Prof. Ivo Krejci recommends an approach to caries prevention that is focused on lifelong dental coaching. (Photograph: Ivo Krejci)

Interview: “Prevention is not just for children and young people”

By DTI

Three years ago, Professor of Cariology and Endodontontology Ivo Krejci from the University of Geneva, Switzerland, published an article in which he made the case that professional motivation, instruction and check-ups, as well as precise, non-invasive therapies, should be the core competence of a practice team in order to maintain oral health. Dental Tribune International spoke with him about his assertions.

Prof. Krejci, what is your main message when it comes to modern caries prophylaxis?

The aim of modern dentistry is not only to treat and repair heavy clinical symptoms in the form of large decaying lesions and deep periodontal pockets, but rather the lifelong dental health of the population, which I define as the absence of clinical symptoms. My article focused on one aspect of this concept, namely the causes, symptoms and treatment of caries, a chronic lifelong infection of the biofilm, the clinical symptoms of which, in the form of decaying lesions, are still some of the most common reasons for extractions. I am aware that I am speaking against the common teaching opinion, which treats caries and periodontitis as non-communicable diseases, but it would be too much for this interview to explain the reasons for this stance in detail.

Besides increasingly criticised fluoridation, bioavailable calcium, acid neutralisation and harmless sugar substitutes can be identified as important factors in preventing caries symptoms in so far as the patient doesn’t want to curb excess sugar consumption. Three further measures are at least just as important: firstly, early diagnosis of the initial caries, secondly, the lifelong, periodic professional motivation, instruction and monitoring of an efficient, atraumatic home dental care routine in the sense of primary prevention; and thirdly, the use of non-invasive adhesive composite restoration to stop or at least delay subclinical caries symptoms in the sense of secondary prophylaxis. Direct and indirect restorations complement this philosophy in patients entering into this concept with existing large decaying lesions or with existing restorations.

Why do we still separate periodontitis prophylaxis and caries prophylaxis?

It’s difficult to say, as both problems have to do with immunology and a...
pathogenic biofilm. This separation makes no sense at all. We should always speak of simultaneous caries and periodontitis prophylaxis, not of separate problems. Depending on the individual patient’s situation, the focus may be more on caries and/or periodontitis prophylaxis, but it should never be forgotten that a lifelong prevention-oriented concept should take not just caries and periodontitis into account, but also erosion, abrasion, trauma, dental misalignment and infection.

You mentioned pathogenic biofilm. What do you recommend: completely remove or disrupt the biofilm? The biofilm actually protects our teeth, so is vital for survival. Its permanent removal from the mouth would therefore be counterproductive. Through its currently unpreventable infection with bacteria that cause caries and periodontitis, it becomes potentially pathogenic. This pathogenicity can only develop if two conditions are present: firstly, the biofilm must be sufficiently structured, which requires around 24 to 48 hours after its formation, and secondly, certain parameters must be present. An example of this is the repeated excess of sugar in the cavity ingress. These deductions form the basis of the preventative concept: we accept the infection and potentially pathogenic biofilm and do not remove it permanently from the mouth. We accept the conditions—for example, through a drastic reduction in sugar consumption—would be very welcome, but difficult to implement in the long term in practice. We therefore approach the structure of the biofilm and prevent its pathogenicity from developing. The solution is simple: we just have to regularly, that is every 24 hours, disrupt the structure of the biofilm intensively on all surfaces of the tooth. Chemicals and medications don't help a great deal, as the biofilm has very potent defensive mechanisms.

In your article, you spoke about lifelong dental coaching. What do you mean by that? Prevention is not just for children and young people. As caries and periodontitis are lifelong infections and decayed lesions, periodontal pockets, erosion, abrasions, trauma and dental infections can arise at any age, lifelong prophylaxis is unavoidable. This lifelong dental coaching is based on the preventative measures already mentioned, complemented by regular professional monitoring with high-tech diagnostics to catch symptoms in the subclinical stage, thereby allowing non-invasive therapy where needed.

