLO Forum in Salvador da Bahia—a cohort study in Salvador da Bahia—a cohort study—she expressed enthusiasm to work with VOX, the FDI new communication platform, in the quest to rebuild the oral health capabilities of her country. Eight months after an earthquake devastated Haiti, many of the dental offices are still in ruins.

Chantal Noël plans to enlist the support of NDIAs worldwide in the rebuilding and re-equipping efforts. She will use VOX to communicate with all FDI members about the equipment that is needed by Haitian dentists. Chantal gave insight into the benefit that such a tool can bring to a National Association which has been affected by a natural disaster.

Already engaged, the American Dental Association is raising funds for Haiti through a campaign called “Adopt-a-Practice; Rebuilding Dental Offices in Haiti”. The ADA will use VOX to promote this campaign and is urging other National Dental Associations to participate. Without help, most Haitian dentists will not be able to rebuild their practices. The campaign aims to raise $550,000 by the end of 2010. For more information or to donate go to: www.ada.org/4412.aspx.

FDI successfully launches new communication platform—VOX

The platform was presented to members in both the FDI General Assembly and National Liaison Officers forum, following online access being made available to members.

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The Data Mirror launched by FDI and Unilever Oral Care.

An outlook of the FDI AWDC 2010 in Mexico City.

Welcome to the new FDMI members!

The General Assembly B in Salvador da Bahia has elected the following new members:

- Egypt – Egyptian Dental Association
- Belarus – Belarusian Dental Association
- Vanuatu – South Pacific Smiles

Supporting:
- Academy of General Dentistry – AGD
- Brazilian Academy of Dentistry – BADC

"The FDI has created The Data Mirror so that the data from The Oral Health Atlas can benefit all health promotion and disease prevention public health projects including the FDI’s own, Live. Learn. Laugh., the World Dental Development Fund, the Global Carries Initiative and regional strategies. The data will also help with advocacy and workforce projects. Moreover, the FDI and National Dental Associations (NDAs) will be able to better plan, implement and evaluate oral health projects by using this data. It is expected that The Data Mirror will also help generate updated data for the second edition of The Oral Health Atlas.

FDI & Unilever Oral Care launch the second phase of their global partnership

The FDI World Dental Federation and Unilever Oral Care have launched Phase II of their unique global partnership. The FDI World Dental Federation, in collaboration with the National Dental Associations (NDAs) and Unilever Oral Care brands in 37 countries, have committed to continue to work together to improve oral health globally and are pleased to be taking their partnership forwards.

To mark the launch of Phase II, the partners held a Global Launch Workshop at the FDI Annual Dental Congress, attended by NDA representatives from participating countries and from the global partnership team at FDI and Unilever. Two members of the FDI World Dental Development and Health Promotion Committee, Professors Prathip Phanthumvanit and Juan Carlos Llodra also gave presentations on the efficacy of twice daily brushing with fluoride toothpaste and support them in taking up this fundamentally important oral health behaviour.

As organizers of the 2011 FDI Annual World Dental Congress, FDI and the Mexican Dental Association, in collaboration with the Mexican Dental Industry, are going all out to provide a memorable experience on all levels.

Hosted at the new, state-of-the-art Centro Banamex Convention Centre, participants will enjoy optimal conditions to participate in the scientific programme. This year’s theme “New Horizons in Oral Health Care” will explore the latest challenges and opportunities in the world of dentistry. In addition, the FDI World Dental Exhibition will showcase International and Mexican manufacturers and retailers, who will be exhibiting their latest products and services to FDI delegates.

The experience will be completed by opportunities for a full immersion into Mexican culture through optional tours, excursions and social events, as well as experience the welcoming Mexican hospitality, world-famous cuisine and rich cultural diversity.

Our official hotels are located in Polanco, one of the most dynamic areas of the city. In this neighbourhood you will be able to find the most sophisticated hotels, restaurants and the best shopping district. The main attraction of Polanco is being both residential and commercial.

For more information, visit the FDI website www.fdiworldental.org.
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Oral-Systemic Health:

What is it?

Good oral health has taken a new meaning today. Studies have shown that diabetes and coronary heart disease have some association with gum disease (periodontitis).

Unfortunately, many periodontists (dentists who specialize in treatment of gum disease) notice that gum disease is frequently disregarded by most patients since early disease cause little to no signs or symptoms. Studies have shown that diabetics are more likely to suffer from periodontitis. Therefore, gum disease is known and acknowledged to be another potential complication of diabetes.

