Popular Energy Drinks Cause Tooth Erosion

For more than 10 years, energy drinks in the United States have been on the rise, promising consumers more "oomph" in their day. In fact, it is estimated that the energy drink market will hit $10 billion by 2010. While that may be great news for energy drink companies, it could mean a different story for the oral health of consumers who sometimes rely daily on these drinks for that extra boost.

Previous scientific research findings have helped to warn consumers that the pH (potential of hydrogen) levels in beverages such as soda could lead to tooth erosion, the breakdown of tooth structure caused by the effect of acid on the teeth that leads to decay. The studies revealed that, whether diet or regular, ice tea or root beer, the acidity level in popular beverages that consumers drink every day contributes to the erosion of enamel.

However, in a recent study that appears in the November/December 2007 issue of General Dentistry, the Academy of General Dentistry’s (AGD) clinical, peer reviewed journal, the pH level of soft drinks isn’t the only factor that causes dental erosion. A beverage’s "buffering capacity," or the ability to neutralize acid, plays a significant role in the cause of dental erosion.

The study examined the acid levels of five popular beverages on the market. The results showed that popular "high energy" and sports drinks had the highest mean buffering capacity, resulting in the strongest potential for erosion of enamel.

According to the study, the popularity of energy drinks is on the rise, especially among adolescents and young adults. Their permanent teeth are more susceptible to acid found in soft drinks, due to the porous quality of their immature tooth enamel. As a result, there is high potential for erosion among this age demographic to increase.

In fact, Raymond Martin, DDS, MAGD, AGD spokesperson, says he treats more patients in their teens to 20s for tooth erosion. "They drink a great deal more sodas, sports drinks, and energy drinks," he says. "The results, if not treated early and if extensive, can lead to very severe dental issues that would require full mouth rehabilitation to correct," says Dr. Martin.

He found his team through the Yellow Pages, scanning over 500 letters asking for volunteers to treat asylum seekers unable to obtain medical benefits. Twenty doctors - GPs and specialists - replied. He sent 600 letters to dentists, and heard back from 16.

"I met a family who have been like this [without access to free medical care] for the last seven years," he said. Yet Dr Barnouti is not shocked.

"When you are there [in Iraq] and see the ‘91 war you think being seven years here without medical care is nothing, I have seen much worse things," he said. He was in the United Arab Emirates during the 2005 bombardment of Baghdad.

Dr Dawood Haddad, 47, who practices in Fairfield, was one of the first GPs to sign up for the scheme. "A lot of my patients come from refugee countries," he said. "I know how much suffering they have been through."

"I don’t want them to have more suffering" by depriving them of very basic health needs. Taking one patient out of 50 without charging is no big deal." He has one or two pro bono families on his books at any time.

Nicole Cunningham, the Red Cross’s refugee services co-ordinator, said that the program was in making health care accessible.

"I am focused on early intervention rather than crisis intervention," she said. "I have met asylum seekers with very advanced stages of cancer and wondered what if we had treated them earlier." Ms Cunningham said the Red Cross program provided $140 a month to asylum seekers who did not qualify for government assistance.

She said the most common reason they did not qualify was that they had not applied for asylum within 45 days of arriving in Australia.

Dr Barnouti gets the Yellow Pages again, this time to write to pharmacy, biology and pathology companies, because after diagnosis, the patients are unable to pay for the prescription or tests.

"Drug companies will spend $10,000 on one lunch for doctors, to show them new products," she said. "They can afford to help."

"Dr Haddad backed the campaign. Most of the things needed, such as antibiotics, were not sophisticated, he said.

Barnouti said. "They can afford to treat them earlier."

"In theory," he added, "their hypotheses may be valid. For example, the odor-causing species may have been replaced by some 'good' species in the yogurt."

Researchers collected samples from the participants’ saliva and tongue coatings, and measured volatile sulfide compound concentrations in the air of people’s mouths. Those measures showed that, at six weeks, hydrogen sulfide levels decreased in 80 percent of volunteers who had bad breath. "So we thought two yogurts per day did work for improving (bad breath)," Maeda said.

In addition, plaque and gingivitis were significantly reduced in people with bad breath after the yogurt-intake phase of the study, compared with the initial phase when they did not consume yogurt. However, the authors said there were no noteworthy differences in the number of oral bacteria in the mouths of people before and after eating yogurt.

Bruce J. Foster, senior staff member in the department of molecular genetics at The Forsyth Institute in Boston, suggested the authors may have looked for all the bacteria that were present. "Typically, the bacterial microbiota has only been replaced by some ‘good’ species in the yogurt."

Research participants consumed yogurt made especially for the study, but it may be replaced by other yogurts, the starter culture "In theory," he added, "their hypotheses may be valid. For example, the odor-causing species may have been replaced by some ‘good’ species in the yogurt."