Therapy, diagnostics, prevention—what are your concrete recommendations? We must be sufficiently well informed enough how much of a risk a patient has of developing symptoms in the form of decaying lesions or periodontal pockets. It is even more difficult to do this for specific areas of the mouth, and even if we could, things can change at any time. The risk of too little or too much prevention on the wrong tooth surface is therefore very high. This applies to erosions, abrasions and infections in the same way. That’s why it is more efficient to wait for symptoms to develop, providing site-specific risk information. However, if we wait long enough for the symptoms to be clinically visible, it’s already too late and we fall back onaska the patient and inform, educate and monitor him or her as needed. As dental professionals, we have to know that caries and periodontitis prophylaxis, which aims to halt symptoms non-invasively in the early stages so that they do not become more clinically serious. Non-invasive secondary prevention seems to me the tool of choice for our current circumstances and the resources we have available today.

What role does individual home oral hygiene play in caries prophylaxis in your opinion? Individual home oral care by the patient is the most important aspect for me. It might sound presumptuous, but many people can’t brush and don’t know which tools, products and techniques are the best and most efficient for their individual situations. I am convinced that oral care at home can only have a long-term effect when it is overseen by a dental professional. This professional cannot heal the patient, and it wouldn’t make sense for the professional to perfectly remove the patient’s biofilm each day. This would require that the patient come to the practice every day. Even if he or she could afford this, it would lead to public transport chaos and would make very little sense. Therefore, it

Emirates – Kenya outreach success

By EIDHC

In August 2018, Emirates Dental Hygienists, Dentists and Faircare, an initiative by Goughbook, partnered to deploy a team of dental professionals and a general volunteer to Atiog in Kenya. The group was led by Rachael England, President of the EIDHC Faircare in Dubai-based organisation that provides dental care to low income workers for just 15% of the usual cost, ensuring equitable access to quality dental care.

England had previously visited Atiog in 2015, when she realized a dental hygienist service and gave oral health lessons, while a team of dentists carried out basic restorative treatment and pain relieving extractions. This time, with the support of an amazing team of 17 volunteers from four countries, they planned to go a step further and establish an ongoing service.

Following one missed flight, two cancelled flights, a brief struggle to import 2000 toothbrushes and 2000 tubes of toothpaste and a bone shattering 6-hour bus ride, the team finally met in Atiog in Kenya, where they set up the mobile dental clinic within the village medical centre.

Stainless and cross infection can be an issue in developing countries when carrying out humanitarian work, but careful planning by Hygiene Tribunewas well prepared with an entire decon- tamination process and two presencess of the team were carried out dental screen- ments for the local school children, preventative treatment and prophylaxis scaling. Abdalla and Ravena also held fun and interactive oral health lessons for groups of children, where they sang and learned about toothbrushing and healthy snacks. Patients often request cleaning to remove the brown stains seen frequently in the Mara, however this discolouration is due to the high levels of dust and particles found in the ground water. Despite community efforts, filters to remove such high concentrations are expensive to maintain and following generations continue to be afflicted with severe fluorosis.

In the main surgery: patients were triaged by dental hygienists Karina Carniato and Stephanie Gardner who used their full skills sets to assess and anaesthetise patients ready for dental therapist Made- lyn Tanzer and dentist Dr Tamar Taitie. Taitie carried out basic restorative care and extractions. Dr Taitie’s
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Disease

Dr. Parveen Jones, Australia
Sitting is a Health Hazard
for the Dental Team: How the Dental
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Dr. Nadia Moth, Australia
Oral Facial Pain

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Dental Assisting Course,
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Dr. Jamshed and Zohra meet the Maasai Chief and his son

Lisa Hicks registers patients visiting the dental clinic

Lisa Hicks registers patients visiting the dental clinic

Dr. Jamshed works in the background assisted by kannatu, Hadli triages a patient with analgesic assisted by Stephany

Mariana and Shamin carry out dental hygiene treatment, buckets become spittoons!