Recent research also suggests an association between gum disease and coronary heart disease. Thus patients with untreated periodontitis may be exposed to increased risk of developing coronary heart disease.

What is Periodontitis?

In simple words, it is a chronic mixed bacterial infection of the tissues surrounding the tooth. The World Health Organization has shown that between 5-15% of the population suffer from severe periodontitis. But unfortunately, as opposed to tooth decay, the public has little knowledge or understanding about gum disease or periodontitis. While dentists know that gum disease is a leading reason for tooth loss in adults aged 40 and above plus it is a ‘silent disease’, not causing pain until reaching the severe stage, yet many patients remain in the dark. As it is with diabetes and other medical conditions, it is important for everyone to be screened regularly so as to facilitate early detection. The diagnostic tool used to detect periodontitis is the simple basic periodontal examination and evaluation and dental X-rays.

Since early signs are easily missed, how can periodontitis be recognized, treated and kept under control? Apart from a little bleeding during brushing, accompanied sometimes with bad breath, itchy or vague uneasy feeling in the gums, there are no painful symptoms that could serve as an alarm. Therefore, it is important to consult the dentist to perform clinical tests with X-rays to check for the presence of gum disease.

The good news is that periodontitis can be treated and the best treatment results are obtained when it is detected at an early stage. The 2nd piece of good news is that periodontal therapy can, through surgical procedures in some advanced cases, regenerate bone and gum tissue.

The final piece of good news is that with regular professional reviews and practice of good daily personal oral hygiene, with the help of an anti-bacterial and anti-inflammatory toothpaste/mouthrinse, periodontitis can be kept under control and recurrence can be minimized.

Regular dental visits with good personal oral hygiene practice can help keep the mouth healthy and even help prevent other serious conditions from arising.
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Restoring missing mandibular incisors with implants

Dr Chonghwa Kim & Sangwoo Lee
Korea

Mandibular incisors can be vulnerable to early loss due to their inherently weak periodontal support and high prevalence with respect to periodontal disease. What are the most common treatment options for missing mandibular incisors? Aside from removable prosthetic options, the restorative options for a fixed prosthetic include a conventional bridge, a resin-bonded bridge (Maryland Bridge) and implants. For a case in which one or two mandibular central incisors are missing, a three- or four-unit bridge has often been the treatment of choice. A resin-bonded bridge, in these cases, can achieve another alternative to a conventional bridge, whereas implant treatment, more often than not, is not suitable due to insufficient space. When more than two incisors are missing, the treatment option may become the first choice for most clinicians these days.

Preparing mandibular incisors for bridge abutments is an extremely delicate procedure that often leads to root-canal treatment due to pulp damage that might occur during the procedure. Even without the risk of pulp damage, it is still quite a challenge to recreate natural contour and shade on such tiny dentition.

Dental implants have, in many cases, become the treatment of choice for restoring missing teeth and have been documented to have a high degree of success. With implant therapy, the preparation of healthy teeth adjacent to the edentulous area can be avoided. An additional advantage to the implant restoration is the maintenance of the alveolar bone, which otherwise would undergo resorption with other restorative options, hence, often compromising aesthetics.

What’s happening in the real world? Are we comfortable enough placing implants in the mandibular anterior region? In spite of understanding both the disadvantages of conventional fixed bridgework and the advantages of implant restorations, we often make the treatment choice for missing mandibular incisors in favour of the bridge. Why is that? What hinders us from providing an implant option for patients in such cases? Restoring mandibular incisors with implants can be one of the most difficult dental treatments to perform due to the limited amount of bone and interdental space. Placing implants in the mandibular anterior region can be challenging due to:

1. insufficient facio-lingual bone volume;
2. insufficient mesio-distal space between adjacent teeth;
3. insufficient height of remaining alveolar bone;
4. the presence of mento-labial depression, which limits the facio-lingual angulation of implants;
5. the preservation or recreation of the interdental papilla being an extremely delicate procedure.