Research participants consumed yogurt made especially for the study, but it may be replaced by other yogurts, the starter culture consisted of a combination of Streptococcus thermophilus and Lactobacillus bulgaricus. What differed was the strain of bacteria they used, she said.

The yogurt maker that helped fund the study hopes to make its product commercially available this fall, she added.

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Medications Plus Dental Materials May Equal Infection for Diabetic Patients

People who live with diabetes on a daily basis are usually instructed to eat right, maintain regular physical activity, and if necessary, take medication. What many may not know is that these medications that help control healthy insulin levels may lead to unexpected events at the dentist’s office. According to a study in the November/December 2007 issue of General Dentistry, the AGD’s clinical, peer-reviewed journal, diabetic patients especially need to communicate special needs to their dentists. This is due to harmful interactions that could occur because of the materials and medications used at dental appointments.

According to the study, more than 184 million people worldwide have diabetes, and health officials estimate that this figure will double or triple in less than 20 years. “It is imperative that diabetic patients inform their dentist of their needs in order to anticipate medication interactions and physical reactions to treatment,” says Lee Shackelford, DDS, FAGD, spokesperson for the AGD. “The doctor must know if the patient is taking insulin, and has taken their daily dose of insulin, in order to anticipate the length of the appointment.”

Teen teeth bleaching

Girls and boys alike, from elementary to high school, are bleaching their teeth.

“Kids are under a lot of pressure, as adults are, to look good, to have white teeth,” says Dentist Dr. David Carroll.

“White teeth just pretty much make everyone seem more attractive. Even if you have straight teeth and they’re yellow they’re still not that nice,” says Patient Taryn Barg.

Don’t be blinded by the white. Dentists warn that children’s teeth aren’t fully developed. Bleaching can make them overly translucent and trigger tooth and gum sensitivity.

“If I ate certain food it would just kind of tingle and it didn’t feel too good,” says Barg.

“There could be extreme tooth sensitivity if it’s used improperly, if it’s kept on the teeth for too long, and if the directions are not followed closely,” says Carroll.

That should be a red flag to parents who may not know their child is using a tooth whitener.

“If the child all of a sudden can’t drink cold water or can’t eat ice cream for some reason that might be an indication that they have started using some of these products,” says Carroll.

To avoid problems, kids who want whiter teeth should see a dentist before starting the bleaching process.

“Get a thorough examination, find out why, what is the cause of discoloration of the teeth. There’s nothing wrong with over the counter methods if they’re done in cooperation with the dentist and if they’re supervised by an adult,” says Carroll.

Taryn admits she’s addicted

“You just like glow kind of, just makes everything about you look nicer,” she says.

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Are graduates of dental school ready for the reality of practicing dentistry? Four out of five dentists don’t think so, according to a survey by The Wealthy Dentist, citing a lack of business savvy and little knowledge of dental practice management.

Many feel that dental school must also fill the role of business school. “Dental school needs really good business courses to help students get started in practice, even if they are going into an employment situation,” opined a Tennessee dentist.

But is business training really within the scope of dental school? “Today’s graduates are not prepared to start a business, but neither were we. Business sense is hard to get in a classroom setting,” observed a North Carolina dentist. “It’s like preparing for parenting: how do you know when you’re ready?”

Though dental technology has advanced rapidly, it’s not clear that dental education has followed. “It has not changed enough in at least the last 25 years. Clinically, dental students have just enough knowledge and experience to provide basic care and hopefully will understand that they need to continue to learn and develop their capabilities,” wrote an Illinois dentist. “There should be some basic business requirement in the pre-dental education, but I don’t see that there is room in dental school to cover this (running a business) in any but the most cursory way.”

Doing well in dental school is no guarantee that a student will become a good clinician. “Dental school prepares you for your board exams, not the real world of dentistry,” commented a New Jersey dentist. “Academically graduates are over-prepared, and clinically they tend to be under-prepared,” agreed a general dentist from Missouri

Of course, some feel that dental schools provide an excellent education. “Dental school has tried to address issues of practice management, dental insurance issues, and advanced restorative techniques including implants and periodontal surgery,” said a Pennsylvania periodontist. One Michigan dentist reported being disappointed by his young associates. “I have gone through a few associates. I have a high-tech, high-end practice, and I try to show them all the tricks. They are not only clueless, but they don’t even try—poor confidence level out of school. They want to make the money but they don’t want to work the hours or try to learn the communication and practical skills that today’s public demands... I think that in the future I’m going to charge a training fee.”

“Dental schools might be great, but they’re notoriously bad at addressing business issues,” said Jim Du Molin, dental management consultant and founder of The Wealthy Dentist. “Students learn lots of science and very little about practice management. But how can graduates expect to practice dentistry if they can’t run a dental practice?”

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