Enalati Hotel staff and the team

wife, Zohra oversaw the surgery, tracking the treatments that had been carried out and helping with patient care.

Outside, the general volunteer Lisa Hicks registered patients and created a basic filing system to ensure future expeditions have patient treatment records. Four local young men were recruited to assist in translation and clinic organisation, one of whom, Delama, had been both deaf and mute since childhood when he contracted an illness, yet the whole community were able to do sign language with him.

The first day in clinic went smooth-ly as word spread throughout the community that a dental team was in town. The local host, Simi ensured the welfare of the team and also managed to secure hotel accommodation—an upgrade from the expected campsite.

It was not all work and no play for the team. Sunday, Wednesday and Thursday were spent in the Maasai Mara National Park, where they were lucky enough to see elephants, lions, leopards, buffalo and chen- tahan amongst the spectacular scenery inhabited by these incredible animals. They were also welcomed by the village elder at a local Man-yatta (Maasai village) with tradi-tional singing and dancing. Maasai are great pastoralists, living semi-nomadic lives that have remained unchanged for hundreds of years. They are easily recognised by their colourful clothes, elaborate beaded jewellry, stretched earlobes and removal of the lower central incisors. Their diet mostly consists of milk, meat, vegetables and maize, leading to low rates of dental caries and virtually no heart disease!

Monday and Tuesday were long days in the clinic, working from 08:30 to the last light of the day although it was school holidays, the local Head Teacher, Mr. Ndaraai Durma, had arranged for local chil-dren to return for the day to have a dental screening and any treatment needed. Fortunately, about 150 children made the trip back, who then in a huge surprise performed songs for the team.

Many children live at the school to avoid the perilous walk across the Mara to reach their lessons. Fac-ilites are basic, but clean and safe with wonderful, enthusiastic teach-ers. England and the team will be working with the school in future to ensure more children are able to receive an education that costs $20 per month—insurmountable to many families who wanted their children to stay in school throughout their school holidays, yet the whole community were able to do sign language with him.

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Evaluation of an ex vivo porcine model to investigate the effect of low abrasive airpolishing

By Gregor Peterikia, Ralph Heckel, Raphael Koch, Benjamin Emke, Nicole Arweiler

**Aim**
To assess the usability of pig jaws periodontal treatment model for low abrasive airpolishing and to histologically gauge the effect of various instrumentation techniques.

**Material and methods**
- From 150 Pig mandibles, the buccal part of one molar was chosen randomly and fixed in a way allowing controlled instrumentation.
- 5 modes of instrumentation were evaluated
- **Group A:** Low Abrasive airpolishing using glycine of 25 μm (EMS Perio Powder, EMS, Nyon, Switzerland)
- **Group B:** Low Abrasive airpolishing using erythritol powder of 34 μm (EMS PLD5 Powder, EMS, Nyon, Switzerland)
- **Group C:** Panoramic scaling using Perio Slim FS instrument (EMS) - EMS Perion Master was used at medium power and water setting.
- **Group D:** 7/8 Gracey Curette (Deppeler, Rolle, Switzerland)
- **Group E:** Untreated biopsy samples served as negative control

**Results**
- Hand instrumentation had the most pronounced damage
- Hand instrumentation and ultrasonic scaling caused higher tissue destruction than both airpolishing powders
- Ultrasoundics was slightly less traumatic than hand instrumentation with no statistically significant difference
- Between the low abrasive airpolishing powders, glycine showed slightly lesser destruction, however, no statistically significant difference was observed between glycine and erythritol
- The porcine model is apt for use in histological evaluation

**Conclusions**
- Pig jaws could be used to assess the histological effects of different instrumentation on periodontal tissues before conducting studies on humans.
- Low abrasive airpolishing powders had an overall low potential of soft tissue damage and could be used safely to remove biofilm subgingivally.

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Sitting is a health hazard – an innovative way for the dental team to avoid workplace problems

**By Dr. Penelope Jones, Australia**

We have known for years that dental offices face a general problem. Millions have been spent trying to address this problem, yet the literature is still full of articles confirming, ‘Sitting for long periods increases your risk of cardiovascular disease, diabetes and even cancer’.