One of the prerequisites for the successful placement of an implant is the presence of adequate bone volume. Tarnow et al. stated that a submerged implant, following the delivery of the prosthetic, will create circumferential and horizontal bone resorption of 1.5 to 4.4 mm. Grunder et al. also stated that at least 2 mm of lateral alveolar bone must be present beyond the body of the implant to compensate for the effects of bone remodelling. If this amount of bone is not present, part or all of the facial or buccal bone plate will be lost after remodelling, with the subsequent risk of soft-tissue recession. This amount of bone around an implant rarely exists in the mandibular anterior region. Therefore, ridge augmentation procedures are often required to create adequate bone volume to maintain 2.2 mm alveolar thickness following implant placement.

Another prerequisite for successful implant treatment is sufficient interdental space. The creation of a natural-looking implant restoration largely depends on the appropriate placement of the implant during surgery. In order to achieve this goal, careful planning and precise implant placement are essential. An implant requires a minimum distance of 1.5 mm between the implant and adjacent tooth to maintain interproximal bone and interdental papilla. Standard diameter implants of 4 mm or greater therefore require a mesio-distal space of at least 7 mm to place an implant. For an interdental papilla between two adjacent implants to be established, the interproximal distance should be more than 7 mm.

Thus, a minimum mesio-distal space of 14 mm is required to place two standard-diameter implants adjacent to each other. Implant manufacturers have introduced narrow-diameter implants (5.0 to 5.5 mm) in an attempt to solve these problems. However, these implants still require a minimum mesio-distal space of 6.8 to 6.5 mm to allow adequate implant.

Fig. 1: Pre-op.—Fig. 2: Pre-op peri-apical X-ray.—Fig. 3: Resin-bonded provisional restoration.—Fig. 4: Lingual view.—Fig. 5: Twelve weeks post-extraction.

Fig. 6: Following implant placement.—Fig. 7: Pre-op peri-apical X-ray at implant insertion.—Fig. 8: Immediate provisionalisation.—Fig. 9: Modification of provisional restoration.—Fig. 10: Eight weeks post-implant placement.

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Mandi-nute implants (MDI) are not synonymous with narrow-diameter implants. MDIs are smaller in diameter than narrow implants and have a diameter of 2.7 mm or less. Because of their smaller diameters, MDIs require minimal interdental space while preserving more of the alveolar bone following the osteotomies for implant placement. MDIs were initially developed to support transitional prostheses and were ultimately intended to be removed. However, these implants exhibited a bone-to-implant contact similar to that of implants with conventional diameters. Numerous studies have indicated that MDIs appear to be an effective treatment option for missing mandibular incisors. Nevertheless, one of the primary disadvantages of MDIs is the reduced resistance to occlusal loading. The retention of an implant is correlated to the length of the implant and not the diameter. This implies that MDIs may be used in situations where excessive occlusal loading is not present.

Mini-diameter implants (MDI) are composed of three portions—the bone-anchoring (fixation) portion and prosthetic abutment portion. The advantages of one-piece implants include minimally invasive surgery, simple restorative procedures and no screw loosening. Furthermore, the amount of bone resorption may be minimised, since there is no micro-gal or micro-movement between the implant and its abutment. Therefore, the angulation of the implant and its abutment is possible. Without the abutment, the internal surface of an implant approaches 3 mm or less, the abutment screw becomes too small or the internal axial walls of the implant become too thin to withstand the functioning load. These concerns can be overcome with a one-piece design. One-piece implants are not new to implant dentistry; yet, one-piece implants include minimally invasive surgery, simple restorative procedures and no screw loosening. Case reports

Case I

A 67-year-old female patient presented with occasional throbbing pain in the mandibular anterior region. The patient’s medical history was non-contributory. Clinical and radiographic evaluation revealed two separate periapical lesions, delayed placement of implants was planned. The teeth were carefully luxated with a periosteal and atraumatically extracted, preserving the thin facial bone. A wire-embellished provisional restoration was fabricated and bonded to the adjacent canines with flowable resin (Figs. 5 & 6). After seven weeks of healing, the provisional restoration was removed. The distance measured between the two mandibular canines was 15 mm (Fig. 5).

