Dear reader,

There has been a major outcry after my last editorial was released and I have to admit that I expected this due to the mixed reactions that overseas dental work usually evokes among many dental professionals. Offshore production might have become a major business in Asia, however, it is not definitely one that most people involved are happy to speak about.

Regarding the fact that most of my readers are from countries where these products are made, I do not have to stress how much impact this development had where these products are made, of my readers are from countries I expected this due to the mixed shift between regulators, den-

The market cries out for the primary cause of tooth decay is not refined sugar—it’s acid.

I was shocked to see an article in DT Asia Pacific recently about a study at Harvard actually recommending that people apply strongly acidic things to their teeth to whiten them. Lemon juice will certainly whiten teeth, but it does this by demineralising the enamel. How many of you have seen teenagers with white hands around their front teeth at the gin-gival line? The enamel is white, all right, but they are well on their way to rampant decay problems.

I have seen hundreds of pa-tients with severe decay. But after eliminating the acidic things from their diets (primarily pop), decay isn’t nearly as much of a problem. And, these people often have acid reflux issues. Hydrochloric acid from the stomach causes the same damage that phosphoric acid in pop does.

If you want to really help your decay-prone patients, there are a few things you can do. First, have them eliminate all acidic things from their daily diet, such as pop, lemons, grapefruit, sour candies or chewable vitamin C. Show them a method of ﬂossing that’s really effective (under the gum) and have them buy and brush with Mylanta or Maalox a few times a day to neutralise acid. Finally, chewing gum or Maalox a few times a day to neutralise acid because it increases salivary flow.

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To the Editor

Re: Editorial “Digital technology does not make better dentists” (Dental Tribune Asia Pacific No. 1-2, Vol. 8, page 4)

Technology may make an ethical, competent dentist better, but it will not make a “fast food/Pennies/Hasbipay” prac-tice perform clinically better. I am op-posed to the use of technology as a marketing tool without the ability of the clinician to perform in the first place. Technology is wonderful, but it does not substitute for clinical quality.

Dr. James Craig, USA

Re: Editorial “And the battle goes on…” (Dental Tribune Asia Pacific No. 10, Vol. 7, page 4)

Root canals and implants are not in-terchangeable procedures. Case selec-tion is paramount for successful pro-gnosis for both endodontic treatment and implants. According to Dr Carl Misch in his text Contemporary Implant Dentistry, there are 17 reasons alone for NOT re-placing a mandibular second molar with an implant. While an implant would most likely osseointegrate, it does not guarantee long-term success once re-stored and placed in function, parti-cularly in the posterior maxilla.

It is a given that a case focused on aesthetics as the expense of function is not in a patient’s best interest and will have a poor prognosis long term. And, an implant certainly does not guarantee better aesthetics in comparison to a tooth. Not every tooth can or should be saved. However, not every tooth should be extracted. The assumption that an implant is better.

An increasing number of endodon-tists are gaining extensive continuing edu-cation in the ﬁeld of implantology. These clinicians will be the best resource for me-toring in which procedure should be done in each individual situation. If the dental community as a whole continues to hold a cavalier attitude about extracting teeth that can be saved, it is the patients who will lose this battle, not the endodontists.

Lisa P. Germain, USA

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