Recently, many have been made by members of the dental team by increasing their fitness levels and making a point of moving around as often as they can during the day.

Unfortunately, the basic problem has not been properly addressed. The problem, as expressed by Dr. Penelope Jones of the ‘Working Posture’ programme is, how we sit. Jones has been helping people turn this around successfully for over 25 years.

Have you ever noticed what happens when you concentrate, need to perform intricate work or even just deal with a stressful situation? You tend to reduce your breathing. You are unaware of it, and as time goes on, your breathing muscles (intercostal muscles and diaphragm) become tighter. As you can imagine, doing this every day is eventually going to lead to tighter and tighter muscles and a more rigid chest. Our other unconscious responses to stress are raised shoulders (part of our natural startle reflex) and shortening our posture at the front of our body part of the reaction to protect ourselves from emotional stress. At the end of the day so many muscles that are not needed to perform our work are chronically tight and we feel “uptight”. No surprises there.

These tight muscles are sabotaging our comfort, and we are completely unaware of how it impacts us. We rest and do exercises and the tightness relaxes slightly, but in root cases the muscles never completely relax, so it is almost as if we are wearing a neurological strait jacket, even when we sleep.

Dr. Jones has been teaching her unique workshops for almost 30 years, both in Australia and internationally. Her workshop has helped people to prevent and recover from workplace injuries caused by chronic poor sitting at work.

Working Posture uses easy gentle movement lessons along with good breathing techniques to allow you to unwind your old muscular tension and learn to align yourself with far better form. You will learn how to find good balance with strength as well as greater flexibility for the fine work of dentistry. It is easier and more enjoyable than you would imagine and does not involve strenuous exercise.

Dr. Jones has restored many a dental career. She is an international speaker and has been teaching in the faculty for over 20 years.

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Interview: “BlueM supports the body’s own healing process”

By Franziska Beier, DTI

Dental Tribune Middle East & Africa Edition  |  5/2018

Awareness of the importance of oral care during pregnancy has been increasing, and this is also apparent in the dental products available today. Dutch company BlueM, for example, offers an oral care range that is safe for pregnant women and children. Denise Leusink, oral health adviser at BlueM, spoke to Dental Tribune International about the background behind development of the BlueM line, its effects on oral health and particular concerns for pregnant women regarding oral care.

Ms Leusink, the founding of the BlueM brand was somewhat of a coincidence arising from Fokke Jan Middendorp sustaining an injury during a hockey game. Can you elaborate on this story?

Ha, I love this story! Fokke Jan is a former international hockey player and one day was injured during a game. Dr Peter Blijdorp, a maxillofacial surgeon, was watching the game. He came to Fokke Jan and asked him if he could apply a gel on his knee to relieve the pain. It turned out that Peter was determined to achieve a new and different way of practising dentistry—not one that was unhealthy or aggressive, but one that was gentle on the body. All he wanted for his patients was minimally invasive surgery, meaning a minimal amount of pain and the fastest recovery possible. During his quest, he discovered the power and beneficial effect of oxygen and developed a gel based on oxygen that accelerated wound healing. Fokke Jan was so enthusiastic that he wanted to help Peter and together they started BlueM. The first product they launched was the oral gel, which is the perfected version of Peter’s oxygen gel.

What was it that motivated you and your team to develop the BlueM product line?

BlueM is different from other oral care brands. Peter wanted to make a difference for his patients and help as many people as possible with body-friendly solutions. The realisation of Peter’s dream is what drives us as the BlueM team. We receive many, many stories from BlueM users from all around the world and we are constantly impressed by the remarkable, almost magical results. It is both exciting and humbling and as a team we feel grateful to continue on the journey started by our founder.

What active agents do the products contain and how do they work?