A crestal incision was made and a limited soft-tissue flap was reflected to expose the alveolar crest of bone. In this fashion, the patient experiences reduced post-operative swelling and discomfort. With a 1.6 mm twist drill and copious irrigation, osteotomies were performed at a speed of 1,500 rpm. The angulation of the twist drill was carefully monitored throughout the osteotomies. Following completion of the prepared implant sites, visual and tactile inspection of the internal bony walls was performed to ensure the absence of any fenestration or dehiscence at the cervical area. Two 2.5 mm-diameter implants (MDI) were then placed in the ideal 5:1 position and torqued to 25 Ncm with a manual torque wrench. The superior margin of the transmucosal portion was positioned 2 mm apical to the soft-tissue margin (Figs. 6a & 7). Immediately following implant placement, provisional restorations were fabricated at chairside using prefabricated temporary abutments and adhesive resin.

The provisional restorations were trimmed into position using the friction-fit temporary abutments, eliminating the use of

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  • Full body waxing and other intricate features can be achieved.
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SafeSore Disinfection Line

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* 1 ml concentrate = 12.5 ml of solution

Fig. 11: Friction-fit impression caps.—Fig. 12: Working cast.—Fig. 13: Top view.—Fig. 14: Final prosthesis.—Fig. 15: Thirteen-month follow-up.—Fig. 16: Periapical X-ray.
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Case II
A 58-year-old male patient presented with severe mobility and peri-apical lesions on teeth #23 and 24 (Fig. 17). A provisional restoration was fabricated and bonded to the adjacent natural teeth immediately following extraction (Fig. 18). The provisional restoration was left undisturbed for 11 weeks and the interdental papillae were preserved with ovate pontics (Figs. 19 & 20).

The interdental distance measured between teeth #22 and 25 was 8 mm, and two 2.5 mm-diameter implants were placed in position. The superior margin of the transmucosal portion was positioned sub-gingivally, and the height of the abutments was reduced to ensure adequate initial clearance (Fig. 21). Owing to the limited interdental space, the impression cap was modified (Fig. 22). An indexing jig was used to avoid any undue stress applied to implant fixtures during the impression procedure (Fig. 25). An altered cast was made, and a definitive prosthesis was fabricated and bonded to the adjacent natural teeth immediately following extraction (Fig. 18). The provisional restoration was left undisturbed for 11 weeks and the interdental papillae were preserved with ovate pontics (Figs. 19 & 20).

The provisional prosthesis was made, and a definitive prosthesis was placed in position. The patient was instructed to avoid any function of the implant for eight weeks. After a healing phase of two months, a final impression was produced using friction-fit impression caps (Figs. 10 & 11). Definitive restorations were then fabricated on the working cast and adjusted to have slight occlusal contacts in eccentric occlusion and excursive movements (Figs. 12–14). The clinical re-evaluation demonstrated a minimal gingival change around the prosthesis, and a stable horizontal bone level was observed radiographically at the 15-month follow-up (Figs. 15 & 16).

Conclusion
Based on the clinical cases presented in this article, the utilization of one-piece MDFs appears to be a good treatment option for replacing missing mandibular incisors. Considering the simplicity, ease of implant placement and immediate provisionalisation, this treatment offers a new option for patient care.

Contact Info
Dr Chonghwa Kim specialises in prosthodontics and implantology. He works in a private practice in downtown Seoul, Korea. He can be contacted at kimchonghwa@hotmail.com.
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Aesthetic restoration created with composite

The new generation of resin composite materials in combination with modern layering techniques allows today’s practitioners to treat their patients with minimally invasive, highly aesthetic direct restorations. Owing to their enhanced properties, these materials produce results that are hardly distinguishable from natural dentition, especially with regard to colour, which is particularly desirable in anterior teeth.

The new composite IPS Empress Direct (Ivoclar Vivadent) enables us to create restorations that are almost invisible to the human eye. The appropriate increment technique together with correct handling of the materials and high-gloss polishing produces predictable, aesthetic results directly in the mouth. Owing to its nano-hybrid structure, the material can also be used to restore posterior teeth. IPS Empress Direct materials are available in various levels of opacity, translucency and brightness. By combining the different materials, toothlike light scattering can be achieved. The working steps of the technique used to place IPS Empress Direct are described in this article.

Clinical case: Step-by-step restorative procedure

A young patient presented with a defective resin composite filling in tooth #11. The margin was no longer tight and the interface between the tooth structure and the restoration exhibited staining. What is more, the chroma, opalescence and shade of the filling did not correspond to that of the natural dentition (Fig. 1).