The basis of BlueM is sodium perborate, honey, xylitol and lactoferrin. Sodium perborate slowly releases a body-friendly amount of active oxygen. Oxygen plays a key role in wound healing because it accelerates the wound healing process. Active oxygen kills anaerobic bacteria, which are the cause of most oral problems. Honey is a carrier of oxygen and has many antibacterial functions. Xylitol stimulates salivary flow, helps remineralisation and kills Streptococcus mutans. Last but not least is lactoferrin, an immune-boosting protein that stimulates bone regrowth.

Does BlueM toothpaste contain fluoride?

We have two toothpastes: one without fluoride and one with 1,000 ppm calcium fluoride. When BlueM started, we focused on patients with implants. Fluoride corrodes the titanium surface layer of implants, which means that one should rather use fluoride-free toothpaste. Since many people without implants are using our products nowadays and dental professionals asked for a fluoride toothpaste, we created one.

Does the toothpaste contain sugar because of the added honey?

The sugar in the biological, cold-extracted honey is converted into water and oxygen when it comes into contact with liquids. The catalyst in this process is called glucose oxidase. The sugar in honey is completely converted, which means there is no risk of caries.

Why is this product suitable for pregnant women?

BlueM supports the body’s own healing process. Because of the products’ natural effects, they are suitable for long-term use. Other products, which are mostly chemical, can only be used for a short period. Blue m products are safe for children and pregnant women.

Gain a child, lose a tooth—truth or myth?

It is true that many women develop caries after their pregnancy. During pregnancy, there are many changes: fluctuating levels of calcium and magnesium, altered nutrition resulting from consuming more snacks, hormone fluctuations and even less time for oral hygiene. All these external factors can lead to caries. Therefore, I believe it to be a myth because the development of caries is caused by many factors beyond pregnancy.

Periodontitis is associated with systemic diseases such as diabetes and heart disease. What adverse consequences of this correlation might be of particular concern for pregnant women?

Periodontitis causes an increase in the prostaglandin level, which induces contraction of the vessels. Studies show that women with periodontitis have a two to seven times greater chance of preterm birth due to this high level of prostaglandin. It also works the other way around: treatment of periodontitis can reduce the chance of preterm birth.

That is why it is so important to be aware of the effects of your oral health when you are pregnant.

Why is the topic of oral care in pregnant women not as widely discussed as it should be?

I think that many midwives are not aware of the risk of poor oral health for the unborn child, as it is not part of their protocol. Luckily, I see that more and more pregnant women are being referred to dental hygienists by their midwives. This is a good thing and I believe that this inter-professional cooperation should become part of the protocol. I truly hope this awareness grows in the future.

What oral hygiene measures do you recommend to pregnant women?

Make sure that you do not have gingival bleeding! So, brush twice a day and use toothpicks or interdental brushes on a daily basis. Especially during the second trimester, prevalence of gingivitis and anaerobic bacteria increases. That makes it even more important to work on your oral hygiene. The BlueM products can be a great addition to your routine.

Does BlueM have a unique position on the dental market because it specifically offers oral health products for pregnant women?

BlueM products have not been specifically developed for pregnant women, but it is true that the products are safe to use during pregnancy, in contrast to many other oral health products.

Do you recommend the use of BlueM also for non-pregnant women?

BlueM products have a wide range of use. We see that blue m is most commonly used by people with implants, periodontal problems or oral wounds. Since it accelerates wound healing, it has many indications. For example, the elderly use our oral foam to take care of their gingiva and clean their dentures. Our oxygen fluid is often used by cancer patients to support wound healing after thermo- or radiotherapy.

What sets BlueM apart from other products?

BlueM supports the body’s own healing process. That is unique oral care.

Where is the product available and how much does it cost?

BlueM is promoted by top dental professionals in more than 40 countries. You can buy it online, in various clinics and in many pharmacies. We have distributors worldwide; for an overview, see our website https://www.bluemcare.com/international-distribution/. The price ranges from €5.95 for a mouth spray to €24.95 for the oxygen fluid, which is a medical product.

Thank you very much for the interview.
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