According to the treatment plan, the filling would be removed, the cavity prepared along minimally invasive principles and the tooth restored with a direct resin composite. In order to achieve impeccable integration of the restoration in the oral environment and an aesthetic smile line with a uniform colour, the composite would have to be placed using the increment technique. As the cavity had walls on all sides, there was no need to create a wax-up or a silicone template to restore the tooth shape. A layering scheme was established before the treatment was begun.

During the dental examination, the general preoperative situation, the natural colour of the patient’s teeth and individual characteristics were photographically documented. The layering scheme was prepared on the basis of the photographs. The different materials that would be used for the restoration were established in the process. In order to reproduce the special characteristics of the patient’s tooth anatomy, the appropriate dentine and enamel shades were selected along with an opalescent material and a white-opaque material (from the IPS Empress Direct range).

At a second appointment, the operating field was isolated with a rubber dam, since absolute moisture control is indispensable in the placement of resin composites (Fig. 2). The outer margins of the old filling were traced with a pencil. This was done to highlight the transition between the filling and the tooth structure in the removal of the old filling. A small chamfer was prepared on the vestibular side, as this is indicated for this type of restoration (Fig. 5). Next, the enamel and dentine were etched with 37% phosphoric acid (Total Etch) and a three-component adhesive (Syntac) was applied (Figs. 4 & 5).

In order to obtain the desired tooth shade, the dentine part of the restoration was built up first with dentine material (IPS Empress Direct Dentin A2; Fig. 6). A translucent and opalescent material (Trans Opal from the IPS Empress Direct range) was placed to build up the enamel part (Fig. 7). Thin white-opaque strips (IPS Empress Direct Bleach XL) were applied over the dentin segment to enhance the brightness. Finally, an appropriately shaded enamel material (IPS Empress Direct Enamel A2) was placed over the entire facial surface of the restoration to cover all the previously placed materials (Fig. 8).

The creation of surface texture as well as finishing and polishing are important working steps in imparting a restoration with a true-to-nature appearance. As a result, they have to be given due attention. In the present case, the surface texture was created with diamond burs at low speed. This allowed the procedure to be precisely controlled. A three-step silicione-polishing system (Aestedsyl) was used to finish and polish the restoration. Finally, the restoration was polished to a high gloss finish using aluminium oxide, diamond pastes (Shiny System, Micerium), brushes and felt wheels.

It is worthwhile recalling the patient for a third appointment to ensure that the restoration blends into the natural environment when the tooth is moist and to establish whether any shape or colour adjustments need to be made (Fig. 9).
**Case acceptance in complex-care dentistry**

Dr Paul Homoly

I enjoy seeing the articles in **DENTALTRIBUNE** where clinicians recount their creation of art through digital restorative dentistry. In most of the case studies included, the patient fees reach well over US$15,000 or more.

Let me ask you this: what percentage of your patients whose fee is US$15,000 or more are ready to start care immediately after you present your treatment plan? I have directed this question to thousands of my dental audience members over the last decade and the overwhelming response is “fewer than five patients.” It is not the fault of dentists; treatment recommendations often do not fit into their budgets! Chances are that both these apply.

As dentists we are pretty good at helping patients understand our treatment recommendations. What we are not good at is understanding our patients and the manner in which our treatment recommendations fit into their lives. If you have heard it once, you have heard it a thousand times; the key to case acceptance is patient education. Go to dental seminars, read journals, listen to consultants, most of it sounds the same—educate, educate, educate. Now let me ask you this: is it true? Is patient education the solution to case acceptance?

If it is, then why do many new patients who have been thoroughly examined, educated and offered comprehensive treatment plans leave your office without any treatment and never return for care? Is it that you did not educate them sufficiently? Or is it that the challenge of case acceptance, patient education is not the only one?

Let’s consider the new patient process and case presentation and learn when patient education works for us and when it chases patients out the door.

**Inside-out versus outside-in**

How do we get patient education across the threshold? Let’s make the distinction between an inside-out versus outside-in. In the traditional new patient process is inside-out. It begins by studying the flow of the patient’s mouth—the examination, diagnosis and treatment plan. It is after this inside look that we educate the patient with regard to all the procedures that we will do, how much she/he will be charged, and what we can do about them, for example, if the patient did not know about porcelain crowns. In our practice, we quote our fees and discuss financial arrangements. It is only once we have gone through our inside process that we discover what is happening outside the patient’s mouth—his/her budget, work schedule, time and significant life issues. The flow of conversation starts with inside-the-mouth conditions and ends with outside-the-mouth issues. I label this traditional way of managing the new patient the inside-out process (Fig. 1).

For patients with uncomplicated dental needs—fees of US$5,500 or less—the inside-out approach with appropriate patient education works well. Here’s why:

First, patients with minimal clinical needs are often unaware of treatments. Patients who do not understand periprosthetic disease, asymptomatic peri-implantitis, subgingival and incipient carious lesions must be made aware of them and educated about their consequences. Patient education is the driver of case acceptance when patients are unaware of their conditions.

Next, the inside-out process works well for patients with fees of US$5,500 or less because the outside-the-mouth issues—fees, time in treatment and life issues—are such that most patients can proceed with your treatment without undue hardships or inconvenience. Dental insurance reimbursements, patient payment plans such as CareCredit and credit cards usually sooth the sting of fees for US$5,500 or less. Fees at this level are not insurmountable and usually do not anger or embarrass patients out of your office. But if you present complex dentistry for more than US$5,500?

Let’s suppose your fee is US$10,000 and it involves multiple, long appointments and your patient would lose time from work. Do outside-the-mouth issues get in the way of case acceptance? Yes, they do. Does patient education make the unaffordable affordable? No, it does not. How do I know? You have proven it, have you not?

It is with the patient whose fee is greater than US$5,500 that we recommend an outside-in approach. Employing an outside-in approach involves initiating your new patient procedures with conversations—telephoning the new patient interview—that focus on understanding what is happening outside the patient’s mouth, such as significant life issues, budget and work obligations. Later in this article, I’ll show you how.

After we have an understanding of outside-the-mouth issues, we do our examination. Then, during the post-examination conversation and case presentation, we link our treatment recommendations to the realities of their outside-the-mouth issues. Let me show you how.

The flow of conversation starts with outside-the-mouth issues and ends with inside-the-mouth treatment recommendations. I label this an outside-in process (Fig. 2). An excellent example of an outside-in process is the purchase of a home. Imagine you and your spouse decide to buy a new house. You go to a real estate agent and, just a few minutes into the conversation, you talk about price range, neighbourhood, schools, proximity to work, financing and down payment. These are all big picture, outside-in concepts. It is with the patient whose mouth—the examination, diagnosis and treatment plan. It is after this inside look that we educate the patient with regard to all the procedures that we will do, how much she/he will be charged, and what we can do about them, for example, if the patient did not know about porcelain crowns. In our practice, we quote our fees and discuss financial arrangements. It is only once we have gone through our inside process that we discover what is happening outside the patient’s mouth, such as significant life issues. Once you settled on the broad outside-the-home issues then, and only then, does it make sense to begin discussing the inside-the-home issues, such as room size, carpet and tile selection, lighting, etc. Good estate agents discover what the suitability factors of home buying are (price, down payment, monthly payments, location, etc.) before they get into the inside details. In other words, the flow of conversation is outside-in. Now imagine you and your spouse go to the estate agent, but this time she is a former dentist and uses the traditional inside-out process she used as a dentist. As soon as you sit down she begins educating you on the inside-home issues— and where you want to live. What would you think? You would think about finding an other estate agent, would you not?

How many of your complex-care patients, after experiencing your inside-out process, find another dentist for the most likely reason that you spent a bunch of time educating them on inside-the-mouth details before you had any idea what was suitable for them? You educated them right out your door.

An outside-in process works best for complex-care patients. Here patient education is not the driver of case acceptance. This is why: first, patients with complex needs often come into your office with a specific complaint—embarrassment about their appearance, aggravation by their dentures or fear of losing their teeth. They do not need to be educated about their chief complaint. They may not be aware of all their conditions, but it is most likely that they have lived with the complaint that brought them into your office for a long time.

Next, many complex-care patients have heard the patient education lecture about plaque, pockets and sugar many times before. It’s old news and thus not a subject that distinguishes you. For many patients, patient education efforts bounce off like BBs fired at icebergs. Expecting to influence them into a US$10,000 treatment plan that does not fit into their budget by showing them how to floss well is naive.

Let me be clear at this point: we are going to spend some time on the patient education process with complex-care patients, it is just not one of the earlier influencers in my dental career emphasised that a significant part of being a good dentist is to get patients to change. Change the way they clean their teeth, change what they eat and alter the priorities in their life and put dental health at the top. It took me ten years and thousands of patients to realise that patients change when they are ready, not when I tell them to.

I learned to replace the concept of change with the concept of fit. Instead of telling patients they need to change to accommodate my treatment plan, I learned to accommodate my treatment plan to fit their life situation. Patients, especially the complex-care patients, have complex fit situations. These include finances, family hassles, work schedules, special current events, travel, stressors, health factors, significant emotional issues; in short, any issues dominating the patient’s energy and attention. When you present complex-care dentistry, it has to fit into the patient’s life.

Think about it. If you offer most patients a US$10,000 treatment plan, something in their life has to happen. People need time to wait for their tax refund, wait for a child to graduate from college, become
For the third year in a row, the DTSC hosts its annual CE Symposia at the GNYDM, offering four days of focused lectures in various areas of dentistry. Find us on the Exhibition Floor in Aisle 6000, Room # 3.

Each day will feature a variety of presentations on topics, which will be led by experts in that field. Participants will earn ADA CERP CE credits for each lecture they attend. DTSC is the official online education partner of GNYDM.

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SUNDAY, NOVEMBER 28
10:00 - 11:00 Howard Glazier, DDS, FAGD
BEAUTIFUL G7 WITH THE FLOW - COURSE: 3920
11:20 - 12:20 John Pock, DDS
LIGHT CURED ADHESIVE DENTISTRY - SCIENCE AND SUBSTANCE - COURSE: 3030
1:30 - 2:30 Martin Goldstein, DMD
A SIMPLIFIED APPROACH TO MULTI-LAYER DIRECT COMPOSITE BONDING - COURSE: 3040
2:40 - 3:40 Jay Reznick, DMD, MD
3D IMAGING AND CT-GUIDED DENTAL IMPLANT SURGERY - 3050
4:00 - 5:00 Louis Malamachar, DDS, MAGD
TOTAL FACIAL ESTHETICS FOR EVERY DENTAL PRACTICE - COURSE: 3060

MONDAY, NOVEMBER 29
10:00 - 11:00 Ms. Noel Kiwi-Kampf
ECO-FRIENDLY INFECTION CONTROL UNDERSTANDING THE BALANCE - COURSE: 4130
11:20 - 12:20 Gregory Kutzman, DDS
INTEGRATING NEW ADVANCES IN DENTAL MATERIALS AND TECHNIQUES INTO YOUR RESTORATIVE PRACTICE - COURSE: 4130
1:30 - 2:30 Damien Mirkar, DDS
OPTIMIZING YOUR PRACTICE WITH 3D CONE BEAM TECHNOLOGY - COURSE: 4140
2:40 - 3:40 Edward Katz, DDS
IMPROVING PATIENT CARE WITH 3D CONE BEAM COMPUTERIZED TOMOGRAPHY - COURSE: 4150
4:00 - 5:00 George Friedman, Fay Goldstein and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 4160

TUESDAY, NOVEMBER 30
10:00 - 11:00 George Friedman, Fay Goldstein and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 3110
11:20 - 12:20 Greg Diamond, DDS
LASERS IN PERIODONTAL THERAPY - COURSE: 5120
1:20 - 2:20 Dov Almog, DMD
INTRODUCTION TO CONE BEAM CT (CBCT), ESPECIALLY AS IT PERTAINS TO PREVENTION OF FAILURES IN ORAL IMPLANTOLOGY - COURSE: 5130
2:30 - 3:30 Maria Ryan, DDS, PhD
DETECTING CORONARY HEART THROUGH PERIODONTITIS AND PERIIMPLANTITIS - COURSE: 5140
4:00 - 5:00 Dwayne Keadle, DDS
CONTEMPORARY CONCEPTS IN TOOTH REPLACEMENT: PARADIGM SHIFT - COURSE: 5150

WEDNESDAY, DECEMBER 1
10:00 - 11:00 Mr. Al Dake
BEST MANAGEMENT PRACTICE, WASTE MANAGEMENT FOR THE DENTAL OFFICE, AND OSHA COMPLIANCE - COURSE: 6060
11:20 - 12:20 Glenn van As, DDS
HARD AND SOFT TISSUE LASERS - COURSE: 6070
12:45 - 1:45 Dr. Benoît Balthazar, Dr. David Hauser, Dr. Jeffrey Horwitz, Dr. Dwayne Keadle, Dr. Enrico Menzo, Dr. Ethan Pender
THE FIRST ANNUAL CSEB UNIVERSITY SUMMIT: IMPLANT DRIVEN DENTISTRY - COURSE: 6080

THIS PROGRAM IS SUBJECT TO CHANGE
I am very good at helping patients fit their dentistry into what is going on in their life."

Whether you are using an indirect fit-chat or a direct approach to discovering fit issues, I know I can help. What I do not know is whether this is the right time for you. You mentioned you travel a lot and your company is in the middle of a big re-organisation. Do you go abroad with your treatment now? Do we wait until later? Or do we do it over time? Help me understand how I can best fit your treatment into everything that is going on in your life."

This advocacy statement leads to a conversation about the patient's fit issues. This conversation reveals what treatment fits and what does not. You will find that this approach results in many complex-care patients doing their treatment over time, allowing them to stay within the limitations of their fit issues. This is a good thing. I would rather treat two patients for US$5,000 each than no patients for US$10,000. It also yields lifetime patients for you. Patients will exhibit fierce loyalty to you when they experience advocacy.

Discovering fit issues

Your team often knows what is going on in the patient's life. How do they know? They talk— they chat— with the patients and they make friends. Another purpose of chat-chat is to learn about those fit issues in your patient's life impacting their treatment decision. When chat-chat is intentional, I call it fit-chat—an indirect way of discovering patient fit issues.

When you fit-chat, be curious and listen more than talk. Listen to the manner in which patients spend their time and what is important to their life—health, money and/or family issues. If they mention something you believe may influence a treatment decision, be curious, listen attentively and encourage them to talk more about it. Through indirect fit-chat, you are going to discover what's going on in patients' lives.

Some patients do not fit-chat well. They are simply not talkers. I am that way. When I get my hair cut, the last thing I want is a chatty experience. When you have a complex-care patient who will not fit-chat, you can try a more direct approach to discovering fit issues.

An absolute prerequisite to a fruitful conversation is for you to have a connected communication style. This means you hold good eye contact, listen carefully and patiently; you maintain a conversational tone of voice and your speaking rate is relaxed. Be sure to pause long enough to let what you are saying sink in.

If you attempt to use a direct approach to fit issues but have a disconnected style (do not look at the patient in the eye, speak too quickly, do not listen attentively), your conversation may be perceived as being in an inappropriate, unprofessional and seeking to diagnose their pocketbook snarkily.

Advocacy

Advocacy is the experience of patients when they realise that you are guiding them towards and not selling them into a disconnected style (do not look at the patient in the eye, speak too quickly, do not listen attentively), your conversion may be perceived as being in an inappropriate, unprofessional and seeking to diagnose their pocketbook snarkily.

Here is an example of a direct approach: "Kevin, I know from the line of work you are in that you are busy and travel quite a bit. I also know you are aggravated by food trapping around your lower partial dentures. Let's talk about your choices and how we can best fit your dentistry into what is going on in your life. Is now a good time to talk about this?"

Here is another example of a direct approach: "Kevin, most people like you are busy, on-the-go and have lots of irons in the fire. I need to know if any of these irons are affecting the amount of stress you are under, the amount of time you can spend here with us, or if there are financial issues I need to consider when planning your care. I want to reassure you that dental health. To be an advocate is to be a guide. To guide patients into complex care effectively you need to take the fit circumstances of their life into account."

The conference will feature the most up-to-date information on the diagnosis and treatments available from international experts including:

- Renowned Dental Personality, Prof Hasser Bagha, Winner and Head of Dentist - Esthetic Dentistry, University of Texas, San Antonio, USA
- Diplomat of the American Board of Oral Medicine, Prof Juan Yepes, Associate Professor and Director of Radiology, University of Kentucky, USA
- Award Winner: Excellence in Dental Education, Prof Patrick Reynolds, University of Florida Dentistry - Dental Institute, Gainesville, USA
- Member of the American Academy of Oral Medicine, Prof E. J. Ackerman, Director of Oral Medicine, Michigan, USA
- Winner of the Dental Academy of Oral Medicine, Prof N. C. Brown, Director of Oral Medicine, Michigan, USA

"Kevin, now that I have looked at your teeth, I know I can help you. We treat many patients like you with partial dentures that do not work well.

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